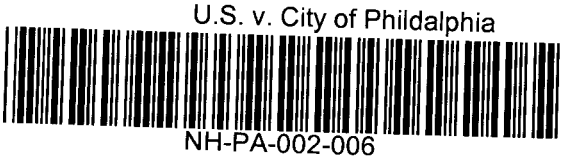

UNITED STATES OF AMERICA V. CITY OF PHILADELPHIA, ET AL.

Settlement Agreement Exhibits

1. HHS Regulations and Guidelines
2. Interdisciplinary Environmental Rounds Process
3. Resident Accountability
4. Behavioral Unit, Adult Unit, Dementia Unit
5. MDS/RAP: The Resident Assessment Instrument
6. Interdisciplinary Resident Plan of Care
7. Assessment of Resident with Acute Mental Status Change or Suspected Intoxication
8. Mental Health Services
9. Medical Services
10. Verbal Order Policy
11. Twenty-Four Hour Report Form
12. Medication Procedures
13. Resident Medication Refusal
14. Narcotic and Barbiturate Count Procedure
15. Skin Assessment (Routine Skin Care Prevention Protocols, Incontinence Protocol)
16. Wound Assessment (Wound Staging Process)
17. Skin Care Guidelines
18. Braden Scale
19. Pressure Ulcer Treatment Guidelines
20. Medical Nutrition Therapy for Residents with Pressure Ulcers
21. Aseptic Technique
22. Resident Call Bell
23. Provision of Fresh Water
24. Meal Delivery System
25. Meal Consumption Record
26. Resident's Weight
27. Nutritional Assessments
28. Restorative Dining Program
29. Dysphagia Team
30. Gastrostomy (Peg) Tube Feeding
31. Enteral Feedings
32. Weaning from Enteral Feedings
33. Tuberculosis Skin Testing Program
34. Rehabilitation Services
35. Medical Records

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F150	§483.5 Definitions. For purposes of this subpart-- "Facility" means, a skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of sections 1819 or 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution specified in §440.40 of this chapter, but does not include an institution for the mentally retarded or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution. For Medicare, a SNF (see section 1819(a)(1)), and for Medicaid, a NF (see section 1919(a)(1)) may not be an institution for mental diseases as defined in §435.1009.	Guidelines: §483.5 The following are the statutory definitions at §§1819(a) and 1919(a) of the Social Security Act (the Act) for a SNF and a NF: "Skilled nursing facility" is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(l)) with one or more hospitals having agreements in effect under §1866; and meets the requirements for a SNF described in subsections (b), (c), and (d) of this section. "Nursing facility" is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(l)) with one or more hospitals having agreements in effect under §1866; and meets the requirements for a NF described in subsections (b), (c), and (d) of this section. If a provider does not meet one of these definitions, it cannot be certified for participation in the Medicare and/or Medicaid programs. NOTE: IF THE SURVEY TEAM FINDS SUBSTANDARD CARE IN §§483.13, 483.15, OR 483.25, FOLLOW THE INSTRUCTIONS FOR PARTIAL EXTENDED OR EXTENDED SURVEYS.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	§483.10 Resident rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:	Guidelines: §483.10 All residents in long term care facilities have rights guaranteed to them under Federal and State law. Requirements concerning resident rights are specified in §§483.10, 483.12, 483.13, and 483.15. Section 483.10 is intended to lay the foundation for the remaining resident's rights requirements which cover more specific areas. These rights include the resident's right to: o Exercise his or her rights (§483.10(a)); o Be informed about what rights and responsibilities he or she has (§483.10(b)); o If he or she wishes, have the facility manage his personal funds (§483.10( )); o Choose a physician and treatment and participate in decisions and care planning (§483.10(d)); o Privacy and confidentiality (§483.10(e)); o Voice grievances and have the facility respond to those grievances (§483.10(f)); o Examine survey results (§483.10(g)); o Work or not work (§483.10(h)); o Privacy in sending and receiving mail (§483.10(i)); o Visit and be visited by others from outside the facility (§483.10(j)); o Use a telephone in privacy (§483.10(k)); o Retain and use personal possessions (§483.10(l)) to the maximum extent that space and safety permit; o Share a room with a spouse, if that is mutually agreeable (§483.10(m)); o Self-administer medication, if the interdisciplinary care planning team determines it is safe (§483.10(n)); and o Refuse a transfer from a distinct part, within the institution (§483.10(o)). A facility must promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.
F151	(a) Exercise of rights. (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.	Guidelines: §483.10(a)(1) Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F151 Cont.	(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.	Intent: §483.10(a)(2) This regulation is intended to protect each resident in the exercise of his or her rights. Guidelines: §483.10(a)(2) The facility must not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility behaviors designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion. Examples of facility practices that may limit autonomy or choice in exercising rights include reducing the group activity time of a resident trying to organize a residents' group; requiring residents to seek prior approval to distribute information about the facility; discouraging a resident from hanging a religious ornament above his or her bed; singling out residents for prejudicial treatment such as isolating residents in activities; or purposefully assigning inexperienced aides to a resident with heavy care needs because the resident and/or his/her representatvive, exercised his/her rights. Procedures: §483.10(a)(2) Pay close attention to resident or staff remarks and staff behavior that may represent deliberate actions to promote or to limit a resident's autonomy or choice, particularly in ways that affect independent functioning. Because reprisals may indicate abuse, if the team determines that a facility has violated this requirement through reprisals taken against residents, then further determine if the facility has an effective system to prevent the neglect and abuse of residents. (§483.13(c), F224-F225.)
F152	(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. (4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	Guidelines: §483.10(a)(3) and (4) When reference is made to "resident" in the Guidelines, it also refers to any person who may, under State law, act on the resident's behalf when the resident is unable to act for himself or herself. That person is referred to as the resident's surrogate or representative. If the resident has been formally declared incompetent by a court, the surrogate or representative is whoever was appointed by the court - a guardian, conservator, or committee. The facility should verify that a surrogate or representative has the necessary authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. A resident may wish to delegate decision-making to specific persons, or the resident and family may have agreed among themselves on a decision-making process. To the degree permitted by State law, and to the maximum extent practicable, the facility must respect the resident's wishes and follow that process.

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F152 Cont.		The rights of the resident that may be exercised by the surrogate or representative include the right to make health care decisions. However, the facility may seek a health care decision (or any other decision or authorization) from a surrogate or representative only when the resident is unable to make the decision. If there is a question as to whether the resident is able to make a health care decision, staff should discuss the matter with the resident at a suitable time and judge how well the resident understands the information. In the case of a resident who has been formally declared incompetent by a court, lack of capacity is presumed. Notwithstanding the above, if such a resident can understand the situation and express a preference, the resident should be informed and his/her wishes respected to the degree practicable. Any violations with respect to the resident's exercise of rights should be cited under the applicable tag number. The involvement of a surrogate or representative does not automatically relieve a facility of its duty to protect and promote the resident's interests. For example, a surrogate or representative does not have the right to insist that a treatment be performed that is not medically appropriate, and the right of a surrogate or representative to reject treatment may be subject to State law limits. Procedures: §483.10(a)(3) and (4) Determine as appropriate if the rights of a resident who has been adjudged incompetent or who has a representative acting on his/her behalf to help exercise his/her rights are exercised by the legally appointed individual.
Refer to F156	(b) Notice of rights and services. (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such	Intent: §483.10(b)(1) This requirement is intended to assure that each resident know his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, as appropriate during the resident's stay, and when the facility's rules change. Guidelines: §483.10(b)(1) "In a language that the resident understands" is defined as communication of information concerning rights and responsibilities that is clear and understandable to each resident, to the extent possible considering impediments which may be created by the resident's health and mental status. If the resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident must be available and implemented. For foreign languages

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	information, and any amendments to it, must be acknowledged in writing;	commonly encountered in the facility locale, the facility should have written translations of its statements of rights and responsibilities, and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, however, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to his/her acknowledgement of receipt. For hearing impaired residents who communicate by signing, the facility is expected to provide an interpreter. Large print texts of the facility's statement of resident rights and responsibilities should also be available. "Both orally and in writing," means if a resident can read and understand written materials without assistance, an oral summary, along with the written document, is acceptable. Any time State or Federal laws relating to resident rights or facility rules change during the resident's stay in the facility, he/she must promptly be informed of these changes. "All rules and regulations" relates to facility policies governing resident conduct. A facility cannot reasonably expect a resident to abide by rules he or she has never been told about. Whatever rules the facility has formalized, and by which it expects residents to abide, should be included in the statement of rights and responsibilities.
F153	(2) The resident or his or her legal representative has the right-- (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and (ii) 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 2 working days advance notice to the facility.	Guidelines: §483.10(b)(2) An oral request is sufficient to produce the current record for review. In addition to clinical records, the term "records" includes all records pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility. "Purchase" is defined as a charge to the resident for photocopying. If State statute has defined the "community standard" rate, facilities should follow that rate. In the absence of State statute, the "cost not to exceed the community standard" is that rate charged per copy by organizations such as the public library, the Post Office or a commercial copy center, which would be selected by a prudent buyer in addition to the cost of the clerical time needed to photocopy the records. Additional fees for locating the records or typing forms/envelopes may not be assessed.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F154	(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;	Guidelines: §483.10(b)(3) "Total health status" includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. Information on health status must be presented in language that the resident can understand. This includes minimizing use of technical jargon in communicating with the resident, having the ability to communicate in a foreign language and the use of sign language or other aids, as necessary. (See §483.10(d)(3), F175 for the right of the resident to plan care and treatment.) Procedures: §483.10(b)(3) Look, particularly during observations and record reviews, for on-going efforts on the part of facility staff to keep residents informed. Look for evidence that information is communicated in a manner that is understandable to residents and communicated at times it could be most useful to residents, such as when they are expressing concerns, or raising questions, as well as on an on-going basis.
F155	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and	Guidelines: §483.10(b)(4) "Treatment" is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. "Experimental research" is defined as development and testing of clinical treatments, such as an investigational drug or therapy, that involve treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitated. As provided under State law, a resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes. A facility may not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are met. (See §483.12(a)(1) and (2).)

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F155 Cont.		If the resident is unable to make a health care decision, a decision by the resident's surrogate or representative to forego treatment may, subject to State law, be equally binding on the facility. The facility should determine exactly what the resident is refusing and why. To the extent the facility is able, it should address the resident's concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for this resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services. If a resident's refusal of treatment brings about a significant change, the facility should reassess the resident and institute care planning changes. A resident's refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal. The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment (e.g., medication, treatment) and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining residents' permission. Procedures: §483.10(b)(4) If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? In this regard, §483.75(c) Relationship to Other HHS Regulations applies (i.e., the facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research). See §483.10(b)(8) F156 with respect to the advance directive requirement.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F156	(5) The facility must-- (i) 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 of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. (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 those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	Guidelines: §483.10(b)(5) and (6) Residents should be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes. "Periodically" means that whenever changes are being introduced that will affect the residents liability and whenever there are changes in services. A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided the notice provisions of §483.10(b)(6), if applicable, are met. Procedures: §483.10(b)(5) and (6) See §483.10(c)(8) for those items and services that must be included in payment under skilled nursing and nursing facility benefits.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F156 Cont.	(7) The facility must furnish a written description of legal rights which includes-- (i) A description of the manner of protecting personal funds, under paragraph (c) of this section; (ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) 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; (iii) 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 licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and (iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.	Guidelines: §483.10(b)(7) "The protection and advocacy network" refers to the system established to protect and advocate the rights of individuals with developmental disabilities specified in the Developmental Disabilities Assistance and Bill of Rights Act, and the protection and advocacy system established under the Protection and Advocacy for Mentally Ill Individuals Act. Procedures: §483.10(b)(7) At the Entrance Conference, request a copy of the written information that is provided to residents regarding their rights and review it to determine if it addresses the specified requirements. Additional requirements that address the implementation of these rights are cross-referenced below.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F156 Cont.	(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	Guidelines: §483.10(b)(8) This provision applies to residents admitted on or after December 1, 1991. 42 CFR 489.102 specifies that at the time of admission of an adult resident, the facility must: o Provide written information concerning his/her rights under State law (whether or not statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives; o Document in the resident's medical record whether or not the individual has executed an advance directive; o Not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive; o Ensure compliance with requirements of State law regarding advance directives; o Provide for educating staff regarding the facility's policies and procedures on advance directives; and o Provide for community education regarding the right under State law (whether or not recognized by the courts of the State) to formulate an advance directive and the facility's written policies and procedures regarding the implementation of these rights, including any limitations the facility may have with respect to implementing this right on the basis of conscience. The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows the provider to conscientiously object. (See §483.10(b)(4), F155.) The sum total of the community education efforts must include a summary of the State law, the rights of residents to formulate advance directives, and the facility's implementation policies regarding advance directives. Video and audio tapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience. Procedures: §483.10(b)(8) During Resident Review, review the records of two selected sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements. o Determine to what extent the facility educates its staff regarding advance directives. o Determine to what extent the facility provides education for the community regarding one's rights under State law to formulate advance directives.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F156 Cont.	(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	Guidelines: §483.10(b)(9) "Physician responsible for his or her care" is defined as the attending or primary physician or clinic, whichever is responsible for managing the resident's medical care, and excludes other physicians whom the resident may see from time to time. When a resident has selected an attending physician, it is appropriate for the facility to confirm that choice when complying with this requirement. When a resident has no attending physician, it is appropriate for the facility to assist residents to obtain one in consultation with the resident and subject to the resident's right to choose. (See §483.10(d)(1), F163.) If a facility uses the services of a clinic or similar arrangement, it may be sufficient for residents to have the name and contact information for the primary physician and/or a central number for the clinic itself.
	(10) 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.	Guidelines: §483.10(b)(10) To fulfill this requirement, the facility may use written materials issued by the State Medicaid agency and the Federal government relating to these benefits. Facilities may fulfill their obligation to orally inform residents or applicants for admission about how to apply for Medicaid or Medicare by assisting them in contacting the local Social Security Office or the local unit of the State Medicaid agency. Nursing facilities are not responsible for orally providing detailed information about Medicare and Medicaid eligibility rules. "Refunds for previous payments" refers to refunds due as a result of Medicaid and Medicare payments when eligibility has been determined retroactively. As part of determining Medicaid eligibility, at the time of admission, a married couple has the right to request and have the appropriate State agency assess the couple's resources.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F157	(11) Notification of changes. (i) A 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 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a). (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is-- (A) A change in room or roommate assignment as specified in §483.15(e)(2); or	Guidelines: §483.10(b)(11) For purposes of §483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before). In the case of a competent individual, the facility must still contact the resident's physician and notify interested family members, if known. That is, a family that wishes to be informed would designate a member to receive calls. Even when a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident. The requirements at §483.10(b)(1) require the facility to inform the resident of his/her rights upon admission and during the resident's stay. This includes the resident's right to privacy (§483.10(e), F164). If, after being informed of the right to privacy, a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident's interested family member or legal representative, if known. If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements. In the case of a resident who is incapable of making decisions, the representative would make any decisions that have to be made, but the resident should still be told what is happening to him or her. In the case of the death of a resident, the resident's physician is to be notified immediately in accordance with State law. The failure to provide notice of room changes could result in an avoidable decline in physical, mental, or psychosocial well-being.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F157 Cont.	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	
	(c) Protection of Resident Funds.	Guidelines: §483.10(c)(1) through (3) This requirement is intended to assure that residents who have authorized the facility in writing to manage any personal funds have ready and reasonable access to those funds. If residents choose to have the facility manage their funds, the facility may not refuse to handle these funds, but is not responsible for knowing about assets not on deposit with it.
F158	(1) 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.	
F159	(2) Management of personal funds. 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, as specified in paragraphs (c)(3)-(8) of this section. (3) Deposit of funds. (i) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the	Placement of residents' personal funds of less than $50.00 ($100.00 for Medicare residents) in an interest bearing account is permitted. Thus, a facility may place the total amount of a resident's funds, including funds of $50.00 ($100.00 for Medicare residents) or less, into an interest-bearing account. The law and regulations are intended to assure that residents have access to $50.00 ($100.00 for Medicare residents) in cash within a reasonable period of time, when requested. Requests for less than $50.00 ($100.00 for Medicare residents) should be honored within the same day. Requests for $50.00 ($100.00 for Medicare residents) or more should be honored within three banking days. Although the facility need not maintain $50.00 ($100.00 for Medicare residents) per resident on its premises, it is expected to maintain amounts of petty cash on hand that may be required by residents. If pooled accounts are used, interest must be prorated per individual on the basis of actual earnings or end-of-quarter balance. Residents should have access to petty cash on an ongoing basis and be able to arrange for access to larger funds. "Hold, safeguard, manage and account for," means that the facility must act as fiduciary of the resident's funds and report at least quarterly on the status of these funds in a clear and understandable manner. Managing the resident's financial affairs includes money that an individual gives to the facility for the sake of

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F159 Cont.	facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) (ii) Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. NOTE: The Social Security Amendments of 1994 amended §1819(c)(6)(B)(i) to raise the limit from $50.00 to $100.00 for the minimum amount of resident funds that facilities must entrust to an interest bearing account. This increase applies only to Medicare SNF residents. While a facility may continue to follow a minimum of $50.00, the regulations do not require it.	providing a resident with a noncovered service (such as a permanent wave). It is expected that in these instances, the facility will provide a receipt to the gift giver and retain a copy. "Interest bearing" means a rate of return equal to or above the passbook savings rate at local banking institutions in the area. Although the requirements are silent about oral requests by residents to have a facility hold personal funds, under the provisions regarding personal property (§483.10(l)), and misappropriation of property (§483.13(c)), residents may make oral requests that the facility temporarily place their funds in a safe place, without authorizing the facility to manage those funds. The facility has the responsibility to implement written procedures to prevent the misappropriation of these funds. If you determine potential problems with funds through interviews, follow-up using the following procedures as appropriate: If the facility does not have written authorization to handle resident's funds, but is holding funds for more than a few days, determine if the facility is managing these funds without written authorization. There must be written authorization for the facility to be in compliance with this requirement. To assure that facilities are not using oral requests by residents as a way to avoid obtaining written authorization to hold, manage, safeguard and account for resident's funds, make sure that: o There is a written declaration by the resident that the funds are being held for no more than a few days by the facility at the resident's request; o These funds are not held for more than a few days; and o The facility provides the resident a receipt for these funds and retains a copy for its records. Review the administrative or business file and the bookkeeping accounts of residents selected for a comprehensive review who have authorized the facility to handle their personal funds. o Are residents' funds over $50.00 ($100.00 for Medicare residents) or, at the facility's option, all resident funds, in an interest bearing account(s)? o What procedure was followed when residents requested their funds? o How long does it take for residents to receive: (a) petty cash allotments; (b)

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F159 Cont.		funds needing to be withdrawn from bank accounts? o Were limits placed on amounts that could be withdrawn? If yes, was the reason based on resident care needs or facility convenience? o Are funds records treated with privacy as required at F164? NOTE: Banks may charge the resident a fee for handling their funds. Facilities may not charge residents for managing residents' funds because the services are covered by Medicare or Medicaid. If problems are identified, review also §483.10(b(7), F156. Monies due residents should be credited to their respective bank accounts within a few business days.
	(4) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	Guidelines: §483.10(c)(4) This requirement constitutes the overall response of the facility to the resident's right to have the facility manage the resident's funds. "Generally accepted accounting principles" means that the facility employs proper bookkeeping techniques, by which it can determine, upon request, the amount of individual resident funds and, in the case of an interest bearing account, how much interest these funds have earned for each resident, as last reported by the banking institution to the facility. Proper bookkeeping techniques would include an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving his or her personal funds are recorded and maintained. The record should have information on when transactions occurred, what they were, as well as maintain the ongoing balance for every resident. Anytime there is a transaction the resident should be given a receipt and the facility retains a copy. Monies due residents should be credited to their respective bank accounts within a few business days.

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F159 Cont.		"Quarterly statements," are to be provided in writing to the resident or the resident's representative within 30 days after the end of the quarter.
	(5) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-- (i) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.	Guidelines: §483.10(c)(5) The Social Security District Office can provide you with information concerning current SSI resource limits. Procedures: §483.10(c)(5) If problems are identified for sampled residents who are Medicaid recipients, review financial records to determine if their accounts are within $200.00 of the SSI limit. If there are sampled residents in this situation, ask them or their representatives if they have received notice.
F160	(6) Conveyance upon death. 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 resident's estate.	Procedures: §483.10(c)(6) As part of closed records review, determine if within 30 days of death, the facility conveyed the deceased resident's personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate as provided by State law.
F161	(7) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	Guidelines: §483.10(c)(7) A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (depending on State law, either the resident or the State acting on behalf of the resident), wherein the facility and the insurance company agree to compensate the resident (or the State on behalf of the resident) for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for.

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F161 Cont.		The purpose of the surety bond is to guarantee that the facility will pay the resident (or the State on behalf of the resident) for losses occurring from any failure by the facility to hold, safeguard, manage, and account for the residents' funds, i.e., losses occurring as a result of acts or errors of negligence, incompetence or dishonesty. Unlike other types of insurance, the surety bond protects the obligee (the resident or the State), not the principal (the facility), from loss. The surety bond differs from a fidelity bond, which covers no acts or errors of negligence, incompetence or dishonesty. The surety bond is the commitment of the facility in an objective manner to meet the standard of conduct specified in §483.10(c)(2), that the facility will hold, safeguard, manage and account for the funds residents have entrusted to the facility. The facility assumes the responsibility to compensate the obligee for the amount of the loss up to the entire amount of the surety bond. Reasonable alternatives to a surety bond must: o Designate the obligee (depending on State law, the resident individually or in aggregate, or the State on behalf of each resident) who can collect in case of a loss; o Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds; and o Be managed by a third party unrelated in any way to the facility or its management. The facility cannot be named as a beneficiary. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation, or similar entity, also are not acceptable alternatives. Procedures: §483.10(c)(7) As part of Phase 2, if your team has any concerns about residents' funds, check the amount of the surety bond to make sure it is at least equal to the total amount of residents' funds, as of the most recent quarter.

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F161 Cont.		If the State survey agency determines that individual circumstances associated with a facility's surety bond or its alternative are such that the survey agency cannot determine whether or not the facility is in compliance with the requirements at §483.10(c)(7), then it would be appropriate to make the referral to the State's fiscal department. If a corporation has a surety bond that covers all of its facilities, there should be a separate review of the corporation's surety bond by the appropriate State agency, such as the State's fiscal department, to ensure that all the residents in the corporation's facilities within the State are covered against any losses due to acts or errors by the corporation or any of its facilities. The focus of the review should be to ensure that if the corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.
F162	(8) Limitation or charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)	Intent: §483.10(c)(8) The intent of this requirement is to specify that facilities not charge residents for items and services for which payment is made under Medicare or Medicaid. Guidelines: §483.10(c)(8) The facility may charge the resident the difference for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or co-payment required by the plan to be paid by the individual.) If a State plan does not cover an item or service, such as eyeglasses, the resident may purchase that item or service out of his/her funds. See §483.15(g), F250 for the facility's responsibility to assist the resident in obtaining those services. §483.10(c)(8)(i)(E): Prescription drugs are part of the pharmaceutical services that facilities are required to provide. (See §483.25(l) and (m), and §483.60.) However, at times, a resident needs a medical service that is recognized by State law, but not covered by the State plan. Such a medical service includes a prescription drug that is not on the State's formulary or that exceeds the number of medications covered by Medicaid. It may also include prescription eyeglasses or dentures. If a resident needs a recognized medical service over what is allowed by the State plan, the resident has the right under the Medicaid statute to spend his/her income on that service. If the service is more than what Medicaid pays, the resident may deduct the actual cost of

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F162 Cont.	(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.30 of this subpart. (B) Dietary services as required at §483.35 of this subpart. (C) An activities program as required at §483.15(f) of this subpart. (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.	the service from the Medicaid share of the cost. The facility must assist the resident in exercising his or her right to the uncovered medical expense deduction and may not charge the resident for such services. "Hair hygiene supplies" refers to comb, brush, shampoos, trims and simple hair cuts provided by facility staff as part of routine grooming care. Hair cuts, permanent waves, hair coloring, and relaxing performed by barbers and beauticians not employed by a facility are chargeable. "Nail hygiene services" refers to routine trimming, cleaning, filing, but not polishing of undamaged nails, and on an individual basis, care for ingrown or damaged nails. "Basic personal laundry" does not include dry cleaning, mending, washing by hand, or other specialty services that need not be provided. A resident may be charged for these specialty services if he or she requests and receives them. §483.10(c)(8)(ii)(I) Social events. Facilities are required by §483.15(f) to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident, and cannot charge residents for these services, whether they occur at the facility or off-site. Resident funds should not be charged for universal items such as bookmobile services or local newspaper subscriptions intended for use by more than one resident. However, if a resident requests and attends a social event or entertainment that is not part of the activities assessment and care plan for that resident, a facility may charge that resident's account only for actual expenses. Further, because of expenses associated with transportation, escorts and other related costs, a resident may be charged for actual expenses for an event or entertainment he or she requests and attends that may be free to the public. §483.10(c)(8)(ii)(L) Specially prepared food. A resident may refuse food usually prepared and food substitutions of similar nutritive value because of personal, religious, cultural, or ethnic preference. If the resident requests and receives food that is either not commonly purchased by the facility or easily prepared, then the facility may charge the resident. For example, the facility may charge the resident's account for specially prepared food if the facility has a restricted diet policy and notified the resident on admission of the fact, in accordance with §483.10(b). The facility may not charge the resident's account for specially prepared foods that are required by the physician's order of a therapeutic diet. If a facility changes its menu so that the menu no longer reflects the food preferences of residents, see F165, F242 and F243 to determine compliance with these requirements.

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F162 Cont.	(F) Medically-related social services as required at §483.15(g) of this subpart. (ii) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone; (B) Television/radio for personal use; (C) Personal comfort items, including smoking materials, notions and novelties, and confections; (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare; (E) Personal clothing; (F) Personal reading matter; (G) Gifts purchased on behalf of a resident; (H) Flowers and plants; and (I) Social events and entertainment offered outside the	§483.10(c)(8)(iii) Requests for items and services. A facility may not charge a resident or the resident's representative for items and services that are not requested by the resident or representative, whether or not the item or services is requested by a physician. The item or service ordered by the physician should fit in with the resident's care plan. Procedures: §483.10(c)(8) As appropriate during Phase 2 of the survey, review the written information given to Medicare/Medicaid eligible residents and family members on admission that notifies them of the items and services that are covered under Medicare or the State plan. Review a sample of residents' monthly statements to ensure that personal funds are not used to pay for covered services. If charges found on monthly statements indicate that residents may have paid for covered items or services, determine if these items or services are over and above what is paid by Medicare or Medicaid. If, through observations or interviews of residents selected for comprehensive or focused review, the team determines that families or residents hire sitters, and/or that a large number of residents or families are paying for outside food, determine if these practices reflect inadequate staffing and/or food.

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F162 Cont.	scope of the activities program, provided under §483.15(f) of this subpart. (J) Noncovered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart. (iii) Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. (B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay. (C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.	

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	(d) Free Choice. The resident has the right to-	Guidelines: §483.10(d)(1) The right to choose a personal physician does not mean that the physician must or will serve the resident, or that a resident must designate a personal physician. If a physician of the resident's choosing fails to fulfill a given requirement, such as §483.25(1)(1), Unnecessary drugs, §483.25(1)(2), Antipsychotic drugs, or §483.40 frequency of physician visits, the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment. A facility may not place barriers in the way of residents choosing their own physicians. For example, if a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his or her choice in finding another physician. Before consulting an alternate physician, one mechanism to alleviate a possible problem could involve the facility's utilization of a peer review process for cases which cannot be satisfactorily resolved by discussion between the medical director and the attending physician. Only after a failed attempt to work with the attending physician or mediate differences in delivery of care should the facility request an alternate physician when requested to do so by the resident or when the physician will not adhere to the regulations. If it is a condition for admission to a continuing care retirement center, the requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges at the retirement center. A resident in a distinct part of a general acute care hospital can choose his/her own physician, unless the hospital requires that physicians with residents in the distinct part have hospital admitting privileges. If this is so, the resident can choose his/her own physician, but cannot have a physician who does not have hospital admitting privileges. If residents appear to have problems in choosing physicians, determine how the facility makes physician services available to residents.
F163	(1) Choose a personal attending physician;	
Refer to F154	(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	Guidelines: §483.10(d)(2) "Informed in advance" means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives.

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Refer to F280	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	Guidelines: §483.10(d)(3) "Participates in planning care and treatment" means that the resident is afforded the opportunity to select from alternative treatments. This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment. The resident's right to participate in care planning and to refuse treatment are covered in §§483.20(d)(2) and 483.10(b)(4). A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been formally declared incompetent by a court, should, to the extent practicable, be kept informed and be consulted on personal preferences. Whenever there appears to be a conflict between a resident's right and the resident's health or safety, determine if the facility attempted to accommodate both the exercise of the resident's rights and the resident's health, including exploration of care alternatives through a thorough care planning process in which the resident may participate. Procedures: §483.10(d)(3) Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes (e.g., ask residents or their representatives during interviews).
F164	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	Guidelines: §483.10(e) "Right to privacy" means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual, and, to the extent desired, for visits or other activities, auditory privacy. Private space may be created flexibly and need not be dedicated solely for visitation purposes. For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility's administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents.

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F164 Cont.	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when-- (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.	With the exception of the explicit requirement for privacy curtains in all initially certified facilities (see §483.70(d)(1)(v)), the facility is free to innovate to provide privacy for its residents, as exemplified in the preceding paragraph. This may, but need not, be through the provision of a private room. Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual's consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services. Personal and clinical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated or other. Additional guidelines on mail, visitation rights and telephone communication are addressed in §483.10(i), (j) and (k). See §483.70(d)(1)(iv) for full visual privacy around beds. Procedures: §483.10(e)(1) - (3) Document any instances where you observe a resident's privacy being violated. Completely document how the resident's privacy was violated (e.g., Resident #12 left without gown or bed covers and unattended), and where and when this occurred (e.g., 2B Corridor, 3:30 pm, February 25). If possible, identify the responsible party.
	(f) Grievances. A resident has the right to--	Intent: §483.10(f) The intent of the regulation is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution.

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F165	(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and	Guidelines: §483.10(f) "Voice grievances" is not limited to a formal, written grievance process but may include a resident's verbalized complaint to facility staff. "Prompt efforts...to resolve" include facility acknowledgment of complaint/grievances and actively working toward resolution of that complaint/grievance.
F166	(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	If residents' responses indicate problems in voicing grievances and getting grievances resolved, determine how the facility deals with and makes prompt efforts to resolve resident complaints and grievances. o With permission, review resident council minutes. o Interview staff about how grievances are handled. o Interview staff about communication (to resident) of progress toward resolution of complaint/grievance. If problems are identified, also investigate compliance with §483.10(b)(7)(iii).
	(g) Examination of survey results. A resident has the right to--	
F167	(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and	Guidelines: §483.10(g)(1)-(2) "Results of the most recent survey" means the Statement of Deficiencies (HCFA-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s). "Made available for examination" means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person. "Place readily accessible to residents" is a place (such as a lobby or other area frequented by most residents) where individuals wishing to examine survey results do not have to ask to see them.
F168	(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	

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F169	(h) Work. The resident has the right to-- (1) Refuse to perform services for the facility; (2) Perform services for the facility, if he or she chooses, when-- (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	Guidelines: §483.10(h)(1)-(2) "Prevailing rate" is the wage paid to workers in the community surrounding the facility for essentially the same type, quality, and quantity of work requiring comparable skills. All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident's desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated. Procedures: §483.10(h)(1)-(2) Are residents engaged in what may be paid or volunteer work (e.g., doing housekeeping, doing laundry, preparing meals)? Pay special attention to the possible work activities of residents with mental retardation or mental illness. If you observe such a situation, determine if the resident is in fact performing work and, if so, is this work, whether voluntary or paid, described in the plan of care?
	(i) Mail. The resident has the right to privacy in written communications, including the right to--	
F170	(1) Send and promptly receive mail that is unopened; and	Guidelines: §483.10(i)(1)-(2) "Promptly" means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

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F171	(2) Have access to stationery, postage, and writing implements at the resident's own expense.	
F172	(j) Access and Visitation Rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following: (i) Any representative of the Secretary; (ii) Any representative of the State; (iii) The resident's individual physician; (iv) The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); (v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); (vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);	Guidelines: §483.10(j)(1) and (2) The facility must provide immediate access to any representative of the Secretary of the Department of Health and Human Services, the State, the resident's individual physician, the State long term care ombudsman, or the agencies responsible for the protection and advocacy of developmentally disabled or mentally ill individuals. The residents cannot refuse to see surveyors. Representatives of the Department of Health and Human Services, the State, the State ombudsman system, and protection and advocacy agencies for mentally ill and mentally retarded individuals are not subject to visiting hour limitations. Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. However, the facility may try to change the location of visits to assist care giving or protect the privacy of other residents, if these visitation rights infringe upon the rights of other residents in the facility. For example, a resident's family visits in the late evening, which prevents the resident's roommate from sleeping. Non-family visitors must also be granted "immediate access" to the resident. The facility may place reasonable restrictions upon the exercise of this right such as reasonable visitation hours to facilitate care giving for the resident or to protect the privacy of other residents, such as requiring that visits not take place in the resident's room if the roommate is asleep or receiving care. An individual or representative of an agency that provides health, social, legal, or other services to the resident has the right of "reasonable access" to the resident, which means that the facility may establish guidelines regarding the timing or other circumstances of the visit, such as location. These guidelines must allow for ready access of residents to these services. Procedures: §483.10(j)(1) and (2) If you identify problems during interviews, determine how the facility ensures access to: o Representatives of the State; o Representatives of the U.S. Department of Health and Human Services; o The resident's individual physician; o Representatives of the State long-term care ombudsman;

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F172 Cont.	(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and (viii) 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 facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.	o Representatives of agencies responsible for protecting and advocating rights of persons with mental illness or developmental disabilities; o Family or relatives; and o Other visitors.
F173	(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.	Procedures: §483.10(j)(3) Ask the ombudsman if the facility allows him/her to examine residents' clinical records with the permission of the resident, and to the extent allowed by State law.
F174	(k) Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.	Guidelines: §483.10(k) Telephones in staff offices or at nurses' stations do not meet the provisions of this requirement. Examples of facility accommodations to provide reasonable access to the use of a telephone without being overheard include providing cordless telephones or having telephone jacks in residents' rooms. "Reasonable access" includes placing telephones at a height accessible to residents who use wheelchairs and adapting telephones for use by the residents with impaired hearing.

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Refer to F252	(l) Personal Property. 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.	Intent: §483.10(l) The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits. Guidelines: §483.10(l) All residents' possessions, regardless of their apparent value to others, must be treated with respect, for what they are and for what they may represent to the resident. The right to retain and use personal possessions assures that the residents' environment be as homelike as possible and that residents retain as much control over their lives as possible. The facility has the right to limit the resident's exercise of this right on grounds of space and health or safety. Procedures: §483.10(l) If residents' rooms have few personal possessions, ask residents, families and the local ombudsman if: o Residents are encouraged to have and to use them; o The facility informs residents not to bring in certain items and for what reason; o Personal property is safe in the facility. Ask staff if the facility sets limits on the value of the property that residents may have in their possession or requires that residents put personal property in the facility's safe. See §483.15(h)(l) F252 for "use of his or her personal belongings to the extent possible, when the resident is not allowed to use his/her own personal possessions within the facility, or when the facility does not encourage the resident to retain and use his/her personal property.
F175	(m) Married couples. 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.	Guidelines: §483.10(m) The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. The requirement means that when a room is available for a married couple to share, the facility must permit them to share it if they choose. If a married resident's spouse is admitted to the facility later and the couple want to share a room, the facility must provide a shared room as quickly as possible. However, a couple is not able to share a room if one of the spouses has a different payment source for which the facility is not certified (if the room is in a distinct part, unless one of the spouses elects to pay for his or her care).

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F176	(n) Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	Guidelines: §483.10(n) If a resident requests to self-administer drugs, it is the responsibility of the interdisciplinary team to determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible (the resident or the nursing staff) for storage and documentation of the administration of drugs, as well as the location of the drug administration (e.g., resident's room, nurses' station, or activities room). Appropriate notation of these determinations should be placed in the resident's care plan. The decision that a resident has the ability to self-administer medication(s) is subject to periodic re-evaluation based on change in the resident's status. The facility may require that drugs be administered by the nurse or medication aide, if allowed by State law, until the care planning team has the opportunity to obtain information necessary to make an assessment of the resident's ability to safely self-administer medications. If the resident chooses to self-administer drugs, this decision should be made at least by the time the care plan is completed within seven days after completion of the comprehensive assessment. Medication errors occurring with residents who self-administer drugs should not be counted in the facility's medication error rate (see Guidelines for §483.25(m)), but should call into question the judgment made by the facility in allowing self-administration for those residents. Probes: §483.10(n) For residents selected for a comprehensive review or a focused review, as appropriate: o Does resident self-administer drugs? Which ones? How much? How often? o Does the care plan reflect self-administration?
F177	(o) Refusal of Certain Transfers. (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate-- (i) A resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or	Guidelines: §483.10(o) This requirement applies to transfer within a physical plant. These provisions allow a resident to refuse transfer from a room in one distinct part of an institution to a room in another distinct part of the institution for purposes of obtaining Medicare or Medicaid eligibility. If a resident refuses to transfer from a portion of the institution that is not Medicare certified, the resident forgoes the possibility of Medicare coverage for the care received there. If that portion of the institution is Medicaid certified and the resident is Medicaid-eligible, then Medicaid covered services would be paid by Medicaid. If the resident is Medicaid-eligible, but that portion of the institution is not Medicaid certified, then the resident would assume responsibility for payment for the services. If the resident is unable to pay

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F177 Cont.	(ii) A resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.	for those services, then the facility may, after giving the resident a 30-day notice, transfer the resident under the provisions of §483.12(a). When a resident occupies a bed in a distinct part NF that participates in Medicaid and not in Medicare, he or she may not be moved involuntarily to another part of the institution by the facility (or required to be moved by the State) solely for the purpose of assuring Medicare eligibility for payment. Such moves are only appropriate when they occur at the request of a resident (for example, when a privately paying Medicare beneficiary believes that admission to a bed in a Medicare-participating distinct part of the institution may result in Medicare payment). See Guidelines: §483.12 for further discussion regarding transfers. For transfers of residents between Medicare or Medicaid approved distinct parts: o Is there a documented medical reason for the transfer? o Was the resident transferred because of a change in payment source? o If a Medicare or Medicaid resident is notified that he/she is no longer eligible, does the facility transfer the resident? Did the facility give the resident the opportunity to refuse the transfer? How? What happened? o Ask the local ombudsman about facility compliance with transfer requirements. See also §483.12 - Criteria for Transfer.

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	§483.12 Admission, transfer and discharge rights.	Guidelines: §483.12 This requirement applies to transfers or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility's decision, these requirements apply whenever a facility initiates the transfer or discharge. "Transfer" is moving the resident from the facility to another legally responsible institutional setting, while "discharge" is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care. If a resident is living in an institution participating in both Medicare and Medicaid (SNF/NF) under separate provider agreements, a move from either the SNF or NF would constitute a transfer. Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility may not transfer or discharge the resident unless: 1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility; 2. 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; 3. The safety of individuals in the facility is endangered; 4. The health of individuals in the facility would otherwise be endangered; 5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or 6. The facility ceases to operate. To demonstrate that any of the events specified in 1 - 5 have occurred, the law requires documentation in the resident's clinical record. To demonstrate situations 1 and 2, the resident's physician must provide the documentation. In situation 4, the documentation must be provided by any physician. (See §483.12(a)(2).)
	(a) Transfer and discharge: (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.	

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		Moreover, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility's notice must include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a developmentally disabled individual, the notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled, and in the case of a mentally ill individual, the name, address and phone number of the agency responsible for advocating for mentally ill individuals. (See §483.12(a)(3) and (5).) Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of: o Endangerment to the health or safety of others in the facility; o When a resident's health has improved to allow a more immediate transfer or discharge; o When a resident's urgent medical needs require more immediate transfer; and o When a resident has not resided in the facility for 30 days. In these cases, the notice must be provided as soon as practicable before the discharge. (See §483.12(a)(4).) Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. (See §483.12(a)(6).) Under Medicaid, a participating facility is also required to provide notice to its residents of the facility's bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).) A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay. §483.10(o), F177 addresses the right of residents to refuse certain transfers within an institution on the basis of payment status.

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F201	(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) 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; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered; (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or	Guidelines: §483.12(a)(2) and (3) If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. (See §483.20(b)(4)(iv), F274, for information concerning assessment upon significant change.) Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment. Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy. Procedures: §483.12(a)(2) and (3) During closed record review, determine the reasons for transfer/discharge. o Do records document accurate assessments and attempts through care planning to address resident's needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident's customary routines? o Did the resident's physician document the record if: The resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization)? or The resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility. o Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered? o Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? Did the survey team observe residents with similar safety concerns in the facility? If so, determine differences between these residents and those who were transferred or discharged. o Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a)(2). o Ask the ombudsman if there were any complaints regarding transfer and/or discharge. If there were, what was the result of the ombudsman's investigation? o If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of this resident.

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F202	(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-- (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.	
F203	(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-- (i) 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. (ii) Record the reasons in the resident's clinical record; and (iii) Include in the notice the items described in paragraph (a)(6) of this section.	Procedures: §483.12(a)(4)-(6) If the team determines that there are concerns about the facility's transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including: o Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge); o Reason for transfer/discharge; o The effective date of the transfer or discharge; o The location to which the resident was transferred or discharged; o Right of appeal; o How to notify the ombudsman (name, address, and telephone number); and o How to notify the appropriate protection and advocacy agency for residents with mental illness or mental retardation (mailing address and telephone numbers). Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.

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F203 Cont.	(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when- (A) the safety of the individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section; (B) The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or (E) A resident has not resided in the facility for 30 days. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:	

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F203 Cont.	(i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman; (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.	

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F204	(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	Guidelines: §483.12(a)(7) "Sufficient preparation" means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost; orienting staff in the receiving facility to resident's daily patterns; and reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan. Procedures: §483.12(a)(7) During Resident Review, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.
F205	(b) Notice of bed-hold policy and readmission -- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies--	Guidelines: §483.12(b)(1) and (2) The nursing facility's bed-hold policies apply to all residents. These sections require two notices related to the facility's bed-hold policies to be issued. The first notice of bed-hold policies could be given well in advance of any transfer. However, reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice, which specifies the duration of the bed-hold policy, must be issued at the time of transfer.

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F205 Cont.	(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. Bed-hold for days of absence in excess of the State's bed-hold limit are considered non-covered services which means that the resident could use his/her own income to pay for the bed-hold. However, if such a resident does not elect to pay to hold the bed, readmission rights to the next available bed are specified at §483.12(b)(3). Non-Medicaid residents may be requested to pay for all days of bed-hold. If residents (or their representatives in the case of residents who are unable to understand their rights) are unsure or unclear about their bed-hold rights, review facility bed-hold policies. o Do policies specify the duration of the bed-hold? o Is this time period consistent with that specified in the State plan? During closed record review, look at records of residents transferred to a hospital or on therapeutic leave to determine if bed-hold requirements were followed. Was notice given before and at the time of transfer? During closed record review, look at records of residents transferred to a hospital or on therapeutic leave to determine if bed-hold requirements were followed. Was notice given before and at the time of transfer?
F206	(3) Permitting resident to return to facility. A 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 the facility immediately upon the first availability of a bed in a semi-private room if the resident--	Guidelines: §483.12(b)(3) "First available bed in a semi-private room" means a bed in a room shared with another resident of the same sex. (See §483.10(m) for the right of spouses to share a room.) Medicaid-eligible residents who are on therapeutic leave or are hospitalized beyond the State's bed-hold policy must be readmitted to the first available bed even if the residents have outstanding Medicaid balances. Once readmitted, however, these residents may be transferred if the facility can demonstrate that non-payment of charges exists and documentation and notice requirements are followed. The right to readmission is applicable to individuals seeking to return from a transfer or discharge as long as all of the specific qualifications set out in §483.12(b)(3) are met.

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F206 Cont.	(i) Requires the services provided by the facility; and (ii) Is eligible for Medicaid nursing facility services.	Procedures: §483.12(b)(3) For Medicaid recipients whose hospitalization or therapeutic leave exceeds the bed-hold period, do facility policies specify readmission rights? Refer to the Minimum Data Set (MDS), Section A.10, Discharge Planned; MDS 2.0, section Q, Discharge Potential and Overall Status. Review the facility's written bed-hold policy to determine if it specifies legal readmission rights. Ask the local ombudsman if there are any problems with residents being readmitted to the facility following hospitalization. In closed record review, determine why the resident did not return to the facility. Ask the social worker or other appropriate staff what he/she tells Medicaid-eligible residents about the facility's bed-hold policies and the right to return and how Medicaid-eligible residents are assisted in returning to the facility. If potential problems are identified, talk to discharge planners at the hospital to which residents are transferred to determine their experience with residents returning to the facility.
F207	(c) Equal access to quality care. (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment; (2) The facility may charge any amount for services furnished to non-Medicaid residents consistent	Guidelines: §483.12(c) Facilities must treat all residents alike when making transfer and discharge decisions. "Identical policies and practices" concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law. All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities that are mandated by the law must be provided to residents according to residents' individual needs, as determined by assessments and care plans. Procedures: §483.12(c) Determine if residents are grouped in separate wings or floors for reasons other than care needs.

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F207 Cont.	with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and (3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan. (d) Admissions policy.	
F208	(1) The facility must-- (i) not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.	Guidelines: §483.12(d)(1) This provision prohibits both direct and indirect request for waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, requires residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver includes requiring the resident to pay private rates for a specified period of time, such as two years ("private pay duration of stay contract") before Medicaid will be accepted as a payment source for the resident. Facilities must not seek or receive any kind of assurances that residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. Procedures: §483.12(d)(1) If concerns regarding admissions procedures arise during interviews, review admissions packages and contracts to determine if they contain prohibited requirements (e.g., "side agreements" for the resident to be private pay or to supplement the Medicaid rate). Ask staff what factors lead to decisions to place residents in different wings or floors. Note if factors other than medical and nursing needs affect these decisions. Do staff know the source of payment for the residents they take care of? Ask the ombudsman if the facility treats residents differently in transfer, discharge and covered services based on source of payment. With respect to transfer and discharge, if the facility appears to be sending residents to hospitals at the time (or shortly before) their payment source changes from private-pay or Medicare to Medicaid, call the hospitals and ask their discharge planners if they have detected any pattern of dumping. Also, ask discharge planners if the facility readmits Medicaid recipients who are ready to return to the facility. During the tour, observe possible differences in services.

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F208 Cont.		o Observe if there are separate dining rooms. If so, are different foods served in these dining rooms? For what reasons? Are residents excluded from some dining rooms because of source of payment? o Observe the placement of residents in rooms in the facility. If residents are segregated on floors or wings by source of payment, determine if the facility is providing different services based on source of payment. Be particularly alert to differences in treatment and services. For example, determine whether less experienced aides and nursing staff are assigned to Medicaid portions of the facility. Notice the condition of the rooms (e.g., carpeted in private-pay wings, tile in Medicaid wings, proximity to the nurses' station, quality of food served as evening snacks). As part of closed record review, determine if residents have been treated differently in transfers or discharges because of payment status. For example, determine if the facility is sending residents to acute care hospitals shortly before they become eligible for Medicaid as a way of getting rid of Medicaid recipients. Ask social services staff to describe the facility's policy and practice on providing services, such as rehabilitative services. Determine if services are provided based on source of payment, rather than on need for services to attain or maintain functioning.
	(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 financial liability, to provide facility payment from the resident's income or resources.	Guidelines: §483.12(d)(2) The facility may not require a third person to accept personal responsibility for paying the facility bill out of his or her own funds. However, he or she may use the resident's money to pay for care. A third party guarantee is not the same as a third party payor, e.g., an insurance company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.
	(3) In the case of a person eligible for Medicaid, a nursing 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. However,--	Guidelines: §483.12(d)(3) This requirement applies only to Medicaid certified nursing facilities. Facilities may not charge for any service that is included in the definition of "nursing facility services" and, therefore, required to be provided as part of the daily rate. Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes deposits from Medicaid-eligible residents or their families, or any promise to pay private rates for a specified period of time.

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F221 F222 Cont.		been provided to the resident. (See §483.10(a)(3) and (4).) However, the surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely because a surrogate or representative has approved or requested them. "Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as: o Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; o Tucking in a sheet so tightly that a bed bound resident cannot move; o Using wheel chair safety bars to prevent a resident from rising out of a chair; o Placing a resident in a chair that prevents rising; and o Placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Orthotic body devices may be used solely for therapeutic purposes to improve overall functional capacity of the resident. Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Bed rails used as restraints add risk to the resident. They potentially increase the risk of more significant injury from a fall from a bed with raised bed rails than from a fall from a bed without bed rails. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Other interventions that the facility might incorporate in care planning include: o Providing restorative care to enhance abilities to stand safely and to walk; o A trapeze to increase bed mobility; o Placing the bed lower to the floor and surrounding the bed with a soft mat; Equipping the resident with a device that monitors attempts to arise; o Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or o Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information. When used for mobility or transfer, assessment should include a review of the resident's:

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F221 F222 Cont.		o Bed mobility (e.g., would the use of the bed rail assist the resident to turn from side to side? Or, is the resident totally immobile and cannot shift without assistance?); and o Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised bed rail add risk to the resident's ability to transfer?). However, as with other restraints, for residents who have been restrained by bed rails, it is expected that the process facilities employ to reduce the use of bed rails as restraints is systematic and gradual (e.g., lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell). Before a resident is restrained, the facility must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his or her highest level of physical and psychosocial well-being. Appropriate exercise, therapeutic interventions such as orthotic devices, pillows, pads, or lap trays often assist in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use. Restraints may not be used to permit staff to administer treatment to which the resident has not consented. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. Procedures: §483.13(a) Since continued restraint usage is associated with a potential for a decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributable to unavoidable disease progression, versus inappropriate use of restraints. Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. For sampled residents observed as physically restrained during the survey or whose clinical records show the use of physical restraints within 30 days of the survey, determine the intended use of the restraint -- convenience or discipline, or a therapeutic intervention for specified periods to attain and maintain the resident's highest practicable physical, mental or psychosocial well-being. Probes: §483.13(a) This systematic process should answer these questions:

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F208 Cont.	(i) 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 not 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; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. (4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	A nursing facility may charge a Medicaid beneficiary for a service the beneficiary has requested and received, only if: o That service is not defined in the State plan as a "nursing facility" service; o The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and o The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service. Procedures: §483.12(d)(3) Review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services. Determine if the facility requires deposits from residents. If you identify potential problems with discrimination, review the files of one or more residents selected for a focused or comprehensive review to determine if the facility requires residents to submit deposits as a precondition of admission besides what may be paid under the State plan. If interviews with residents suggest that the facility may have required deposits from Medicaid recipients at admission, except those admitted when Medicaid eligibility is pending, corroborate by, for example, reviewing the facility's admissions documents or interviewing family members.

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	§483.13 Resident behavior and Facility Practices	Intent: §483.13(a) The intent of this requirement is for each person to reach his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.
F221* F222**	(a) Restraints. 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 resident's medical symptoms. * Use tag #F221 for deficiencies concerning physical restraints. ** Use tag #F222 for deficiencies concerning chemical restraints.	Guidelines: §483.13(a) "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. "Chemical Restraint" is defined as a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms. "Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents. "Convenience" is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the residents' best interest. Restraint use may constitute an accident hazard and professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances. Therefore, medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. It is further expected that for those residents whose care plans indicate the need for restraints that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). The resident's right to participate in care planning and the right to refuse treatment are addressed at §§483.20(d) and 483.10(b), respectively, and include the right to accept or refuse restraints. For the resident to make an informed choice about the use of restraints, the facility should explain to the resident the negative outcomes of restraint use. Potential negative outcomes include incontinence, decreased range of motion, and decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. In the case of a resident who is incapable of making a decision, the surrogate or representative may exercise this right based on the same information that would have

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F221 F222 Cont.		1. What are the symptoms that led to the consideration of the use of restraints? 2. Are these symptoms caused by failure to: a. Meet individual needs in accordance with section III of the MDS, Customary Daily Routines (MDS version 2.0 section AC), in the context of relevant information in sections I and II of the MDS (MDS version 2.0 sections AA and AB)? b. Use aggressive rehabilitative/restorative care? c. Provide meaningful activities? d. Manipulate the resident's environment, including seating? 3. Can the cause(s) be removed? 4. If the cause(s) cannot be removed, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use? (See Physical Restraints Resident Assessment Protocol (RAP), paragraph I). 5. If the alternatives have been tried and found wanting, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce negative outcomes while continually trying to find and use less restrictive alternatives? 6. Did the resident make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained? 7. Does the facility use the Physical Restraints RAP to evaluate the appropriateness of restraint use? 8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained resident's strength and mobility? If responses to these questions indicate that restraint use may not comply with these requirements, is there evidence of restraints used for staff convenience: restrained residents left alone for long periods, not toileted and not provided with exercise. Refer to MDS sections Customary Daily Routine, K, N, E, H, L, (MDS version 2.0 sections AC, J, M, G, E and K respectively) and relevant RAPS, and to notes from other health professionals to determine if restrained residents have maintained their physical, mental, psychosocial and functional status; or if the use of restraints has been associated with an increase in falls, urinary or fecal incontinence, pressure sores, loss of muscle tone, loss of independent mobility, increased agitation, loss of balance, symptoms of withdrawal or depression, reduced social contact, or decreased appetite. Refer to §§483.20, Resident Assessment, 483.25, Quality of Care and 483.15, Quality of Life to assist in determining compliance with this requirement.

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F223	(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	Guidelines: §483.13(b)(c) These requirements specify the right of each resident to be free from abuse, corporal punishment, and involuntary seclusion, and the facility's responsibilities to prevent not only abuse, but also those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. "Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. "Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. "Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. "Involuntary seclusion" is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

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F223 Cont.		Procedures: §483.13(b) Offsite, presurvey review of complaints can focus the survey team's on-site review of actual incidents and predisposing factors to abuse or neglect and misappropriation of property. Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act, the nature of the abuse, and where and when it occurred. Ensure that the facility addresses that incident immediately. If the survey team's observations and residents' responses signal the presence of abuse, determine how the facility prevents and reports abusive behavior as described in §483.13(c). If a resident is being temporarily separated from other residents, i.e., for less than 24 hours, as an emergency short-term intervention, answer these questions: 1. What are the symptoms that led to the consideration of the separation? 2. Are these symptoms caused by failure to: a. Meet individual needs in accordance with section III (MDS version 2.0 section AC), Customary Daily Routines, in the context of relevant information in sections I (MDS and II of the MDS (MDS version 2.0 sections AA and AB)? b. Provide meaningful activities? c. Manipulate the resident's environment? 3. Can the cause(s) be removed? 4. If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation? 5. If these alternatives have been tried and found wanting, does the facility use the separation for the least amount of time? 6. To what extent has the resident, surrogate or representative participated in care planning and made an informed choice about separation? 7. Does the facility monitor and adjust care to reduce negative outcomes, while continually trying to find and use less restrictive alternatives? 8. If residents are temporarily separated in secured units, staff should carry keys to these units at all times. 9. If the purpose of the unit is to provide specialized care for residents who are cognitively impaired (through a program of therapeutic activities designed to enable residents to attain and maintain the highest practicable physical, mental or psychosocial well-being) then placement in the unit is not in violation of resident rights, as long as the resident's individual care plan indicates the need for the stated purpose and services provided in the unit and the resident, surrogate, or representative has participated in the placement decision. 10. If the purpose of the unit is to provide an emergency short-term monitored separation for a resident who showed temporary behavior problems (such as brief

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F223 Cont.		catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staff or others in the facility) then answer the questions with regard to temporary separation set out above.
F224	(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must-- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	Intent: §483.13(c) The intent of this regulation is to assure that the facility has in place an effective system that regardless of the source (staff, other residents, visitors, etc), prevents mistreatment, neglect and abuse of residents, and misappropriation of resident's property. However, such a system cannot guarantee that a resident will not be abused; it can only assure that the facility does whatever is within its control to prevent mistreatment, neglect, and abuse of residents or misappropriation of their property. Such steps include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents, an assessment of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abusive behavior, and reassessment of the strategies on a regular basis.
F225	(ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	For each sampled resident in a secured unit, determine the facility's stated purpose for the unit and the facility's intent in placing the individual in the unit. Guidelines: §483.13(c) "Neglect", is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (See Older Americans Act, §302(a)(19).) Neglect occurs on an individual basis when a resident does not receive a lack of care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces). "Misappropriation of resident property" is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Procedures: §483.13(c)(2)(3)(4) During Sample Selection: 1. If the team has identified problems in mistreatment, neglect or abuse of residents or misappropriation of their property, then request: a. A copy of the facility's policies and procedures regarding abuse prevention; note particularly the extent to which those policies concern the areas uncovered through complaints and/or previous survey; b. Reports of action(s) by a court of law against employees; c. Reports of alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident's property; d. Reports of the results of these investigations; e. Records of corrective actions taken;

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F225 Cont.	(2) The facility must ensure that all alleged violations involving 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 in accordance with State law through established procedures (including to the State survey and certification agency). (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	In addition, spot check employment: 3. Applications for questions about convictions or mistreatment, neglect or abuse of residents, or misappropriation of their property. Determine if applicants have answered these questions and if affirmative answers had resulted in rejections of employment candidates. 4. Records for contact with State Nurse Aide Registry. Determine if applicants with a finding concerning mistreatment, neglect, abuse of residents or misappropriation of their property have been rejected. 5. New employees for registry entries. Ask for the results of any in-house investigations of mistreatment, neglect, or abuse of residents, misappropriation of their property, or injuries of unknown source. o Was the administrator notified of the incident and when? o Did investigations begin promptly after the report of the problem? o Is there a record of statements or interviews of the resident, suspect (if one is identified), any eye witnesses and any circumstantial witnesses? o Was relevant documentation reviewed and preserved (e.g., dated dressing which was not changed when treatment record recorded change)? o Was the alleged victim examined promptly (if injury was suspected) and the finding documented in the report? o What steps were taken to protect the alleged victim from further abuse (particularly where no suspect has been identified?) o What actions were taken as a result of the investigation? o What corrective action was taken, including informing the nurse aide registry, State licensure authorities, and other agencies (e.g., long term care ombudsman; adult protective services; Medicaid fraud and abuse unit)? Intent: §483.13(c)(1)(ii) The intent of this regulation is to prevent employment of individuals who have been convicted of abusing, neglecting, or mistreating individuals in a health care related setting, e.g., residents of a nursing facility or patients in a hospital. Facilities must be thorough in their investigations of the past histories of individuals they are

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F225 Cont.		considering hiring. In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility should check all references and make reasonable efforts to uncover information about any past criminal prosecutions. Guidelines: §483.13(c)(1)(ii) "Found guilty...by a court of law" applies to situations where the defendant pleads guilty, is found guilty, or pleads nolo contendere. "Finding" is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents or misappropriation of their property. Guidelines: §483.13(c)(1)(iii) An aide or other facility staff found guilty of neglect, abuse, or mistreating residents or misappropriation of property by a court of law, must have his or her name entered into the nurse aide registry, or reported to the licensing authority, if applicable. Further, if a facility determines that actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), then the facility must report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authorities (if a licensed staff member). Such a determination by the facility is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment. If, during a survey, the survey team is made aware of a previous incident of neglect or abuse, evaluate current residents for evidence of similar problems that might indicate that the facility has not addressed systemic problems to protect residents from neglect, abuse and misappropriation of property.

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F240	§483.15 Quality of life. A 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.	Guidelines: §483.15 The intention of the quality of life requirements is to specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.
F241	(a) Dignity. 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.	Guidelines: §483.15(a) "Dignity" means that in their interactions with residents, staff carry out activities which assist the resident to maintain and enhance his/her self-esteem and self-worth. For example: o Grooming residents as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped); o Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences; o Assisting residents to attend activities of their own choosing; o Labelling each resident's clothing in a way that respects his or her dignity; o Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware, bibs instead of napkins, dining room conducive to pleasant dining, aides not yelling); o Respecting resident's private space and property (e.g., not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possessions without permission); o Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in community setting); and o Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services. Procedures: §483.15(a) For sampled residents, use the Resident Assessment Instrument (RAI) and comprehensive care plan to consider the resident's former life style and personal choices made while in the facility to obtain a picture of characteristic resident behaviors. As part of the team's information gathering and decision-making, look at the actions and omissions of staff and the uniqueness of the individual sampled resident and on the needs and preferences of the resident, not on the actions and omissions themselves.

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F241 Cont.		Throughout the survey, observe: Do staff show respect for residents? When staff interact with a resident, do staff pay attention to the resident as an individual? Do staff respond in a timely manner to the resident's requests for assistance? In group activities, do staff focus attention on the group of residents? Or, do staff appear distracted when they interact with residents? For example, do staff continue to talk with each other while doing a "task" for a resident(s) as if she/he were not present? If the survey team identifies potential compliance issues regarding the privacy of residents during treatment, refer to §483.10(e) F164.
F242	(b) Self-determination and participation. The resident has the right to-- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.	Procedures: §483.15(b) Observe how well staff know each resident and what aspects of life are important to him/her. Determine if staff make adjustments to allow residents to exercise choice and self-determination. Review MDS Background Information III (MDS version 2.0 section AC) for customary routines. For sampled residents, review MDS to determine level of participation in assessment and care planning by resident and family members. Review MDS, Section G (MDS version 2.0 section F) for Psychosocial Well-Being and Care Planning. If the facility has failed to reasonably accommodate the preferences of the resident consistent with interests, assessments and plan of care, see F246, §483.15(e). Guidelines: §483.15(b)(3) The intent of this requirement is to specify that the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. For example, if a facility changes its policy and prohibits smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting, this may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission. (See §483.10(b)(1).) Or, if a resident mentions that her therapy is scheduled at the time of her favorite television program, the facility should accommodate the resident to the extent that it can.

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F243	(c) Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the facility; (2) A resident's family has the right to meet in the facility with the families of other residents in the facility; (3) The facility must provide a resident or family group, if one exists, with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result form group meetings;	Guidelines: §483.15(c) This requirement does not require that residents' organize a residents or family group. However, whenever residents or their families wish to organize, facilities must allow them to do so without interference. The facility must provide the group with space, privacy for meetings, and staff support. Normally, the designated staff person responsible for assistance and liaison between the group and the facility's administration and any other staff members attend the meeting only if requested. "A resident's or family group" is defined as a group that meets regularly to: o Discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; o Support each other; o Plan resident and family activities; o Participate in educational activities; or o For any other purpose. The facility is required to listen to resident and family group recommendations and grievances. Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group's recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility should communicate its decisions to the resident and/or family group.
F244	(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	Procedures: §483.15(c) If no organized group exists, determine if residents have attempted to form one and have been unsuccessful, and, if so, why.
F245	(d) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do	Guidelines: §483.15(d) The facility, to the extent possible, should accommodate an individual's needs and choices for how he/she spends time, both inside and outside the facility. Ask the social worker or other appropriate staff how they help residents pursue activities outside the facility.

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F245 Cont.	not interfere with the rights of other residents in the facility.	
	(e) Accommodation of needs. A resident has the right to--	Guidelines: §483.15(e) "Reasonable accommodations of individual needs and preferences," is defined as the facility's efforts to individualize the resident's environment. The facility's physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own preferences, assessment and care plans. The facility should attempt to adapt such things as schedules, call systems, and room arrangements to accommodate residents' preferences, desires, and unique needs.
F246	(1) Reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and	This requirement applies to areas and environment in accordance with needs and preferences NOT addressed at: §§483.10(k), Telephone; 483.10(l), Personal property; 483.10(m), Married couples; 483.15(b), Self-Determination and participation; 483.15(f)(1), Activities; 483.15(g)(1), Social services; 483.15(h)(1), Homelike environment; 483.25(a)(2) and (3), Treatment and Services, Activities of daily living; 483.25(f)(1), Psychosocial functioning; 483.25(h)(2), Accidents, Prevention-assistive devices; 483.35(d)(3), Food prepared in a form designed to meet individual needs.
F247	(2) Receive notice before the resident's room or roommate in the facility is changed.	The facility must demonstrate that it accommodates residents' needs. For example, if the resident refuses a bath because he or she prefers a shower, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstances provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her needs. This includes learning the resident's preferences and taking them into account when discussing changes of room or roommates and the timing of such changes. In addition, this also includes making necessary adjustments to ensure that residents are able to reach call cords, buttons or other communications mechanisms, as well as accommodating food, activities or room choices. Procedures: §483.15(e) Observe resident-staff interaction and determine to what extent staff attempt to accommodate residents' preferences. For those areas not addressed in other regulations, determine what happens when a resident states a preference in the form of a refusal. How does the staff attempt to learn what the resident is refusing, and why, and make adjustments to an extent practicable to meet the resident's needs?

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F247 Cont.		Probes: §483.15(e) o Are rooms arranged such that residents in wheel chairs can easily access personal items and transfer in and out of bed? o Does the facility respond to residents' stated needs and preferences? o If the resident is unable to express needs and preferences that would individualize care, has the family expressed the resident's routine and has the facility responded? Guidelines: §483.15(e)(1) Review the extent to which the facility adapts the physical environment to enable residents to maintain unassisted functioning. These adaptations include, but are not limited to: 1. Furniture and adaptive equipment that enable residents to: a. Stand independently; b. Transfer without assistance (e.g., arm supports, correct chair height, firm support); c. Maintain body symmetry; and d. Participate in resident-preferred activities. 2. Measures that: a. Enable residents with dementia to walk freely; b. Reorient and remotivate residents with restorative potential (e.g., displaying easily readable calendars and clocks, wall hangings evocative of the lives of residents); c. Promote conversation and socialization (pictures and decorations that speak to the resident's age cohort); and d. Promote mobility and independence for disabled residents in going to the bathroom (e.g., grab bars, elevated toilet seats). Determine if staff use appropriate measures to facilitate communication with residents who have difficulty communicating. For example, if necessary, does staff get at eye level, allow the resident to read lips, or remove a resident from noisy surroundings? Determine if staff communicate effectively with residents with cognitive impairments, such as referring in a non-contradictory way to what residents are saying, and addressing what residents are trying to express to the agenda behind their behavior. Probes: §483.15(e)(1)(2) How have residents' needs been accommodated? Do environmental adaptions enhance residents' independence, self-control, and highest practicable well-being? Is the fit between residents' needs and environment positive?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F248	(f) 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.	Guidelines: §483.15(f)(1) Because the activities program should occur within the context of each resident's comprehensive assessment and care plan, it should be multi-faceted and reflect each individual resident's needs. Therefore, the activities program should provide stimulation or solace; promote physical, cognitive and/or emotional health; enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice. Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers and visitors. Probes: §483.15(f)(1) Observe individual, group and bedside activities. 1. Are residents who are confined or choose to remain in their rooms provided with in room activities in keeping with life-long interests (e.g., music, reading, visits with individuals who share their interests or reasonable attempts to connect the resident with such individuals) and in-room projects they can work on independently? Do any facility staff members assist the resident with activities he or she can pursue independently? 2. If residents sit for long periods of time with no apparently meaningful activities, is the cause: a. Resident choice; b. Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities; c. Lack of assistance with ambulation; d. Lack of sufficient supplies and/or staff to facilitate attendance and participation in the activity programs. e. Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex? For residents selected for a comprehensive review, or a focused review, as appropriate, determine to what extent the activities reflect the individual resident's assessment. (See especially MDS III.1 and Sections B, C, D, and I; MDS version 2.0 sections AC, B, C, D and N.) Review the activity calendar for the month prior to the survey to determine if the formal activity program:

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F248 Cont.	(2) The activities program must be directed by a qualified professional who-- (i) Is a qualified therapeutic recreation specialist or an activities professional who-- (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or	o Reflects the schedules, choices and rights of the residents; o Offers activities at hours convenient to the residents (e.g., morning, afternoon, some evenings and weekends); o Reflects the cultural and religious interests of the resident population; and o Would appeal to both men and women and all age groups living in the facility. Review clinical records and activity attendance records of residents receiving a comprehensive review, or a focused review, as appropriate, to determine if: o Activities reflect individual resident history indicated by the comprehensive assessment; o Care plans address activities that are appropriate for each resident based on the comprehensive assessment; o Activities occur as planned; and o Outcomes/responses to activities interventions are identified in the progress notes of each resident. Guidelines: §483.15(f)(2) A "recognized accrediting body" refers to those organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professionals or registered occupational therapists. Procedures: §483.15(f)(2) If there are problems with provision of activities, determine if these services are provided by qualified staff.
F249	(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(g) Social Services.	Intent: §483.15(g) To assure that sufficient and appropriate social services are provided to meet the resident's needs.
F250	(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	Guidelines: §483.15(g)(1) Regardless of size, all facilities are required to provide for the medically related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. It is not required that a qualified social worker necessarily provide all of these services. Rather, it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines. "Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example: o Making arrangements for obtaining needed adaptive equipment, clothing, and personal items; o Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning; o Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications; o Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation); o Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements); o Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities); o Providing or arranging provision of needed counseling services; o Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices; o Building relationships between residents and staff and teaching staff how to understand and support residents' individual needs; o Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality; o Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F250 Cont.		o Finding options that most meet the physical and emotional needs of each resident; o Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet; o Meeting the needs of residents who are grieving; and o Finding options which most meet their physical and emotional needs. Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for: o Dental/denture care; o Podiatric care; o Eye care; o Hearing services; o Equipment for mobility or assistive eating devices; and o Need for home-like environment, control, dignity, privacy. Where needed services are not covered by the Medicaid State Plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid State Plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance. Types of conditions to which the facility should respond with social services by staff or referral include: o Lack of an effective family/social support system; o Behavioral symptoms; o If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his or her re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the resident's behavior); o Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer's disease, schizophrenia); o Depression; o Chronic or acute pain; o Difficulty with personal interaction and socialization skills; o Presence of legal or financial problems; o Abuse of alcohol or other drugs; o Inability to cope with loss of function; o Need for emotional support;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F250 Cont.		o Changes in family relationships, living arrangements, and/or resident's condition or functioning; and o A physical or chemical restraint. For residents with or who develop mental disorders as defined by the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), see §483.45, F406. Probes: §483.15(g)(1) For residents selected for a comprehensive or focused review as appropriate: o How do facility staff implement social services interventions to assist the resident in meeting treatment goals? o How do staff responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly? o How does the care plan link goals to psychosocial functioning/well-being? o Have the staff responsible for social work established and maintained relationships with the resident's family or legal representative? o [NFs] What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan? Look for evidence that social services interventions successfully address residents' needs and link social supports, physical care, and physical environment with residents' needs and individuality. For sampled residents, review MDS, Section H.
F251	(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (3) Qualifications of a social worker. A qualified social worker is an individual with-- (i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and	Procedures: §483.15(g)(2) and (3) If there are problems with the provision of social services in a facility with over 120 beds, determine if a qualified social worker is employed on a full time basis. See also F250.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F251 Cont.	(ii) One year of supervised social work experience in a health care setting working directly with individuals.	
F252	(h) Environment. The facility must provide-- (1) A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	Guidelines: §483.15(h)(1) For "safe" environment, also see Guidelines for §§483.25(h), Accidents, and 483.70(a), Life Safety Code. For personal belongings, also see §§483.10(l), Personal property. For "comfortable" environment, see Guidelines for 483.15(h)(5), Adequate and comfortable lighting levels; 483.15(h)(6), Comfortable and safe temperature levels; and 483.15(h)(7), Comfortable sound levels. A determination of "comfortable and homelike" should include, whenever possible, the resident's or representative of the resident's opinion of the living environment. The absence of a personalized, homelike environment in a resident's room, is not meaningful unless the survey team determines that the absence of personal belongings is a result of facility practices, rather than the result of resident choice or circumstances (e.g., lack of resident funds, lack of family support system, resident's reason for being in the facility, such as short-term rehabilitation). A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression and encourages links with the past and family members. Use this Tag when the facility fails to allow the resident to personalize his or her individual environment to the extent possible. Use Tag F224 (483.15(c)) if the facility fails to have a system in place to prevent the misappropriation of resident's property. See §483.10(l) for the requirement regarding personal property. For purposes of this requirement, "environment" refers to any environment in the facility that is frequented by residents, including the residents' rooms, bathrooms, hallways, activity areas, and therapy areas. If the survey team observes that the rooms of residents with dementia do not appear to be homelike, determine if this decision was made in the context of assessment and care planning; i.e., that this environment assists these residents to maintain their highest practicable functioning levels.

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F252 Cont.		If the team observes non-homelike environments for residents with dementia, determine if each of these residents have the same plan of care and the reason why each of these residents have the same plan of care. By observing the residents' surroundings, what can the survey team learn about their everyday life and interests? Their life prior to residing in the facility? Observe family photographs, books and magazines, bedspreads, knickknacks, mementos, and furniture that belong to the residents. For residents who have no relatives or friends, and have few assets, determine the extent to which the facility has assisted these residents to make their rooms homelike, if they so desire.
F253	(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	Intent: §483.15(h)(2) The intent of this requirement is to focus on the facility's responsibility to provide effective housekeeping and maintenance services. Guidelines: §483.15(h)(2) "Sanitary" includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes toothbrushes, dentures, denture cups, glasses and water pitchers, emesis basins, hair brushes and combs, bed pans, urinals, feeding tubes, leg bags and catheter bags, pads and positioning devices. For kitchen sanitation, see §483.70(h), Physical Environment, other environmental conditions. For facility-wide sanitary practices affecting the quality of care, see §483.65, Infection Control. "Orderly" is defined as an uncluttered physical environment that is neat and well-kept. Procedures: §483.15(h)(2) Balance the resident's need for a homelike environment and the requirements of having a "sanitary" environment in a congregate living situation. For example, a resident may prefer a cluttered room, but does this clutter result in unsanitary or unsafe conditions? Probes: §483.15(h)(2) Is resident care equipment sanitary? Is the area orderly? Is the area uncluttered and in good repair? Can residents and staff function unimpeded?

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F254	(3) Clean bed and bath linens that are in good condition;	Probes: §483.15(h)(3) Are bed linens clean and in good condition? Are there clean towels and wash cloths in good condition available for the resident?
F255	(4) Private closet space in each resident room, as specified in §483.70(d)(2)(iv) of this part;	Guidelines: §483.15(h)(4) §483.70(d)(2)(iv) states: "The facility must provide each resident with individual closet space in his/her bedroom with clothes racks and shelves accessible to the resident." Probes: §483.15(h)(4) Are there individual closet spaces with accessible shelves? Also see F470.
F256	(5) Adequate and comfortable lighting levels in all areas;	Guidelines: §483.15(h)(5) "Adequate lighting" is defined as levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform. For some residents (e.g., those with glaucoma), lower levels of lighting would be more suitable. "Comfortable" lighting is defined as lighting which minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of illumination so that visually impaired residents can maintain or enhance independent functioning. Procedures: §483.15(h)(5) Are there adequate and comfortable lighting levels for individual resident and staff work needs? Consider the illumination available from any source, natural or artificial. For hallways, observe the illumination that is normally present. For resident rooms or for other spaces where residents can control the lighting, turn on the lights and make the rating under these conditions.

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F257	(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81° F; and	Procedures: §483.15(h)(6) "Comfortable and safe temperature levels" means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds. Although there are not explicit temperature standards for facilities certified on or before October 1, 1990, these facilities still must maintain safe and comfortable temperature levels. For facilities initially certified after October 1, 1990, temperatures may exceed the upper range of 81° Fahrenheit for facilities in geographic areas of the country (primarily at the northernmost latitudes) where that temperature is exceeded only during rare, brief episodes of unseasonably hot weather. This interpretation would apply in cases where it does not adversely affect resident health and safety, and would enable facilities in areas of the country with relatively cold climates to avoid the expense of installing air conditioning equipment that would only be needed very infrequently. Conversely, the temperature may fall below 71° Fahrenheit for facilities in areas of the country where that temperature is exceeded only during brief episodes of unseasonably cold weather (minimum temperature must still be maintained at a sufficient level to minimize risk of hypothermia and susceptibility to loss of body heat, respiratory ailments and colds). Measure the air temperature above floor level in resident rooms, dining areas, and common areas. If the temperature is out of the 71-81 degree range, then ask staff what actions they take when residents complain of heat or cold, e.g., provide extra fluids during heat waves and extra blankets and sweaters in cold.
F258	(7) For the maintenance of comfortable sound levels.	Guidelines: §483.15(h)(7) "Comfortable" sound levels do not interfere with resident's hearing and enhance privacy when privacy is desired, and encourage interaction when social participation is desired. Of particular concern to comfortable sound levels is the resident's control over unwanted noise. Procedures: §483.15(h)(7) Determine if the sound levels are comfortable to residents. Do residents and staff have to raise their voices to communicate over background sounds? Are sound levels suitable for the activities occurring in that space during observation? Consider whether residents have difficulty hearing or making themselves heard because of background sounds (e.g., overuse or excessive volume of intercom, shouting, loud TV,

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F258 Cont.		cleaning equipment). Consider if it is difficult for residents to concentrate because of distractions or background noise such as traffic, music, equipment, or staff behavior. Consider the comfort of sound levels based on the needs of the residents participating in a particular activity, e.g., the sound levels may have to be turned up for hard of hearing individuals watching TV or listening to the radio. Consider the effect of noise on the comfort of residents with dementia. o During resident reviews, ask residents if during evenings and at nighttime, sounds are at comfortable levels? (If yes) Have you told staff about it and how have they responded?

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Refer to F272	§483.20 Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.	Intent: §483.20 To provide the facility with the information necessary to develop a care plan and to provide the appropriate care and services for each resident. Guidelines: §483.20 The guidelines for resident assessment are consistent with the requirements for each State's specified RAI. Each State's RAI includes at least the MDS and common definitions, triggers, and utilization guidelines developed by HCFA, which include the RAPs. Refer to F272.
F271	(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.	Intent: §483.20(a) To ensure the resident receives necessary care and services. Guidelines: §483.20(a) "Physician orders for immediate care" are those written orders facility staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. These orders should, at a minimum, include dietary, drugs (if necessary), and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.
F272	(b) Comprehensive assessments. (1) The facility must make a comprehensive assessment of a resident's needs which-- (i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and (ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity.	Guidelines: §483.20(b)(1)(2) The information required in §483.20(b)(2)(i - xiii) is incorporated into the MDS, which forms the core of each State's approved RAI. Additional assessment information is also gathered using triggered RAPS. Each facility must use its State specified RAI (which includes both the MDS and utilization guidelines which include the RAPs) to assess newly admitted residents, annual review and those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPS. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission.

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F272 Cont.	(2) The comprehensive assessment must include at least the following information:	All references to version 2.0 (v. 2.0) of the MDS are effective when the State respecifies its RAI.
	(i) Medically defined conditions and prior medical history;	(This corresponds to MDS Identification Information I.11-12 and Section J; MDS v. 2.0 Section AB9-10 and Section I, Disease Diagnosis, respectively.) "Medically defined conditions and prior medical history" is defined as the resident's medical history before admission and a description of current medical diagnoses. It includes history of mental retardation and current mental illness, if applicable.
	(ii) Medical status measurement;	(This corresponds to MDS sections B1-6, J1-2, K1 and K3, and P1-2; MDS v. 2.0 sections B1-6, I1-2, J1-3, 5 and P1 and 9.) "Medical status measurement" is defined as objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic test.
	(iii) Physical and mental functional status;	(This corresponds to MDS sections E1-8 and G1-3; MDS v. 2.0 sections G1-9 and F1-3.) "Physical and mental functional status" is defined as the resident's ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, or other communication systems. Includes determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility.
	(iv) Sensory and physical impairments;	(This corresponds to MDS sections C1-6, D1-3, E4 and F1-4; MDS v. 2.0 sections C1-7, D1-3, G4, and H1-4.) "Sensory and physical impairments" are defined as neurological or muscular deficits. For example, a decrease in vision or hearing, paralysis, or bladder incontinence.
	(v) Nutritional status and requirements;	(This corresponds to MDS section L1-4; MDS v. 2.0 section K1-6.) "Nutritional status and requirements" are defined as weight, height, hematologic and biochemical assessments, clinical observations of nutrition, nutritional intake, resident's eating habits and preferences, and dietary restrictions.
	(vi) Special treatments or procedures;	(This corresponds to MDS sections L4, N1-4, P1; MDS v. 2.0 sections K5, M5, and P1.) "Special treatments or procedures" are defined as treatments and procedures that are not part of basic services provided. For example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, or respiratory care.

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F272 Cont.	(vii) Mental and psychosocial status;	(This corresponds to MDS sections III (customary routine), G1-3 and H; MDS v. 2.0 sections AC, F1-3, and E.) "Mental and psychosocial status" is defined as the resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood.
	(viii) Discharge potential;	(This corresponds to MDS section A10; MDS v. 2.0 section Q.) "Discharge potential" is defined as the facility's expectation of discharging the resident from the facility within the next three months.
	(ix) Dental condition;	(This corresponds to MDS section M; MDS v. 2.0 section L.) "Dental condition" is defined as the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communication abilities, or quality of life. The assessment should include the need for, and use of, dentures or other dental appliances.
	(x) Activities potential;	(This corresponds to MDS sections I (activities pursuit) and III (customary routine); MDS v. 2.0 sections N and AC.) "Activities potential" is defined as the resident's ability and desire to take part in activities which maintain or improve, physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of activities of daily living (ADLs) which a person pursues in order to obtain a sense of well-being. Also, includes activities which provide benefits in self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence. The assessment should consider the resident's normal everyday routines and lifetime preferences.
	(xi) Rehabilitation potential;	(This corresponds to MDS section E7; MDS v. 2.0 section G8.) "Rehabilitation potential" is defined as the ability to improve independence in functional status through restorative care programs.
	(xii) Cognitive status; and	(This corresponds to MDS section B1-6; MDS v. 2.0 section B1-6.) "Cognitive status" is defined as the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards.
	(xiii) Drug therapy.	(This corresponds to MDS section O; v.2.0 section O.) "Drug therapy" is defined as all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident. This information need not appear in the assessment. However, it must be in the resident's clinical record and included in the care plan.

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F272 Cont.		Probes: §483.20(b)(1)(2) o Has each resident in the sample been comprehensively assessed using the State specified RAI within the regulatory timeframes (i.e., within 14 days of admission, on significant change in status, and at least annually)? o Has the facility gathered supplemental assessment information based on triggered RAPs prior to establishing the care plan? o Does information in the RAI correspond with information obtained during observations of and interviews with the resident, facility staff and resident's family?
	(4) Frequency. Assessments must be conducted--	Intent: §483.20(b)(4) To assess residents in a timely manner.
F273	(i) No later than 14 days after the date of admission; (ii) For current NF residents not later than October 1, 1991; (iii) For current SNF residents, not later than January 1, 1991;	Guidelines: §483.20(b)(4) "Admission" to the facility is defined as an initial stay or a return stay (not a readmission) in the facility. A return stay applies to those residents who are discharged without expectation that they will return to the facility, but who do return to the facility. A "readmission" is an expected return to the facility following a temporary absence for hospitalization, off-site visit or therapeutic leave. A resident who is readmitted and for whom there is a prior RAI on file does not require a new assessment unless a significant change in status has occurred (see below), and should remain on the same schedule as if there had been no temporary absence. An MDS/RAI need not be completed for residents discharged in less than 14 days, although the facility is to provide care appropriate to the resident's needs from admission to discharge. If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment. Facilities may correct errors on the MDS per HCFA policy within 7 days of its completion. The following guidance concerning significant change is applicable until the State respecifies its RAI for version 2.0. A "significant change" may include, but is not limited to, any of the following, or may be determined by a physician's decision if uncertainty exists:
F274	(iv) Promptly after a significant change in the resident's physical or mental condition; and	
F275	(v) In no case less often than once every 12 months.	

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F275 Cont.		o Deterioration in two or more ADLs, or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appears permanent. For example, pronounced deterioration in function and communication following a stroke; o Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush or comb. Temporary loss of ability, such as during an acute illness, is not included; o Deterioration in behavior or mood, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention; o Deterioration in a resident's health status, where this change places the resident's life in danger, e.g., stroke, heart disease, metastatic cancer; is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or is associated with an initial diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, (e.g., Alzheimer's disease or diabetes) or the onset of significant (unplanned) weight loss (5% in last 30 days, 10% in last 180 days); or o Improvement in behavior, mood or functional status to the extent that the plan of care no longer addresses the needs of the resident. Comprehensive resident assessment is not required if declines in physical, mental or psychosocial well-being are short-term or insignificant (i.e., do not require a change in the resident's care plan). This may include: o Discrete and easily reversible symptoms documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level; o Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect a full recovery of the resident's pre-morbid functional abilities and health status; o Well-established symptoms associated with previously diagnosed cyclical conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease; or o If the resident continues to make steady progress under the current course of care, reassessment is required only when the condition has stabilized. "Promptly" means that once it is determined that the resident's change in status is significant or likely to be permanent, a full assessment must be completed within 14 days of this determination. The following definition of and criteria for significant change are effective when the State respecifies its RAI:

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F275 Cont.		A "significant change" is a major change in the resident's status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. According to this definition, a significant change reassessment would be indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement. Following are examples which could indicate a significant change. Decline: o Any decline in ADL physical functioning where a resident is newly coded as 3, 4 or 8 (Extensive assistance, Total dependency, Activity did not occur); o Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1's" for E4B); o Resident's decision making changes from 0 or 1, to 2 or 3; o Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter; o Emergence of sad or anxious mood as a problem that is not easily altered; o Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); o Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before; o Emergence of a condition/disease in which a resident is judged to be unstable; o Emergence of a pressure ulcer at State II or higher, when no ulcers were previously present at Stage II or higher; or o Overall deterioration of resident's condition; resident received more support (e.g., in ADLs or decision-making). Improvement: o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered"; o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports. If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment. Probes: §483.20(b)(4) o Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)? o Has the facility identified those residents who have experienced a significant change?

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F275 Cont.		o Has the facility reassessed residents using the State-specified RAI who had a change in status within 14 days after determining the change was significant or appears to be permanent?
F276	(5) Review of Assessments. The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	Intent: §483.20(b)(5) To assure that the resident's assessment is accurate and reflects the resident's current status. Guidelines: §483.20(b)(5) At least each quarter, the facility shall review each resident with respect to those MDS items specified under the State's quarterly review requirement. At a minimum, this would include all items contained in HCFA's quarterly review form. Until the State respecifies its RAI for version 2.0, facilities are not required to use HCFA's form unless specified by the State. However, when the State respecifies its RAI, the quarterly review form will be required. If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the significant change reassessment. Until the State respecifies its RAI, review at least quarterly: o Cognitive patterns, especially memory and daily decision-making ability; o Communication/hearing ability, especially the ability to make one's self understood and to understand others; o Physical functioning and ADL abilities; o Continence; o Mood and behavior patterns; o New disease diagnoses that have a relationship to current ADL status, behavior status, medical treatments, or risk of death; o Weight loss; o Medication use, particularly psychotropic medications; and o Special treatments and procedures, including restraints. NOTE: These quarterly assessment domains will no longer apply when the State respecifies its RAI. Probes: §483.20(b)(5) o Is the facility assessing and acting, no less than once every 3 months, on the results of resident's functional and cognitive status examinations? o Is the quarterly review of the resident's condition consistent with information in the progress notes, the plan of care and your resident observations and interviews?

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Refer to F279	(6) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.	Procedures: §483.20(b)(6) See §483.20(d).
F277	(7) Coordination. The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.	Intent: §483.20(b)(7) To prevent duplicative data gathering by using MDS assessment information for more than one purpose. Guidelines: §483.20(b)(7) As the facility determines appropriate, if required portions of the comprehensive assessment have been performed as part of a pre-admission screening program, enter the results of the pre-admission screening into the appropriate portion of the comprehensive assessment instrument. Unless a significant change has occurred between preadmission screening and admission, the facility may choose not to repeat those portions of the assessment. For example, medical records containing the resident's history and course of previous hospitalizations, pertinent laboratory results and social history data may be used where applicable to enter information on the assessment form.
F278	(c) Accuracy of assessments. (1) Coordination. (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.	Intent: §483.20(c) To assure that each resident receives an accurate assessment by participation of staff that are qualified to assess relevant care areas and knowledgeable about the resident's status and needs. Guidelines: §483.20(c) "The accuracy of the assessment" means that the appropriate, qualified health professional correctly documents the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. The initial comprehensive assessment is the baseline data for ongoing assessments of resident progress. According to the Utilization Guidelines for each State's RAI, the physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident. Involvement of other disciplines is dependent upon resident status and needs.

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F278 Cont.	(2) Certification. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (3) Penalty for Falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties. The implementing regulations for this statutory authority are located in Part 1003 of this chapter.	The registered nurse will conduct and/or coordinate the assessment, as appropriate. Whether conducted or coordinated by the registered nurse, he or she is responsible for certifying that the assessment has been completed. Probes: §483.20(c) o Have appropriate health professionals assessed the resident? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident? o If the resident's medical status, functional abilities, or psychosocial status declined and the decline was not clinically unavoidable, were the appropriate health professionals involved in assessing the resident? o Based on your total review of the resident, is each portion of the assessment accurate? Procedures: §483.20(c)(3) o If there is evidence that assessments are knowingly and willingly falsified, organize all documentation and obtain photostatic copies of pertinent resident records. Inform your immediate supervisor at the State or HCFA RO who should review the findings and initiate any investigative action. If the State is notified first, it should then communicate its findings to the RO. If the RO is notified initially, it should communicate its finding to the State to pursue an investigation. For Medicare, it is the responsibility of the RO to make a formal request of the appropriate Inspector General's Field Office for further investigation of the facility. For Medicaid, it is the responsibility of the State agency to make a formal request of the appropriate Inspector General's Office for further investigation.
	(4) Use of independent assessors. If a State determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (c)(3) of this section, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.	
	(d) Comprehensive care plans.	
F279	(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and	Guidelines: §483.20(d) An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the RAP Summary or clinical record of the resident's status in triggered RAP areas and

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F279 Cont.	mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	their rationale for deciding whether to proceed with care planning and that they considered the development of care planning interventions for all RAPs triggered by the MDS. The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care. The requirements reflect the facility's responsibility to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment). Probes: §483.20(d)(1) o Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment? o Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths? o Does the care plan reflect standards of current professional practice? o Do treatment objectives have measurable outcomes? o Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment. o Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment. o If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? NOTE: For implementation of care plan, see §483.20(d)(3).

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F280	(2) A comprehensive care plan must be-- (i) Developed within 7 days after the completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Guidelines: §483.20(d)(2) As used in this requirement, "interdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. The physician must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-to-one discussions and conference calls. The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. (See §§483.10(d)(2) and (3) and 483.10(b)(4).) The facility should encourage residents, surrogates, and representatives to participate in care planning, including encouraging attendance at care planning conferences if they so desire. Probes: §483.20(d)(2) 1. Was interdisciplinary expertise utilized to develop a plan to improve the resident's functional abilities? a. For example, did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability? b. Do the dietitian and the speech therapist determine, for example, the optimum textures and consistency for the resident's food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident? c. Is there evidence of physician involvement in development of the care plan (e.g., presence at care planning meetings, conversations with team members concerning the care plan, conference calls)? 2. In what ways do staff involve residents and families, surrogates, and/or representatives in care planning? 3. Do staff make an effort to schedule care plan meetings at the best time of the day for residents and their families? 4. Ask the ombudsman if he/she has been involved in a care planning meeting as a resident advocate. If yes, ask how the process worked. 5. Do facility staff attempt to make the process understandable to the resident/family? (Individual) Have you had concerns or questions about your care and brought them to the attention of facility staff? If yes, what happened as a result?

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F280 Cont.		Guidelines: §483.20(d)(2)(iii) See §483.75(g)(2) for Qualified Person. Probes: §483.20(d)(2)(iii) o Is the care plan evaluated and revised as the resident's status changes?
	(3) The services provided or arranged by the facility must--	Intent: §483.20(d)(3) The intent of this regulation is that persons providing services are qualified to do so, that the resident's plan of care is implemented, and that those services provided meet professional standards of quality.
F281	(i) Meet professional standards of quality; and	Intent: §483.20(d)(3)(i) The intent of this regulation is to assure that services being provided meet professional standards of quality (in accordance with the definition provided below) and are provided by appropriate qualified persons (e.g., licensed, certified).
F282	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.	Guidelines: §483.20(d)(3)(i) "Professional standards of quality" means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include: o Current manuals or textbooks on nursing, social work, physical therapy, etc. o Standards published by professional organizations such as the American Nurses' Association, the National Association of Social Work, the American Dietetic Association, the National Association of Activity Professionals, the American Medical Association, etc. o Clinical practice guidelines published by the Agency for Health Care Policy and Research. o Current professional journal articles. If a negative resident outcome is determined to be related to the facility's failure to meet professional standards, and the team determines a deficiency has occurred, it should be cited under the appropriate quality of care or other relevant requirement. Probes: §483.20(d)(3) Question only those practices which have a negative outcome or have a potential negative outcome. Ask the facility to produce references upon which the practice is based. o Do nurses notify physicians, as appropriate, and show evidence of discussions of acute medical problems?

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F282 Cont.		o Are residents with acute conditions who require intensive monitoring and hospital-level treatments that the facility is unable to provide, promptly hospitalized? o Are there errors in the techniques of medication administration? (Cite actual medication errors at §483.25(m), F333 or F334.) o Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan? o Are physicians' orders carried out, unless otherwise indicated by an advanced directive? o Can direct care giving staff describe the care, services and expected outcomes of the care they provide; have a general knowledge of the care and services being provided by other therapists; have an understanding of the expected outcomes of this care, and understand the relationship of these expected outcomes to the care they provide. Guidelines: §483.20(d)(3)(ii) If you find problems with quality of care, quality of life, or resident rights, are these problems attributable to the qualifications of the facility staff, or lack of, inadequate or incorrect implementation of the care plan?
	(e) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes--	Intent: §483.20(e) To ensure appropriate discharge planning and communication of necessary information to the continuing care provider. Guidelines: §483.20(e) A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for mentally retarded individuals. Resident protection concerning transfer and discharge are found at §483.12. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. "Anticipates" means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident's death. "Adjust to his or her living environment" means that the post-discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple caregivers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/caregiver education needs to restore the
F283	(1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and	
F284	(3) A post-discharge plan of care that is developed with the	

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F284 Cont.	participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	resident/caregiver to meet care needs after discharge. Probes: §483.20(e) o Does the discharge summary have information pertinent to continuing care for the resident? o Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)? o Do discharge plans address necessary post-discharge care? o Has the facility aided the resident and his/her family in locating and coordinating post-discharge services? o What types of pre-discharge preparation and education has the facility provided the resident and his/her family?
F285	(f) Preadmission screening for mentally ill individuals and individuals with mental retardation. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with-- (i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	Intent: §483.20(f) To ensure that individuals with mental illness and mental retardation receive the care and services they need in the most appropriate setting. "Specialized services" are those services the State is required to provide or arrange for that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to NF services--they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF. The statute mandates preadmission screening (PAS) for all individuals with mental illness (MI) or mental retardation (MR) who apply to NFs, regardless of the applicant's source of payment, except as provided below. (See §1919(b)(3)(F).) Residents readmitted and individuals who initially apply to a nursing facility directly following a discharge from an acute hospital stay are exempt if: o They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and o They require care at the nursing facility for the same condition for which they were hospitalized. The State is responsible for providing specialized services to residents with MI/MR residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition. Therefore, if a facility has residents with MI/MR, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

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F285 Cont.	(B) If the individual requires such level of services, whether the individual requires specialized services for mental illness; or (ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B)Individual requires such level of services, whether the individual requires specialized services for mental retardation. (2)Definition. For purposes of this section-- (i)An individual is considered to have "mental illness" if the individual has a serious mental illness as defined at 483.102(b)(1). (ii)An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in 483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1009. F285	If the resident's PAS report indicates that he or she needs specialized services but the resident is not receiving them, notify the Medicaid agency. NF services ordinarily are not of the intensity to meet the needs of residents with MI or MR. Probes: §483.20(f) If sampled residents have MR or MI, did the State Mental Health or Mental Retardation Authority determine: o Whether the residents needed the services of a NF? o Whether the residents need specialized services for their MR or MI?

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	Quality of Care.	Guidelines: §483.25 Use F309 when the survey team determines there are quality of care deficiencies not covered by §§483.25(a)-(m). "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual. The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process. In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present: o An accurate and complete assessment (see §483.20); o A care plan which is implemented consistently and based on information from the assessment; o Evaluation of the results of the interventions and revising the interventions as necessary. Determine if the facility is providing the necessary care and services based on the findings of the RAI. If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine. Use Tag F309 to cite quality of care deficiencies that are not explicit in the quality of care regulations. Procedures: §483.25 Assess a facility's compliance with these requirements by determining if the services noted in the plan of care, based on a comprehensive and accurate functional assessment of the resident's strengths, weaknesses, risk factors for deterioration and potential for improvement, is continually and aggressively implemented and updated by the facility staff. In looking at assessments, use both the MDS and RAPs information, any other pertinent assessments, and resulting care plans. If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided. If quality of care problems are noted in areas of nurse aide responsibility, review nurse aide competency requirements at §483.75(e).
F309	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).	

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	(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that	Intent: §483.25(a) The intent of this regulation is that the facility must ensure that a resident's abilities in ADLs do not deteriorate unless the deterioration was unavoidable.
F310	(1) 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-- (i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Use speech, language, or other functional communication systems.	Guidelines: §483.25(a) The mere presence of a clinical diagnosis, in itself, justify a decline in a resident's ability to perform ADLs. Conditions which may demonstrate unavoidable diminution in ADLs include: o The natural progression of the resident's disease; o Deterioration of the resident's physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities; and o The resident's or his/her surrogate's or representative's refusal of care and treatment to restore or maintain functional abilities after aggressive efforts by the facility to counsel and/or offer alternatives to the resident, surrogate, or representative. Refusal of such care and treatment should be documented in the clinical record. Determine which interventions were identified on the care plan and/or could be in place to minimize or decrease complications. Note also that depression is a potential cause of excess disability and, where appropriate, therapeutic interventions should be initiated. Appropriate treatment and services includes all care provided to residents by employees, contractors, or volunteers of the facility to maximize the individual's functional abilities. This includes pain relief and control, especially when it is causing a decline or a decrease in the quality of life of the resident. If the survey team identifies a pattern of deterioration in ADLs, i.e., a number of residents have deteriorated in more than one ADL or a number of residents have deteriorated in only one ADL (one in bathing, one in eating, one in toileting) and it is determined there is deficient practice, cite at F310. For evaluating a resident's ADLs and determining whether a resident's abilities have declined, improved or stayed the same within the last twelve months, use the following definitions as specified in the State's RAI: 1. Independent - No help or staff oversight; or staff help/oversight provided only 1 or 2 times during prior 7 days. 2. Supervision - Oversight encouragement or cuing provided 3 or more times during the last 7 days, or supervision plus physical assistance provided only 1 or 2 times during the last 7 days.

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F310 Cont.		3. Limited Assistance - Resident highly involved in activity, received physical help in guided maneuvering of limbs, and/or other non-weight bearing assistance 3 or more times; or more help provided only 1 or 2 times over 7-day period. 4. Extensive Assistance - While resident performed part of activity, over prior 7-day period, help of following type(s) was provided 3 or more times; a.Weight-bearing support; or b.Full staff performance during part (but not all) of week. 5. Total Dependence - Full staff performance of activity over entire 7-day period. BATHING, DRESSING, GROOMING Guidelines: §483.25(a)(1)(i) This corresponds to MDS section E; version 2.0, section G, when specified for use by the State. "Bathing" means how resident takes full-body bath, sponge bath, and transfers in/out of tub/shower. Exclude washing of back and hair. "Dressing" means how resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis. "Grooming" means how resident maintains personal hygiene, including preparatory activities, combing hair, brushing teeth, shaving, applying make-up, washing/drying face, hands and perineum. Exclude baths and showers. Procedures: §483.25(a)(1)(i) BATHING, DRESSING, GROOMING For each sampled resident selected for the comprehensive review or the focused review, as appropriate, determine: 1. Whether the resident's ability to bathe, dress and/or groom has changed since admission, or over the past 12 months; 2. Whether the resident's ability to bathe, dress and groom has improved, declined or stayed the same; 3. Whether any deterioration or lack of improvement was avoidable or unavoidable by: 4. Identifying if resident triggers RAPs for ADL functional/rehabilitation potential. a. What risk factors for decline of bathing, dressing, and/or grooming abilities did the facility identify? b. What care did the resident receive to address unique needs to maintain his/her bathing, dressing, and/or grooming abilities (e.g., resident needs a button hook to button his shirt; staff teaches the resident how to use it; staff provides resident with dementia with cues that allow him/her to dress him or herself)?

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F310 Cont.		c. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of bathing, dressing, and/or grooming abilities (e.g., resident now unable to button dress, even with encouragement; will ask family if we may use velcro in place of buttons so resident can continue to dress herself)? Probes: §483.25(a)(1)(i) If the resident's abilities in bathing, dressing, and grooming have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided: o Identify relevant sections of the MDS and consider whether assessment triggers the RAPs and the RAPs were followed. o Are there physical and psychosocial deficits that could affect improvement in functional abilities? o Was the care plan driven by resident strengths identified in the comprehensive assessment? o Was the care plan consistently implemented? What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress might have been possible? TRANSFER AND AMBULATION Guidelines: §483.25(a)(1)(ii) This corresponds to MDS section E; MDS 2.0 section G when specified for use by the State. "Transfer" means how resident moves between surfaces -- to/from: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet.) "Ambulation" means how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair. Procedures: §483.25(a)(1)(ii) TRANSFER AND AMBULATION Determine for each resident selected for a comprehensive review, or a focused review as appropriate, whether the resident's ability to transfer and ambulate has declined, improved or stayed the same and whether any deterioration or decline in function was avoidable or unavoidable. Probes: §483.25(a)(1)(ii) If the resident's transferring and ambulating abilities have declined, what evidence is there that the decline was unavoidable: o What risk factors for decline of transferring or ambulating abilities did the facility identify (e.g., necrotic area of foot ulcer becoming larger, postural hypotension)?

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F310 Cont.		o What care did the resident receive to address risk factors and unique needs to maintain transferring or ambulating abilities (e.g., a transfer board is provided to maintain ability to transfer from bed to wheelchair and staff teaches the resident how to use it)? o What evidence is there that sufficient staff time and assistance are provided to maintain transferring and ambulating abilities? o Has resident been involved in activities that enhance mobility skills? o Were individual objectives of the plan of care periodically evaluated, and if goals were not met, were alternative approaches developed to encourage maintenance of transferring and ambulation abilities (e.g., resident remains unsteady when using a cane, returns to walker, with staff encouraging the walker's consistent use)? o Identify if resident triggers RAPs for ADL functional/rehabilitation potential, psychosocial well-being, or mood state and the RAPs are followed. If the resident's abilities in transferring and ambulating have been maintained, is there evidence that the resident could have improved if appropriate treatment and services were provided? o Are there physical and psychosocial deficits that could affect improvement in functional abilities? o Was the care plan driven by resident strengths identified in the comprehensive assessment? o Was the care plan consistently implemented? What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible? TOILETING Guidelines: §483.25(a)(1)(iii) This corresponds to MDS sections E; MDS 2.0 sections G and H when specified for use by the State. "Toilet use" means how the resident uses the toilet room (or commode, bedpan, urinal); transfers on/off the toilet, cleanses self, changes pad, manages ostomy or catheter, adjusts clothes. Procedures: §483.25(a)(1)(iii) TOILETING Determine for each resident selected for a comprehensive review, or focused review as appropriate, whether the resident's ability to use the toilet has improved, declined or stayed the same and whether any deterioration or decline in improvement was avoidable or unavoidable. Probes: §483.25(a)(1)(iii) TOILETING If the resident's toilet use abilities have declined, what evidence is there that the decline was unavoidable.

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F310 Cont.		o What risk factors for the decline of toilet use abilities did the facility identify (e.g. severe arthritis in hands makes use of toilet paper difficult)? o What care did resident receive to address risk factors and unique needs to maintain toilet use abilities (e.g., assistive devices to maintain ability to use the toilet such as using a removable elevated toilet seat or wall grab bar to facilitate rising from seated position to standing position)? o Is there sufficient staff time and assistance provided to maintain toilet use abilities (e.g., allowing residents enough time to use the toilet independently or with limited assistance)? o Were individual objectives of the plan of care periodically evaluated, and if objectives were not met, were alternative approaches developed to encourage maintaining toilet use abilities (e.g., if resident has not increased sitting stability, seek occupational therapy consult to determine the need for therapy to increase sitting balance, ability to transfer safely and manipulate clothing during the toileting process. For residents with dementia, remind periodically to use the toilet)? o Identify if resident triggers RAPs for urinary incontinence, and ADL functional/rehabilitation potential and the RAPs were used to assess causal factors for decline or potential for decline or lack of improvement. If the resident's toilet use abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided? o Are there physical and psychosocial deficits that could affect improvement in functional abilities? o Was the care plan driven by resident strengths identified in the comprehensive assessment? o Was the care plan consistently implemented? What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible? o Identify if resident triggers RAPs for mood state and psychosocial well-being. EATING Guidelines: §483.25(a)(1)(iv) This corresponds to MDS sections E, L1 and MI; MDS 2.0 sections G and K when specified for use by the State. "Eating" means how resident ingests and drinks (regardless of self-feeding skill). Procedures: §483.25(a)(1)(iv) EATING Determine for each resident selected for a comprehensive review, or focused review, as appropriate, whether the resident's ability to eat or eating skills has improved, declined, or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable.

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F310 Cont.		If the resident's eating abilities have declined, is there any evidence that the decline was unavoidable? 1. What risk factors for decline of eating skills did the facility identify? a. A decrease in the ability to chew and swallow food b. Deficit in neurological and muscular status necessary for moving food onto a utensil and into the mouth c. Oral health status affecting eating ability d. Depression or confused mental state 2. What care did the resident receive to address risk factors and unique needs to maintain eating abilities? a. Assistive devices to improve resident's grasp or coordination b. Seating arrangements to improve sociability c. Seating in a calm, quiet setting for residents with dementia 3. Is there sufficient staff time and assistance provided to maintain eating abilities (e.g., allowing residents enough time to eat independently or with limited assistance)? 4. Identify if resident triggers RAPs for ADL functional/rehabilitation potential, feeding tubes, and dehydration/fluid maintenance, and the RAPs were used to assess causal reasons for decline, potential for decline or lack of improvement. 5. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintaining eating abilities? Probes: §483.25(a)(1)(iv) If the resident's eating abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided: o Are there physical and psychosocial deficits that could affect improvement in functional abilities? o Was the care plan driven by resident strengths identified in the comprehensive assessment? o Was the care plan consistently implemented? What changes are made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible? USE OF SPEECH, LANGUAGE, OR OTHER FUNCTIONAL COMMUNICATION SYSTEMS Guidelines: §483.25(a)(1)(v) This corresponds to MDS, section C; MDS 2.0 sections B and C when specified for use by the State. "Speech, language or other functional communication systems" is defined as the ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in

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F310 Cont.		speech, writing, gesture or a combination of these (e.g., a communication board or electronic augmentative communication device). Procedures: §483.25(a)(1)(v) USE OF SPEECH, LANGUAGE OR OTHER FUNCTIONAL COMMUNICATION SYSTEMS Determine for each resident selected for a comprehensive review, or focused review, as appropriate, if resident's ability to communicate has declined, improved or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable. o Identify if resident triggers RAPs for communication, psychosocial well-being, mood state, and visual function, and if the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement. Probes: §483.25(a)(1)(v) If the resident's communication abilities have diminished, is there any evidence that the decline was unavoidable: o What risk factors for decline of communication abilities did the facility identify and how did they address them (e.g., dysarthria, poor fitting dentures, few visitors, poor relationships with staff, Alzheimer's disease)? o Has the resident received audiologic and vision evaluation? If not, did the resident refuse such services? (See also §483.10(b)(4).) o What unique resident needs and risk factors did the facility identify (e.g., does the resident have specific difficulties in transmitting messages, comprehending messages, and/or using a variety of communication skills such as questions and commands; does the resident receive evaluation and training in the use of assistive devices to increase and/or maintain writing skills)? o What care does the resident receive to improve communication abilities (e.g., nurse aides communicate in writing with deaf residents or residents with severe hearing problems; practice exercises with residents receiving speech-language pathology services; increase number of resident's communication opportunities; non-verbal means of communication; review of the effect of medications on communication ability)? o Is there sufficient staff time and assistance provided to maintain communication abilities? o Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of communication abilities (e.g., if drill-oriented therapy is frustrating the resident, a less didactic approach should be attempted)? Probes: §483.25(a)(1)(v) USE OF SPEECH, LANGUAGE OR OTHER FUNCTIONAL COMMUNICATION SYSTEMS If the resident's speech, language, and other communication abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided: o Are there physical and psychosocial deficits that could affect improvement in functional abilities? o Was the care plan driven by resident strengths identified in the comprehensive assessment?

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F311	(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and	o Was the care plan consistently implemented? What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible? Intent: §483.25(a)(2) The intent of this regulation is to stress that the facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome. Procedures: §483.25(a)(2) Use the survey procedures and probes at §483.25(a)(1)(i) through (v) to assist in making this determination.
F312	(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.	Intent: §483.25(a)(3) The intent of this regulation is that the resident receives the care and services needed because he/she is unable to do their own ADL care independently. Guidelines: §483.25(a)(3) This corresponds to MDS section L; MDS 2.0 section K when specified by the State. "Unable to carry out ADLs" means those residents who need extensive or total assistance with maintenance of nutrition, grooming and personal and oral hygiene, receive this assistance from the facility. Methods for maintenance of good nutrition may include hand feeding of foods served on dishes; tube feedings provided through naso-gastric, gastrostomy, or other external tubes; or total parenteral nutrition provided through a central intravenous line. "Grooming": See §483.25(a)(1)(i) for definition. "Personal hygiene": Those activities described in dressing and bathing as defined in §483.25(a)(1)(i). "Oral hygiene" means maintaining the mouth in a clean and intact condition and treating oral pathology such as ulcers of the mucosa. Services to maintain oral hygiene may include brushing the teeth, cleaning dentures, cleaning the mouth and tongue either by assisting the resident with a mouth wash or by manual cleaning with a gauze sponge; and application of medication as prescribed.

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F312 Cont.		Procedures: §483.25(a)(3) For residents selected for a comprehensive review, or focused review, as appropriate, who are unable to carry out these ADLs without extensive assistance, determine if poor nutritional status, poor grooming, or lack of effective personal and oral hygiene exist. To what extent are these negative outcomes attributable to the lack of receiving necessary services? Identify if residents trigger RAPs for nutritional status, ADL functional/rehabilitation potential, behavior problems, and dental care. Consider whether the RAPs were used to assess causal factors for decline, potential for decline, or lack of improvement. Determine if the facility proceeded properly with care planning and delivery of care for these residents.
F313	(b) Vision and hearing. 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, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	Intent: §483.25(b) The intent of this regulation is to require a facility to assist residents in gaining access to vision and hearing services by making appointments and arranging for transportation, and assistance with the use of any devices needed to maintain vision and hearing. Guidelines: §483.25(b) This corresponds to MDS, sections C and O; MDS 2.0 sections C, D and P when specified for use by the State. Assistive devices to maintain vision include glasses, contact lenses, and magnifying glasses. Assistive devices to maintain hearing include hearing aids. This requirement does not mean that the facility must provide refractions, glasses, contact lenses, conduct comprehensive audiological evaluations (although screening is a part of the required assessment in §483.20(b)) or provide hearing aids. The facility's responsibility is to assist residents and their families in locating and utilizing any available resources (e.g., Medicare or Medicaid program payment, local health organizations offering items and services which are available free to the community) for the provision of the services the resident needs. This includes making appointments and arranging transportation to obtain needed services. Probes: §483.25(b) o Identify if resident triggers RAPs for visual function, and communication. Consider whether the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement. o If the resident needs, and/or requests and does not have vision and/or hearing assistive devices, what has the facility done to assist the resident in making appointments and obtaining transportation to obtain these services?

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F313 Cont.		o If the resident has assistive devices but is not using them, why not (e.g., are repairs or batteries needed)?
F314	(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) 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; and	Intent: §483.25(c) The intent of this regulation is that the resident does not develop a pressure sore while in the facility. If the resident is admitted with or develops a pressure sore, he or she receives care and treatment to heal and prevent further development of pressure sores. For additional information on prevention, staging and treatment, refer to the staging system found in the booklet "Pressure Ulcers in Adults: Prevention and Treatment, Public Health Service Agency for Health Care Policy and Research." Guidelines: §483.25(c) This corresponds to MDS, section N; MDS 2.0 section I, M and P when specified for use by the State. "Pressure sore" means ischemic ulceration and/or necrosis of tissues overlying a bony prominence that has been subjected to pressure, friction or shear. The staging system presented below is one method of describing the extent of tissue damage in the pressure sore. Pressure sores cannot be adequately staged when covered with eschar or necrotic tissue. Staging should be done after the eschar has sloughed off or the wound has been debrided. Vascular ulcers due to Peripheral Vascular Disease (PVD) have to be considered separately. They usually occur on the lower legs and feet and are very persistent even with aggressive treatment. Stage I: A persistent area of skin redness (without a break in the skin) that is nonblanchable. Redness can be expected to be present for one-half to three-fourths as long as the pressure applied that has occluded blood flow to the areas. For example: If a resident is laying on his right side for 30 minutes and turned to his back, redness may be noticed over his right hip bone. Redness in that area can be expected to remain for up to 20 minutes. The survey team then would check to see if the area is nonblanchable. Just having the redness does not indicate a stage I. To identify the presence of stage I pressure ulcers in residents with darkly pigmented skin, look for changes such as changes in skin color (grayish hue), temperature, swelling, and tenderness or texture. Stage II: A partial thickness loss of skin layers either dermis or epidermis that presents clinically as an abrasion, blister, or shallow crater. Stage III: A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone. Procedures: §483.25(c) Identify if resident triggers RAPs for urinary incontinence, nutritional status, cognitive loss/dementia, psychotropic drug use, and physical restraints. Consider

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F314 Cont.		whether the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement. If the resident is moribund (i.e., the resident is terminally ill; semi-comatose or comatose) and life-sustaining measures have been withdrawn or discouraged as documented in the record, pressure sores may be clinically difficult to prevent. A determination that development of a pressure sore was unavoidable may be made only if routine preventive and daily care was provided. Routine preventive care means turning and proper positioning, application of pressure reduction or relief devices, providing good skin care (i.e., keeping the skin clean, instituting measures to reduce excessive moisture), providing clean and dry bed linens, and maintaining adequate nutrition and hydration as possible. Clinical conditions that are the primary risk factors for developing pressure sores include, but are not limited to, resident immobility and: 1. The resident has two or more of the following diagnoses: a. Continuous urinary incontinence or chronic voiding dysfunction; b. Severe peripheral vascular disease; c. Diabetes; d. Severe chronic pulmonary obstructive disease; e. Severe peripheral vascular disease; f. Chronic bowel incontinence; g. Continuous urinary incontinence or chronic voiding dysfunction; h. Paraplegia; i. Quadriplegia; j. Sepsis; k. Terminal cancer; l. Chronic or end stage renal, liver, and/or heart disease; m. Disease or drug-related immunosuppression; or n. Full body cast. 2. The resident receives two or more of the following treatments: a. Steroid therapy; b. Radiation therapy; c. Chemotherapy; d. Renal dialysis; or e. Head of bed elevated the majority of the day due to medical necessity. 3. Malnutrition/dehydration, whether secondary to poor appetite or another disease process, places resident at risk for poor healing, and may be indicated by the following lab values: a. Serum albumin below 3.4 g/dl b. Weight loss of more than 10% during last month

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F314 Cont.		c. Serum transferrin level below 180 mg per dl d. Hgb less than 12 mg per dl. Use these values in conjunction with an evaluation of the resident's clinical condition. 4. If laboratory data are not available, clinical signs and symptoms of malnutrition/dehydration may be: a. Pale skin; b. Red, swollen lips; c. Swollen and/or dry tongue with scarlet or magenta hue; d. Poor skin turgor; e. Cachexia; f. Bilateral edema; g. Muscle wasting; h. Calf tenderness; or i. Reduced urinary output. Probes: §483.25(c)(1) For each sampled resident selected for the comprehensive review, or the focused review at risk of developing pressure sores, determine, as appropriate, if aggressive preventive care is provided? For sampled residents, who upon initial admission to the facility, did not have a pressure sore and now have one, determine if pressure sore development may have been avoided: o Did the facility identify the resident as being at risk for pressure sore(s)? o Did the facility provide aggressive/appropriate preventive measures and care specific to addressing the resident's unique risk factors (e.g., if serum albumin is below 3.4 mg per dl, provide additional protein in daily snacks)? o Was this preventive care plan implemented consistently?
	(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	Probes: 483.25 (c)(2) For all sampled residents who have pressure sores at the time of the survey, including those readmitted from the hospital with a pressure sore that developed in the hospital: o Are measures to assist healing provided per the plan of care (e.g., relieving pressure, moving the resident without causing shearing, instituting topical therapy which creates a favorable environment for healing, and debriding eschar? o Are measures to prevent further contamination followed (e.g., wash hands before caring for sore? Observe clean or sterile technique, as indicated, when dressing is changed). All wounds are contaminated (soiled/contain organisms). An infected wound is accompanied by local or systemic symptoms. Clean technique is adequate when caring for a non-infected wound.

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	(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that--	o Are universal precautions used during all wound care? (See §483.65, Infection Control.) o Have the care plan objectives been evaluated? If the pressure sore is not healing, getting larger, or signs of additional skin breakdown are evident, have alternative interventions been considered or attempted? o Has improvement been noted?
F315	(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and	Guidelines: §483.25(d)(1) This corresponds to MDS section F; MDS 2.0 sections G and H when specified by the State. Intent: §483.25(d)(1) The intent of this regulation is to ensure that an indwelling catheter is only to be used when there is valid medical justification. The resident should be assessed for and provided the care and treatment needed to reach his or her highest level of continence possible. The facility is expected to show evidence of any medical factors which caused the intervention. Examples of clinical conditions demonstrating that catheterization may be unavoidable include: 1. Urinary retention that: a. Is causing persistent overflow incontinence, symptomatic infections, and/or renal dysfunction; b. Cannot be corrected surgically; or c. Cannot be managed practically with intermittent catheter use. 2. Skin wounds, pressure sores, or irritations that are being contaminated by urine; 3. Terminal illness or severe impairment, which makes bed and clothing changes uncomfortable or disruptive (i.e., as in the case of intractable pain). Probes: §483.25(d)(1) For sampled residents selected for a comprehensive or focused review who entered the facility without a catheter and are now catheterized, determine as appropriate if the use of an indwelling catheter was unavoidable. o Was the resident continent upon admission? o If continent at admission, was the resident identified as having risk factors of incontinence (e.g., frequency of urination, with limited mobility)? o What care did the resident receive to promote maintenance of continence? o Did the facility attempt to manage the incontinence and increase bladder function without the use of an indwelling catheter (e.g., a bladder training program, prompted voiding schedule, external [illegible])?

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F316	(2) 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.	o Identify if resident triggers RAPs for urinary incontinence, ADL functional/rehabilitation potential, and cognitive loss/dementia and the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement. If the resident has an indwelling catheter: o Is the staff following the facility's protocol and/or written procedures for catheterization? o Do all personnel wash their hands before and after caring for the catheter/tubing/collecting bag? o Does the facility assess for continued need for use of the catheter, as appropriate, utilizing the evaluative data as described and implemented in the care plan? Guidelines: §483.25(d)(2) For purposes of this regulation, "urinary tract infection (UTI)" is defined as colonization (growth of bacteria) of the urinary tract with signs or symptoms of UTI. Asymptomatic colonization is not a UTI. Care should be provided based on the type, severity, and cause (if known) of the urinary incontinence. Antibiotic therapy should be reserved for residents with active symptoms of UTI. Routine and overzealous use could lead to resistance of organisms. Probes: §483.25(d)(2) For each incontinent sampled resident selected for the comprehensive, or focused review determine, as appropriate: o Has the facility identified (or attempted to identify) the cause of the incontinence? o Is the resident adequately hydrated? o How many residents currently have a UTI? Differentiate between bacterial colonization vs. acute infection. (See also §483.65, Infection Control.) o Are risk factors for UTI monitored and managed (e.g., poor fluid intake, previous UTIs)? Are residents with a history of UTI adequately assessed and provided care and treatment to prevent UTI? o Are infection control procedures in place (e.g., adequate fluid intake)? o What care did the resident receive, consistent with the comprehensive assessment, to restore or improve bladder functioning (e.g., pelvic floor exercises, habit training, or maintaining adequate hydration)? o Have the individualized goals of this treatment program been evaluated periodically, and if goals were not reached, have alternative goals and approaches been developed? o If staff determine that continence cannot be improved or maintained, has a plan been implemented to prevent incontinent-related complications and to maintain resident dignity (e.g., skin care will be provided after each episode of incontinence, adult sanitary padding will be worn at all times when the resident is out of bed)?

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F316 Cont.		o Identify if resident triggers RAPs for urinary incontinence, ADL functional/rehabilitation potential, and dehydration/fluid maintenance. Consider whether the RAPs were used to assess causal factors for decline, potential for decline, or lack of improvement.
F317	(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) 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 is unavoidable; and	Intent: §483.25(e) The intent of this regulation is to ensure that the resident reaches and maintains his or her highest level of range of motion and to prevent avoidable decline of range of motion. Guidelines: §483.25(e) This corresponds to MDS section E; MDS 2.0 sections G and P when specified for use by the State. "Range of motion (ROM)" is defined as the extent of movement of a joint. The clinical condition that may demonstrate that a reduction in ROM is unavoidable is: limbs or digits immobilized because of injury or surgical procedures (e.g., surgical adhesions). Adequate preventive care may include active ROM performed by the resident's passive ROM performed by staff; active-assistive ROM exercise performed by the resident and staff; and application of splints and braces, if necessary. Examples of clinical conditions that are the primary risk factors for a decreased range of motion are: o Immobilization (e.g., bedfast); o Deformities arising out of neurological deficits (e.g., strokes, multiple sclerosis, cerebral palsy, and polio); and o Pain, spasms, and immobility associated with arthritis or late state Alzheimer's disease.
F318	(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	This clinical condition may demonstrate that a reduction in ROM is unavoidable only if adequate assessment, appropriate care planning, and preventive care was provided, and resulted in limitation in ROM or muscle atrophy.

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F318 Cont.		Procedures: §483.25(e) For each resident selected for a comprehensive review, or focused review, as appropriate, who needs routine preventive care: o Observe staff providing routine ROM exercises. Are they done according to the care plan? Probes: §483.25(e) Is there evidence that there has been a decline in sampled residents' ROM or muscle atrophy that was avoidable? o Was the resident at risk for decline in ROM? If so, why? o What care did the facility provide, including routine preventive measures that addressed the resident's unique risk factors (e.g., use muscle strengthening exercises in residents with muscle atrophy)? o Was this care provided consistently? For all sampled residents who have limited ROM, what is the facility doing to prevent further declines in ROM? o Are passive ROM exercises provided and active ROM exercises supervised per the plan of care? o Have care plan objectives identified resident's needs and has resident progress been evaluated? o Is there evidence that care planning is changed as the resident's condition changes? o Identify if resident triggers RAPs for ADL functional/rehabilitation potential, visual function, and communication. Consider whether the RAPs used to assess causal factors for decline, potential for decline or lack of improvement.

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	(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that--	Intent: §483.25(f) The intent of this regulation is that the resident receives care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.
F319	(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem; and	Guidelines: §483.25(f) This corresponds to MDS, sections G, J and P1; MDS 2.0 sections B, F, E, and I when specified for use by the State. "Mental and psychosocial adjustment difficulties" refer to problems residents have in adapting to changes in life's circumstances. The former focuses on internal thought processes; the latter, on the external manifestations of these thought patterns. Mental and psychosocial adjustment difficulties are characterized primarily by an overwhelming sense of loss of one's capabilities; of family and friends; of the ability to continue to pursue activities and hobbies; and of one's possessions. This sense of loss is perceived as global and uncontrollable and is supported by thinking patterns that focus on helplessness and hopelessness; that all learning and essentially all meaningful living ceases once one enters a nursing home. A resident with a mental adjustment disorder will have a sad or anxious mood, or a behavioral symptom such as aggression. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM/IV), specifies that adjustment disorders develop within 3 months of a stressor (e.g., moving to another room) and are evidenced by significant functional impairment. Bereavement with the death of a loved one is not associated with adjustment disorders developed within 3 months of a stressor. Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include: o Impaired verbal communication; o Social isolation (e.g., loss or failure to have relationships); o Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs); o Spiritual distress (disturbances in one's belief system); o Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and o Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus). Appropriate treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for self-governance; systematic orientation programs; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family.

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F319 Cont.		Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services. (See §483.45(a).) Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty are: (This list is not all inclusive.) o Metabolic diseases (e.g., abnormalities of serum glucose, potassium, calcium, and blood urea nitrogen, hepatic dysfunction); o Endocrine diseases (e.g., hypothyroidism, hyperthyroidism, diabetes, hypoparathyroidism, hyperparathyroidism, Cushing's disease, Addison's disease); o Central nervous system diseases (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease, vascular disease); o Miscellaneous diseases (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure); o Over-medication with anti-hypertensive drugs; and o Presence of restraints. Probes: §483.25(f)(1) For sampled residents selected for a comprehensive or focused review, determine, as appropriate, for those residents exhibiting difficulties in mental and psychosocial adjustment: o Is there a complete accurate assessment of resident's usual and customary routines? o What evidence is there that the facility makes accommodations for the resident's usual and customary routines? o What programs/activities has the resident received to improve and maintain maximum mental and psychosocial functioning? o Has the resident's mental and psychosocial functioning been maintained or improved (e.g., fewer symptoms of distress)? Have treatment plans and objectives been re-evaluated? o Has the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treat her/his condition, if necessary? o Identify if resident triggers RAPs for activities, mood state, psychosocial well-being, and psychotropic drug use. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement. o How are mental and psychosocial adjustment difficulties addressed in the care plan? See §483.45(a), F406 for health rehabilitative services for mental illness and mental retardation.

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F319 Cont.		psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.
F320	(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable.	Procedures: §483.25(f)(2) For sampled residents whose assessment did not reveal a mental or psychosocial adjustment difficulty, but who display decreased social interaction or increased withdrawn, angry, or depressed behaviors, determine, as appropriate, was this behavior unavoidable: Probes: §483.25(f)(2) o Did the facility attempt to evaluate whether this behavior was attributable to organic causes or other risk factors not associated with adjusting to living in the nursing facility? o What care did the resident receive to maintain his/her mental or psychosocial functioning? o Were individual objectives of the plan of care periodically evaluated, and if progress was not made in reducing, maintaining, or increasing behaviors that assist the resident to have his/her needs met, were alternative treatment approaches developed to maintain mental or psychosocial functioning? o Identify if resident triggers RAPs for behavior problem, cognitive loss/dementia, and psychosocial well-being. Consider whether the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement. o Did the facility use the RAPs for behavior problems, cognitive loss/dementia, and psychosocial well-being to assess why the behaviors or change in mental or psychosocial functioning was occurring?
	(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that--	Intent: §483.25(g) The intent of this regulation is that a naso-gastric tube feeding is utilized only after adequate assessment, and the resident's clinical condition makes this treatment necessary.
F321	(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a	Guidelines: §483.25(g) This corresponds to MDS, section L; MDS 2.0 sections G, K, P when specified for use by the State. This requirement is also intended to prevent the use of tube feeding when ordered over the objection of the resident. Decisions about the appropriateness of tube feeding for a resident are developed with the resident or his/her family, surrogate or representative as part of determining the care plan.

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F321 Cont.	naso-gastric tube was unavoidable; and	Complications in tube feeding are not necessarily the result of improper care, but assessment for the potential for complications and care and treatment are provided to prevent complications in tube feeding by the facility. Clinical conditions demonstrating that nourishment via an naso-gastric tube is unavoidable include: o The inability to swallow without choking or aspiration, i.e., in cases of Parkinson's disease, pseudobulbar palsy, or esophageal diverticulum; o Lack of sufficient alertness for oral nutrition (e.g., resident comatose); and o Malnutrition not attributable to a single cause or causes that can be isolated and reversed. There is documented evidence that the facility has not been able to maintain or improve the resident's nutritional status through oral intake. Probes: §483.25(g) For sampled residents who, upon admission to the facility, were not tube fed and now have a feeding tube, was tube feeding unavoidable? To determine if the tube feeding was unavoidable, assess the following: o Did the facility identify the resident at risk for malnutrition? o What did the facility do to maintain oral feeding, prior to inserting a feeding tube? Did staff provide enough assistance in eating? Did staff cue resident as needed, assist with the use of assistive devices, or feed the resident, if necessary? o Is the resident receiving therapy to improve or enhance swallowing skills, as need, is identified in the comprehensive assessment? o Was an assessment done to determine the cause of decreased oral intake/weight loss or malnutrition? o If there was a dietitian consultation, were recommendations followed? For all sampled residents who are tube fed: o Is the NG tube properly placed? o Are staff responsibilities for providing enteral feedings clearly assigned (i.e., who administers the feeding, formula, amount, feeding intervals, flow rate)? o Do staff monitor feeding complications (e.g., diarrhea, gastric distension, aspiration) and administer corrective actions to allay complications (e.g., changing rate of formula administration)? o Are there negative consequences of tube use (e.g., agitation, depression, self-extubation, infections, aspiration and restraint use without a medical reason for the restraint)? o When long term use is anticipated, is G tube placement considered? Is the potential for complications from feedings minimized by: o Use of a small bore, flexible naso-gastric tube, unless contraindicated; o Securely attaching the tube to the nose/face;
F322	(2) A resident who is fed by a naso-gastric or 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 eating skills.	

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F322 Cont.		o Checking for correct tube placement prior to beginning a feeding or administering medications and after episodes of vomiting or sectioning; o Checking a resident with a newly inserted gastric tube for gastric residual volume every 2-4 hours until the resident has demonstrated an ability to empty his/her stomach; o Properly elevating the resident's head; o Providing the type, rate and volume of the feeding as ordered; o Using universal precautions and clean technique and as per facility/manufacturer's directions when stopping, starting, flushing, and giving medications through the tube; o Using hang time recommendations by the manufacturer to prevent excessive microbial growth; o Implement the procedures to ensure cleanliness of supplies, e.g. irrigating syringes changed on a regular bases as per facility policy. It is not necessary to change the irrigating syringe each time it is used; o Using a pump equipped with a functional alarm (if pump used); o The facility's criteria for determining that a resident may be able to return to eating by mouth (e.g., a resident whose Parkinson's symptoms have been controlled); o There are sampled residents meet these criteria; o If so, the facility has assisted them in returning to normal eating; and o Identify if resident triggers RAPs for feeding tubes, nutritional status, and dehydration/fluid maintenance. Consider whether the RAPs were used to assess causal factors for decline, potential for decline and lack of improvement.
F323	(h) Accidents. The facility must ensure that-- (1) The resident environment remains as free of accident hazards as is possible; and	Intent: §483.25(h)(1) The intent of this provision is that the facility prevents accidents by providing an environment that is as free from hazards over which the facility has control. Guidelines: §483.25(h)(1) This corresponds to MDS, section K2; MDS version 2.0 section J, when specified for use by the State. "Accident hazards" are defined as physical features in the NF environment that can endanger a resident's safety, including but not limited to: o Physical restraints (see physical restraints §483.13); o Poorly maintained resident equipment (e.g., wheelchairs or geri-chairs with nonworking brakes, and loose nuts and bolts on walkers); o Bathing facilities that do not have nonslip surfaces; o Hazards (e.g., electrical appliances with frayed wires, cleaning supplies easily accessible to cognitively impaired residents, wet floors that are not obviously labeled and to which access is not blocked);

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F323 Cont.		o Handrails not securely fixed to the wall, difficult to grasp, and/or with sharp edges/splinters; and o Water temperatures in hand sinks or bath tubs which can scald or harm residents. Probes: §483.25(h)(1) (See F221 for guidance concerning the use of bedrails.) See also §483.70(h) - Safe Environment.
F324	(2) Each resident receives adequate supervision and assistance devices to prevent accidents.	Intent §483.25(h)(2) The intent of this provision is that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents. An "accident is an unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care, (e.g., drug side effects or reactions). Procedures: §483.25(h)(2) o If a resident(s) selected for a comprehensive or focused review has had an accident, review the facility's investigation of that accident and their response to prevent the accident from recurring. o Identify if the resident triggers RAPs for falls, cognitive loss/dementia, physical restraints, and psychotropic drug use and whether the RAPs were used to assess causal factors for decline or lack of improvement. o If the survey team identifies a number of or pattern of accidents, in Phase II sampling, review the quality assurance activities of the facility to determine the facility's response to accidents. Probes: §483.25(h)(2): 1. Are there a number of accidents or injuries of a specific type or on any specific shift (e.g., falls, skin injuries)? 2. Are residents who smoke properly supervised and monitored? 3. If the survey team identifies residents repeatedly involved in accidents or sampled residents who have had an accident: a. Is the resident assessed for being at risk for falls? b. What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk? c. How did the facility fit, and monitor, the use of that resident's assistive devices? d. How were drugs that may cause postural hypotension, dizziness, or visual changes monitored?

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	(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--	Intent §483.25(i) The intent of this regulation is to assure that the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate intervention, when there is a nutritional problem. Guidelines: §483.25(i) This corresponds to MDS, section L; MDS 2.0 sections G, I, J, K and L when specified for use by the State. Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels). Weight: Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should be examined in light of the individual's former life style as well as the current diagnosis. Suggested parameters for evaluating significance of unplanned and undesired weight loss are: Interval / Significant Loss / Severe Loss 1 month / 5% / Greater than 5% 3 months / 7.5% / Greater than 7.5% 6 months / 10% / Greater than 10% The following formula determines percentage of loss: % of body weight loss = $\frac{\text{usual weight - actual weight}}{\text{usual weight}} \times 100$ In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food? Suggested laboratory values are: Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion) Plasma Transferrin >60 yr.:180-380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.)
F325	(1) 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; and	
F326	(2) Receives a therapeutic diet when there is a nutritional problem.	

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F326 Cont.		Hemoglobin Males: 14-17 g/dl Females: 12-15 g/dl Hematocrit Males: 41 - 53 Females: 36 - 46 Potassium 3.5 - 5.0 mEq/L Magnesium 1.3 - 2.0 mEg/L Some laboratories may have different "normals". Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values. NOTE: There is no requirement that facilities order the tests referenced above. Clinical Observations: Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting. Risk factors for malnutrition are: 1. Drug therapy that may contribute to nutritional deficiencies such as: a. Cardiac glycosides; b. Diuretics; c. Anti-inflammatory drugs; d. Antacids (antacid overuse); e. Laxatives (laxative overuse); f. Psychotropic drug overuse; g. Anticonvulsants; h. Antineoplastic drugs; i. Phenothiazines; j. Oral hypoglycemics; 2. Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations; 3. Depression or dementia; 4. Therapeutic or mechanically altered diet; 5. Lack of access to culturally acceptable foods; 6. Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and 7. Cancer.

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F326 Cont.		Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be possible include, but are not limited to: o Refusal to eat and refusal of other methods of nourishment; o Advanced disease (i.e., cancer, malabsorption syndrome); o Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns); o Radiation or chemotherapy; o Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism; o Gastrointestinal surgery; and o Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice. " Therapeutic diet " means a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet, (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). Procedures: §483.25(i) Determine if residents selected for a comprehensive review or focused review as appropriate, have maintained acceptable parameters of nutritional status. Where indicated by the resident's medical status, have clinically appropriate therapeutic diets been prescribed? Probes: §483.25(i) For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable: o Did the facility identify factors that put the resident at risk for\ malnutrition? o Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement. o What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)? o Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes? o Was this care provided consistently? o Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?

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F327	(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	Intent: §483.25(j) The intent of this regulation is to assure that the resident receives sufficient amount of fluids based on individual needs to prevent dehydration. Guidelines: §483.25(j) This corresponds to MDS, section L; MDS 2.0 sections G, K, I, J and L when specified for use by the State. "Sufficient fluid" means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates (e.g., increase fluids if resident has fever or diarrhea). Risk factors for the resident becoming dehydrated are: o Coma/decreased sensorium; o Fluid loss and increased fluid needs (e.g., diarrhea, fever, uncontrolled diabetes); o Fluid restriction secondary to renal dialysis; o Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs (e.g., aphasia); o Dementia in which resident forgets to drink or forgets how to drink; o Refusal of fluids; and o Did the MDS trigger RAPs on hydration? What action was taken based on the RAP? Consider whether assessment triggers RAPs and are RAPs used to assess the causal factors for decline, potential for decline or lack of improvement. A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kg times 30cc (2.2 lbs = 1kg), except for residents with renal or cardiac distress. An excess of fluids can be detrimental for these residents. Procedures: §483.25(j) Identify if resident triggers RAPs for dehydration/fluid maintenance, and cognitive loss. Probes: §483.25(j) Do sampled residents show clinical signs of possible insufficient fluid intake (e.g., dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, fever), abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), or urine specific gravity)? Has the facility provided residents with adequate fluid intake to maintain proper hydration and health? If not: o Did the facility identify any factors that put the resident at risk of dehydration?

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F327 Cont.		o What care did the facility provide to reduce those risk factors and ensure adequate fluid intake (e.g., keep fluids next to the resident at all times and assisting or cuing the resident to drink)? Is staff aware of need for maintaining adequate fluid intake? and o If adequate fluid intake is difficult to maintain, have alternative treatment approaches been developed, attempt to increase fluid intake by the use of popsicles, gelatin, and other similar non-liquid foods?
F328	(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:	Intent: 483.25(k) The intent of this provision is that the resident receives the necessary care and treatment including medical and nursing care and services when they need the specialized services as listed below. Guidelines: §483.25(k) This corresponds to MDS section P; MDS 2.0 section P when specified by for use by the State. The non-availability of program funding does not relieve a facility of its obligation to ensure that its residents receive all needed services listed in §1819(b)(4)(A) of the Act for Medicare and §1919(b)(4)(A) of the Act for Medicaid. For services not covered, a facility is required to assist the resident in securing any available resources to obtain the needed services.
	(1) Injections;	Probes: §483.25(k)(1) For sampled residents receiving one or more of these services within 7 days of the survey: o Is proper administration technique used (i.e., maintenance of sterility; correct needle size, route)? o Are there signs of redness, swelling, lesions from previous injections? o If appropriate, is resident observed for adverse reaction after the injection? o Are syringes and needles disposed of according to facility policy and accepted practice (e.g., Centers for Disease Control and Prevention and Occupational Safety and Health Administration guidelines)? o Do nursing notes indicate, as appropriate, the resident's response to treatment (e.g., side effects/adverse actions; problems at the injection site(s); relief of pain)?
	(2) Parenteral and enteral fluids;	Probes: §483.25(k)(2) This corresponds to MDS, sections L4 and P1; MDS 2.0 sections L6 and P1 when specified for use by the State.

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F328 Cont.		For residents selected for a comprehensive review, or focused review as appropriate, receiving one or more of these services within 7 days of the survey: o Are there signs of inflammation or infiltration at the insertion site? o If the IV site, tubing, or bottle/bag is changed, is sterile technique maintained? o Is the rate of administration that which is ordered by the physician? Has the resident received the amount of fluid during the past 24 hours that he/she should have received according to the physician's orders (allow flexibility up to 150cc unless an exact fluid intake is critical for the resident)? Procedures: §483.25(k)(2) See §483.25(g) for enteral feedings (includes gastrostomy).
	(3) Colostomy, ureterostomy, or ileostomy care;	Procedures: §483.25(k)(3) This corresponds to MDS 2.0 sections G, H and P when specified for use by the State. Identify if resident triggers RAPs for urinary incontinence, nutritional status, pressure ulcers (skin care). Probes: §483.25(k)(3) o If appropriate, is the resident provided with self-care instructions? Does the staff member observe and respond to any signs of resident's discomfort about the ostomy or its care? o Is skin surrounding the ostomy free of excoriation (abrasion, breakdown)? o If excoriation is present, does the clinical record indicate an onset and a plan of care to treat the excoriation?
	(4) Tracheostomy care;	Procedures: §483.25(k)(4) (Includes care of the tracheostomy site) This corresponds to MDS, sections N and P; MDS 2.0 sections M and P when specified for use by the State. Observations for tracheostomy care are most appropriate for residents with new or relatively new tracheostomies, and may not be appropriate for those with tracheostomies of long standing. Probes: §483.25(k)(4) (Includes care of the tracheostomy site) o Is the skin around the tracheostomy clean and dry? Are the dressing and the ties clean and dry, with the cannula secure?

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F328 Cont.		o Does the resident have signs of an obstructed airway or need for suctioning (e.g., secretions draining from mouth or tracheotomy; unable to cough to clear chest; audible crackles or wheezes; dyspneic, restless or agitated)? o If appropriate for a specific resident, is there a suction machine and catheter immediately available? o Is there an extra cannula of the correct size at the bedside or other place easily accessible if needed in an emergency? For sampled residents receiving one or more of these services within 7 days of the survey: o Is suction machine available for immediate use, clean, working, and available to a source of emergency power? o Is there an adequate supply of easily accessible suction catheters?
	(5) Tracheal suctioning;	<u>Probes: §483.25(k)(5)</u> This corresponds to MDS, section P; MDS 2.0 section P when specified for use by the State.
	(6) Respiratory care;	<u>Procedures: §483.25(k)(6)</u> This corresponds to MDS, section P; MDS 2.0 section P when specified for use by the State. Includes use of respirators/ventilators, oxygen, intermittent positive pressure breathing (IPPB) or other inhalation therapy, pulmonary care, humidifiers, and other methods to treat conditions of the respiratory tract. Identify if resident triggers RAPs for delirium and dehydration/fluid maintenance. <u>Probes: §483.25(k)(6)</u> For sampled residents receiving one or more of these services within 7 days of the survey: o If oxygen is in use, are precautions observed (e.g., no smoking signs; cylinders secured)? o If the survey team observes a treatment being administered, is the resident encouraged and instructed on how to assist in the treatment? o Is the staff following the facility's protocol and/or written procedures for ventilators (e.g., functioning alarms); frequency of staff monitoring; monitoring of resident response (e.g., use of accessory muscles to breathe, cleanliness of mouth, skin irritation), and availability of manual resuscitators? o If the resident is ventilator dependent, is routine machine maintenance and care done (e.g., water changes/tubing changes, safety checks on alarms, and machine functioning checks)?

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F328 Cont.	(7) Foot care; and	Procedures: §483.25(k)(7) This corresponds with MDS, section M6; MDS 2.0 sections G and M when specified for use by the State. Includes treatment of foot disorders by qualified persons, e.g., podiatrist, Doctor of Medicine, Doctor of Osteopathy), including, but not limited, to corns, neuroma, calluses, bunions, heel spurs, nail disorders, preventive care, to avoid foot problems in diabetic residents and residents with circulatory disorders. Probes: §483.25(k)(7) For residents selected for a comprehensive review, or focused review, as appropriate: o Do nails, corns, calluses, and other foot problems appear unattended; do these foot problems interfere with resident mobility? o Are residents able to see a qualified person when they want? o What preventive foot care do staff provide diabetic residents?
	(8) Prostheses.	Probes: §483.25(k)(8) MDS 2.0 sections D, G, L, M and P when specified for use by the State. Includes artificial limbs, eyes, teeth. For residents selected for a comprehensive review, or focused review, as appropriate: o Is resident able to put on the prosthesis by himself/herself or with some assistance? o Are residents wearing their prostheses? o Does the prosthesis fit correctly? o Is skin/mucous membrane in contact with the prosthesis free of abrasions, wounds, irritation?

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	(1) Unnecessary drugs. (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	It is important to note that these regulations and interpretive guidelines are not meant to cast a negative light on the use of psychopharmacological drugs in long term care facilities. The use of psychopharmacological drugs can be therapeutic and enabling for residents suffering from mental illnesses such as schizophrenia or depression. The goal of these regulations and guidelines is to stimulate appropriate differential diagnosis of "behavioral symptoms" so the underlying cause of the symptoms is recognized and treated appropriately. This treatment may include the use of environmental and/or behavioral therapy, as well as, psychopharmacological drugs. The goal of these regulations is also to prevent the use of psychopharmacological drugs when the "behavioral symptom" is caused by conditions such as: (1) environmental stressors (e.g., excessive heat, noise, overcrowding, etc.); (2) psychosocial stressors (e.g., abuse, taunting, not following a resident's customary daily routine); or (3) treatable medical conditions (e.g., heart disease, diabetes, Chronic Obstructive Pulmonary Disease). Behavioral symptoms resulting from these causes should not be "covered up" with sedating drugs. An excellent differential diagnostic process for behavioral symptoms is described in the RAP on Behavior Problems (soon to be known as behavioral symptoms). Also, a number of very practical manuals are now available that teach nursing personnel how to assess and provide individualized care for behavioral symptoms, which leads to the avoidance of physical restraints, and unnecessary drugs. These manuals include, but are not limited to, the following list: 1. "Managing Behavior Problems in Nursing Home Residents" Department of Preventive Medicine Vanderbilt University School of Medicine 2. "Retrain, Don't Restrain" American Association of Homes and Services for the Aging, or The American Health Care Association 3. "Innovations in Restraint Reduction" American Health Care Association 4. "Avoiding Physical Restraint Use: New Standards in Care", and "Avoiding Drugs Used as Chemical Restraints: New Standards in Care" National Citizens' Coalition for Nursing Home Reform

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F329	(i) in excessive dose (including duplicate therapy); or (ii) for excessive duration; or (iii) without adequate monitoring; or (iv) without adequate indications for its use; or (v) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) any combinations of the reasons above.	Guidelines: §483.25(l)(1) A. Long-Acting Benzodiazepine Drugs The following long-acting benzodiazepine drugs should not be used in residents unless an attempt with a shorter-acting drug (i.e., those listed under B. Benzodiazepine or Other Anxiolytic/Sedative Drugs, and under C. Drugs Used for Sleep Induction) has failed. After an attempt with a shorter-acting benzodiazepine drug has failed, a long-acting benzodiazepine drug should not be used unless: o Evidence exists that other possible reasons for the resident's distress have been considered and ruled out. (See §483.25(l)(1)(iv);) o Its use results in maintenance or improvement in the resident's functional status (to evaluate functional status, see §483.25(a) through (k) and MDS, sections B through P; MDS 2.0 sections B through P). (See §483.25(l)(1)(iv);) o Daily use is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful (see §483.25(l)(1)(ii)); and o Its use is less than, or equal to, the following listed total daily doses unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for the maintenance, or improvement in the resident's functional status. (See §483.25(l)(1)(i).) LONG-ACTING BENZODIAZEPINES NOT MAXIMUM DOSES GENERIC / BRAND / DAILY ORAL DOSAGE Flurazepam (Dalmane) 15mg Chlordiazepoxide (Librium) 20mg Clorazepate (Tranxene) 15mg Diazepam (Valium) 5mg Clonazepam (Klonopin) 1.5mg Quazepam (Doral) 7.5mg Halazepam (Paxipam) 40mg NOTES: When diazepam is used for neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia or seizure disorders), this guideline does not apply. When long-acting benzodiazepine drugs are being used to withdraw residents from short-acting benzodiazepine drugs, this guideline does not apply.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F329 Cont.		When clonazepam is used in bi-polar disorders, management of tardive dyskinesia, nocturnal myoclonus or seizure disorders, this guideline does not apply. The daily doses listed under long-acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence (see Survey Procedures and Probes) to show why it was necessary for the maintenance or improvement in the resident's functional status. "Duplicate drug therapy" is any drug therapy that duplicates a particular drug effect on the resident. For example, any two or more drugs, whether from the same drug category or not, which have a sedative effect. Duplicate drug therapy should prompt the facility to evaluate the resident for accumulation of the adverse effects. For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is clinically contraindicated. E. Benzodiazepine or other Anxiolytic/Sedative Drugs Use of listed Anxiolytic/Sedative drugs for purposes other than sleep induction should only occur when: 1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out. (See §483.25(l)(1)(iv);) 2. Use results in a maintenance or improvement in the resident's functional status, (to evaluate functional status, see §483.25(a) through (k) and MDS, sections B through P; MDS 2.0 sections B through P). (See §483.25(l)(1)(iv);) 3. Daily use (at any dose) is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful. (See §483.25(l)(1)(ii);) 4. Use is for one of the following indications as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions. (See §483.25(l)(1)(iv):) a. Generalized anxiety disorder; b. Organic mental syndromes (now called "delirium, dementia, and amnestic and other cognitive disorders" by DSM-IV) with associated agitated behaviors, which are quantitatively and objectively documented (see note number one) which are persistent and not due to preventable reasons and which constitute sources of distress or dysfunction to the resident or represent a danger to the resident or others;

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F329 Cont.		c. Panic disorder; d. Symptomatic anxisty that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder); and 5.o Use is equal to or less than the following listed total daily doses, unless higher doses (as evidenced by the resident response and/or the resident's clinical record) are necessary for the improvement or maintenance in the resident's functional status. (See §483.25(1)(1)(i), F342.)

SHORT-ACTING BENZODIAZEPINES NOT MAXIMUM DOSES

GENERIC	BRAND	DAILY ORAL DOSAGE
Lorazepam	(Ativan)	2 mg
Oxazepam	(Serax)	30mg
Alprazolam	(Xanax)	0.75mg
Estazolam	(ProSom)	0.5mg
OTHER ANXIOLYTIC AND SEDATIVE DRUGS		
Diphenhydramine	(Benadryl)	50mg
Hydroxyzine	(Atarax,Vistaril	50mg
Chloral Hydrate	(Many Brands)	750mg

NOTES:
1. This documentation is often referred to as "behavioral monitoring charts" and is necessary to assist in: (a) assessing whether the resident's behavioral symptom is in need of some form of intervention, (b) determining whether the behavioral symptom is transitory or permanent, (c) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (d) ruling out environmental causes such as excessive heat, noise, overcrowding, etc., (e) ruling out medical causes such as pain, constipation, fever, infection. For a more complete description of behavioral monitoring charts and how they can assist in the differential diagnosis of behavioral symptoms see the RAP on behavior problems (soon to be know as behavioral symptoms).
2. The daily doses listed under Short-Acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and, when necessary, only gradually increase doses. The facility may exceed these doses if it provides evidence (see survey procedures and probes) to show why it was necessary for the maintenance or improvement in the resident's functional status.
3. For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that a gradual dose reduction is clinically contraindicated.
4. Diphenhydramine, hydroxyzine and chloral hydrate are not necessarily drugs of choice for treatment of anxiety disorders. They are only listed here in the event of their potential use.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F329 Cont.		

C. Drugs for Sleep Induction

Drugs used for sleep induction should only be used if:

o Evidence exists that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) have been ruled out. (See §483.25(l)(1)(iv));

o The use of a drug to induce sleep results in the maintenance or improvement of the resident's functional status (to evaluate functional status, see §483.25(a) through (k) and MDS, Sections B through P; MDS 2.0 sections B through P). (See §483.25(l)(1)(iv);)

o Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful. (See §483.25(l)(1)(ii);) and

o The dose of the drug is equal or less than the following listed doses unless higher doses (as evidenced by the resident response and/or the resident's clinical record) are necessary for maintenance or improvement in the residents functional status. (See §483.25(l)(1)(i).)

HYPNOTIC DRUGS NOT MAXIMUM DOSES

GENERIC	BRAND	DOSE BY MOUTH
Temazepam	(Restoril)	7.5mg
Triazolam	(Halcion)	0.125mg
Lorazepam	(Ativan)	1mg
Oxazepam	(Serax)	15mg
Alprazolam	(Xanax)	0.25mg
Estazolam	(ProSom)	0.5mg
Diphenhydramine	(Benadryl)	25mg
Hydroxyzine	(Atarax,Vistaril)	50mg
Chloral Hydrate	(Many Brands)	500mg
Zolpidem	(Ambien)	5mg

NOTES: 1. Diminished sleep in the elderly is not necessarily pathological.

2. The doses listed are doses for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence (see survey procedures and probes) to show why it was necessary for the maintenance or improvement in the resident's functional status.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F329 Cont.		

3. Diphenhydramine, hydroxyzine, and chloral hydrate are not necessarily drugs of choice for sleep disorders. They are listed here only in the event of their potential use.

4. For drugs in this category, a gradual dose reduction should be attempted at least three times within six months before one can conclude that a gradual dose reduction is clinically contraindicated.

D. Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs

The initiation of the following hypnotic/sedative/anxiolytic drugs should not occur in any dose for any resident. (See Notes for exceptions.) Residents currently using these drugs or residents admitted to the facility while using these drugs should receive gradual dose reductions as part of a plan to eliminate or modify the symptoms for which they are prescribed. A gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is clinically contraindicated. Newly admitted residents using these drugs may have a period of adjustment before a gradual dose reduction is attempted.

(CAUTION: DO NOT ENCOURAGE RAPID WITHDRAWAL OF THESE DRUGS. THIS MIGHT RESULT IN SEVERE PHYSIOLOGICAL WITHDRAWAL SYMPTOMS.)

BARBITURATES (EXAMPLES)

GENERIC	BRAND
Amobarbital	(Amytal)
Butabarbital	(Butisol, others)
Pentobarbital	(Nembutal)
Secobarbital	(Seconal)
Phenobarbital	(Many Brands)
Amobarbital-Secobarbital	(Tuinal)
Barbiturates with other drugs	(e.g., Fiorinal)

MISCELLANEOUS HYPNOTIC/SEDATIVE/ANXIOLYTICS

GENERIC	BRAND
Glutethimide	(Doriden)
Methprylon	(Noludar)
Ethchlorvynol	(Placidyl)
Meprobamate	(Equinal, Miltown)
Paraldehyde	(Many Brands)

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F329 Cont.		

NOTES: 1. Any sedative drug is excepted from this Guideline when used as a single dose sedative for dental or medical procedures.
2. Phenobarbital is excepted from this Guideline when used in the treatment of seizure disorders
3. When Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs are used outside these Guidelines they may be unnecessary drugs as a result of inadequate indications for use. (See Survey Procedures and Probes.)

E. ANTIPSYCHOTIC DRUG DOSAGE LEVELS

The following examples of antipsychotic drugs should not be used in excess of the listed doses for residents with organic mental syndromes (now called "delirium, dementia, and amnestic and other cognitive disorders" by DSM-IV) unless higher doses (as evidenced by the resident's response or the resident's clinical record) are necessary to maintain or improve the resident's functional status. To evaluate functional status, see §§483.25(a) through (k) and MDS, sections B through P; MDS 2.0 sections B through P.

ANTIPSYCHOTIC DRUGS

GENERIC	BRAND	NOT MAXIMUM DOSES DAILY ANTIPSYCHOTIC ORAL DOSAGE FOR RESIDENTS WITH ORGANIC MENTAL SYNDROMES MG/DAY
Chlorpromazine	(Thorazine)	75
Promazine	(Sparine)	150
Triflupromazine	(Vesprin)	20
Thioridazine	(Mellaril)	75
Mesoridazine	(Serentil)	25
Acetophenazine	(Tindal)	20
Perphenazine	(Trilafon)	8
Fluphenazine	(Prolixin, Permitil)	4
Trifluoperazine	(Stelazine)	8
Chlorprothixene	(Taractan)	75
Thiothixene	(Navane)	7
Haloperidol	(Haldol)	4
Molindone	(Moban)	10
Loxapine	(Loxitane)	10
Clozapine	(Clozaril)	50
Prochlorperazine	(Compazine)	10
Risperidone	(Risperdal)	4

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F329 Cont.		

NOTES [illegible] daily doses ([illegible]) for Amnestic and other cognitive disorders by DSM-IV). The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence (see Survey Procedures and Probes) to show why it is necessary for the maintenance or improvement in the resident's functional status.

2. The "specific conditions" for use of antipsychotic drugs are listed under the Guideline for §§483.25(1)(1) and (2).

3. The dose of prochlorperazine may be exceeded for short term (seven day) treatment of nausea and vomiting. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can also be treated with higher doses for longer periods of time.

4. When antipsychotic drugs are used outside these Guidelines without valid reasons for the higher dose, they may be deemed unnecessary drugs as a result of excessive dose.

F. Monitoring for Antipsychotic Drug Side Effects

The facility assures that residents who are undergoing antipsychotic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on the following:

- o Tardive dyskinesia;
- o Postural (orthostatic) hypotension;
- o Cognitive/behavior impairment;
- o Akathisia; and
- o Parkinsonism.

NOTES: For a more detailed description of these side effects, see the RAP: Psychotropic Drug Use, pg. F-72, Resident Assessment Instrument Training Manual and Resource Guide, 1990 edition.

When antipsychotic drugs are used without monitoring for these side effects, they may be unnecessary drugs because of inadequate monitoring.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F329 Cont.		G. Antidepressant Drugs The under diagnosis and under treatment of depression in nursing homes has been documented in a Journal of the American Medical Association paper entitled "Depression and Mortality in the Nursing Home" (JAMA, February 27, 1991-vol. 265, No. 8). HCFA continues to support the accurate identification and treatment of depression in nursing homes. The surveyor should not urge a facility to use behavioral monitoring charts (e.g., documenting quantitatively (number of episodes) and objectively (e.g., withdrawn behavior such as staying in their room, refusal to speak, etc.) when antidepressant drugs are used in nursing homes. Such charts are promoted in the interpretative guidelines for antipsychotic and benzodiazepine and other anxiolytic/sedative drugs (see pages P-185 and P-176), but NOT for antidepressant drugs. These charts may be helpful for monitoring the effects of antidepressant drugs in nursing homes, but they may place additional paperwork burden on the facility and thus act as a deterrent to the appropriate diagnosis and treatment of this condition. The following is a list of commonly used antidepressant drugs: Antidepressant Drugs Generic Name — Brand Name Amitriptyline* (Elavil) Amoxapine (Asendin) Desipramine (Norpramin, Pertofrane) Doxepin* (Sinequan) Imipramine* (Tofranil) Maprotiline (Ludiomil) Nortriptyline (Aventyl, Pamelor) Protriptyline (Vivactil) Trimipramine* (Surmontil) Fluoxetine (Prozac) Sertraline (Zoloft)

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F329 Cont.		Antidepressant Drugs (Cont.) Generic Name — Brand Name Trazodone (Desyrel) Clomipramine* (Anafranil) Paroxetine (Paxil) Bupropion (Wellbutrin) Isocarboxazid* (Marplan) Phenelzine* (Nardil) Tranylcypromine* (Parnate) Venlafaxine (Effexor) Nefazodone (Serzone) Fluvoxamine (Luvox) * These are not necessarily drugs of choice for depression in the elderly. They are listed here only in the event of their potential use. Procedures: §483.25(l)(1) Consider drug therapy "unnecessary" only after determining that the facility's use of the drug is: o In excessive dose (including duplicate drug therapy); o For excessive duration; o Without adequate monitoring; o Without adequate indications of use; o In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or o Any combination of the reasons above. Allow the facility the opportunity to provide a rationale for the use of drugs prescribed outside the preceding Guidelines. The facility may not justify the use of a drug prescribed outside the proceeding Guidelines solely on the basis of "the doctor ordered it." This justification would render the regulation meaningless. The rationale must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Examples of evidence that would support a justification of why a drug is being used outside these Guidelines but in the best interests of the resident may include, but are not limited to:

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F329 Cont.		o A physician's note indicating for example, that the dosage, duration, indication, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate; this note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using drugs outside the Guidelines; o A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) that confirms the physician's judgment that use of a drug outside the Guidelines is in the best interest of the resident; o Physician, nursing, or other health professional documentation indicating that the resident is being monitored for adverse consequences or complications of the drug therapy; o Documentation confirming that previous attempts at dosage reduction have been unsuccessful; o Documentation (including MDS documentation) showing resident's subjective or objective improvement, or maintenance of function while taking the medication; o Documentation showing that a resident's decline or deterioration is evaluated by the interdisciplinary team to determine whether a particular drug, or a particular dose, or duration of therapy, may be the cause; o Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, monitoring; and o Other evidence the survey team may deem appropriate. If the survey team determines that there is a deficiency in the use of antipsychotics, cite the facility under either the "unnecessary drug" regulation or the "antipsychotic drug" regulation, but not both. NOTE: The unnecessary drug criterion of "adequate indications for use" does not simply mean that the physician's order must include a reason for using the drug (although such order writing is encouraged). It means that the resident lacks a valid clinical reason for use of the drug as evidenced by the survey team's evaluation of some, but not necessarily all, of the following: resident assessment, plan of care, reports of significant change, progress notes, laboratory reports, professional consults, drug orders, observation and interview of the resident, and other information.
	(2) Antipsychotic Drugs Based on a comprehensive assessment of a resident, the facility must ensure that--	Guidelines: §483.25(l)(2)(i) For a list of examples of commonly used antipsychotic drugs, see E. under Interpretive Guideline for §483.25 (l)(l), Unnecessary drug.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F330	(i) Residents 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	Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following "specific conditions": 1.Schizophrenia; 2.Schizo-affective disorder; 3.Delusional disorder; 4.Psychotic mood disorders (including mania and depression with psychotic features); 5.Acute psychotic episodes; 6.Brief reactive psychosis; 7.Schizophreniform disorder; 8.Atypical psychosis; 9.Tourette's disorder; 10.Huntington's disease; 11.Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors: a. Which have been quantitatively and objectively documented. This documentation is necessary to assist in: (1) assessing whether the resident's behavioral symptom is in need of some form of intervention, (2) determining whether the behavioral symptom is transitory or permanent, (3) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (4) ruling out environmental causes such as excessive heat, noise, overcrowding, (5) ruling out medical causes such as pain, constipation, fever, infection. For a more complete description of behavioral monitoring charts and how they can assist in the differential diagnosis of behavioral symptoms see the RAP on behavior problems (soon to be known as behavioral symptoms); and b.Which are persistent, and c.Which are not caused by preventable reasons; and d.Which are causing the resident to: (1)Present a danger to himself/herself or to others, or (2)Continuously scream, yell, or pace if these specific behaviors cause an impairment in functional capacity (to evaluate functional capacity, see §483.25 (a) through (k) and MDS sections B through P; MDS 2.0 sections B through P), or

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F330 Cont.		(3)Experience psychotic symptoms (hallucinations, paranoia, delusions) not exhibited as dangerous behaviors or as screaming, yelling, or pacing but which cause the resident distress or impairment in functional capacity; or 12. Short-term (7 days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time. Antipsychotics should not be used if one or more of the following is/are the only indication: o Wandering, o Poor self care, o Restlessness, o Impaired memory, o Anxiety, o Depression (without psychotic features), o Insomnia, o Unsociability, o Indifference to surroundings, o Fidgeting, o Nervousness, o Uncooperativeness, or o Agitated behaviors which do not represent danger to the resident or others.
F331	(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	Guidelines: §483.25(l)(2)(ii) Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual does reduction should be under close supervision. If the gradual dose reduction is causing an adverse effect on the resident and the gradual dose reduction is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether. "Behavioral interventions" means modification of the resident's behavior or the resident's environment, including staff approaches to care, to the largest degree possible to accommodate the resident's behavioral symptoms.

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F331 Cont.		"Clinically contraindicated" means that a resident NEED NOT UNDERGO A "gradual dose reduction" or "behavioral interventions" IF: 1. The resident has a "specific condition" (as listed under one through ten on page P-185) and has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations), which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects, 2. The resident has organic mental syndrome (now called--"Delirium, Dementia, and Amnestic and other Cognitive Disorders" by DSM IV) and has had a gradual dose reduction attempted TWICE in one year and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction, or a return to previous dose reduction was necessary; or 3. The resident's physician provides a justification why the continued use of the drug and the dose of the drug is clinically appropriate. This justification should include: (a) a diagnosis, but not simply a diagnostic label or code, but the description of symptoms, (b) a discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and/or agitated behaviors, and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor), (c) a description of the justification for the choice of a particular treatment, or treatments, and (d) a discussion of why the present dose is necessary to manage the symptoms of the resident. This information need not necessarily be in the physician's progress notes, but must be a part of the resident's clinical record. Procedures: §483.25(l)(2)(i) and (ii) In determining whether an antipsychotic drug is without a specific condition or that gradual dose reduction and behavioral interventions have not been performed, allow the facility an opportunity to justify why using the drug outside the Guidelines is in the best interest of the resident. Examples of evidence that would support a justification of why a drug is being used outside the Guidelines, but in the best interest of the resident, may include, but are not limited to: o A physician's note indicating that the use of the drug, or continued use of the drug is clinically appropriate, and the reasons why this use is clinically appropriate. This note must demonstrate that the physician has carefully considered the risk/benefit to the resident in using drugs outside these Guidelines. o A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) that confirms the physician's judgment that use of a drug outside the Guidelines is in the best interest of the resident.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F331 Cont.		o Physician, nursing, or other health professional documentation indicating that the resident is being monitored for adverse consequences or complications of the drug therapy. o Documentation confirming that previous attempts at dosage reduction have been unsuccessful. o Documentation (including MDS documentation) showing resident's subjective or objective improvement or maintenance of function while taking the medication. o Documentation showing that a resident's decline or deterioration is evaluated by the interdisciplinary team to determine whether a particular drug, or a particular dose, or duration of therapy, may be the cause. o Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration. o Other evidence the surveyor may deem appropriate. While the facility can refer to a physician's justification as a valid justification for use of a drug, it may not justify the use of a drug, its dose, its duration, solely on the basis that "the doctor ordered it." If the survey team determine that there is a deficiency in the use of antipsychotics, cite the facility under either the "unnecessary drug" regulation or the "antipsychotic drug" regulation, but not both.
F332 F333	(m) Medication Errors. The facility must ensure that-- (1) It is free of medication error rates of five percent or greater; and (2) Residents are free of any significant medication errors.	Guidelines: §483.25(m) "Medication error" means a discrepancy between what the physician ordered and what the survey team observe during an observation of an individual or several different individuals administering drugs to residents in the facility. "Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety. Criteria for judging significant medication errors as well as examples are provided under significant and non-significant medication errors. "Medication error rate" is determined by calculating the percentage of errors. The numerator in the ratio is the total number of errors that the survey team observes, both significant and nonsignificant. The denominator is called "opportunities for errors" and includes all the doses the survey team observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows: Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors X 100.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		"Medication error rate" --A medication error rate of 5% or greater includes both significant and nonsignificant medication errors. It indicates that the facility has systemic problems with its drug distribution system and a deficiency should be written. But the error rate must be 5% or greater. Rounding of a lower rate (e.g., 4.6%) to a 5% rate is not permitted. Significant and Nonsignificant Medication Errors "Determining Significance".--The relative significance of medication errors is a matter of professional judgment. Follow three general guidelines in determining whether a medication error is significant or not: o Resident Condition.--The resident's condition is an important factor to take into consideration. For example, a potent diuretic erroneously administered to a dehydrated resident may have serious consequences, but if administered to a resident with a normal fluid balance may not. If the resident's condition requires rigid control, a single missed or wrong dose can be highly significant. o Drug Category.--If the drug is from a category that usually requires the resident to be titrated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This is especially important if the half life of the drug is short. Examples of drug categories which require titration of resident blood levels include anticonvulsants, anticoagulants, and antiarrhythmic, anti-anginal and antiglaucoma agents. o Frequency of Error.--If an error is occurring with any frequency, there is more reason to classify the error as significant. For example, if a resident's drug was omitted several times, as verified by reconciling the number of tablets delivered with the number administered, classifying that error as significant would be more in order. This conclusion should be considered in concert with the resident's condition and the drug category. Examples of Significant and Non-Significant Medication Errors.--Examples of medication errors that have actually occurred in long term care facilities are presented below. Some of these errors are identified as significant. This designation is based on expert opinion without regard to the status of the resident. Most experts concluded that the significance of these errors, in and of themselves, have a high potential for creating problems for the typical long term care facility resident. Those errors identified as nonsignificant have also been designated primarily on the basis of the nature of the drug. Resident status and frequency of error could classify these errors as significant.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		Omissions (Drug ordered but not administered at least once):

DRUG ORDER	SIGNIFICANCE
Haldol 1mg BID	NS*
Motrin 400mg TID	NS
Quinidine 200mg TID	S**
Tearisol Drops 2 both eyes TID	NS
Indocin 25mg TID pc	NS
Lioresal 10mg TID	NS
Thorazine 25mg BID	NS
Ampicillin 500mg TID	NS
Metamucil one packet BID	NS
Inderal 20mg one every 6 hours	S
Multivitamin one daily	NS
Mylanta Susp. one oz., TID AC	NS
Nitrol Oint. one inch	S
Librium 10mg one TID	NS
Cortisporin Otic drop 4 to 5 left ear QID	NS
Aldactone 25mg QID	NS

* Not Significant
** Significant

Unauthorized Drug (Drugs administered without a physician's order):

DRUG ORDER	SIGNIFICANCE
Feosol	NS
Coumadin 4mg	S
Lasix 40mg	S
Zyloprim 100mg	NS
Tylenol 5 gr	NS
Triavil 4-25	NS
Multivitamins	NS
Motrin 400mg	NS

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		

Wrong Dose:

DRUG ORDER	ADMINISTERED	SIGNIFICANCE
Isoptocarpine 1% one drop in the left eye TID	Three drops in each eye	NS
Epinal 1% one drop in eyes BID	Three drops in each eye	NS
Digoxin 0.125mg everyday	0.25mg	S
Lasix 20mg one daily	40mg	NS
Amphojel 30cc QID	15cc	NS
Slow K two TID	one	NS
Dilantin 125 SUSP 12cc	2cc	S
Lasix 40mg daily	20mg	NS

Wrong Route of Administration:

DRUG ORDER	ADMINISTERED	SIGNIFICANCE
Hydergine 0.5 mg SL.L BID	Resident Swallowed	NS
Cortisporin Otic Drops 4 to 5 left ear QID	Left Eye	S

Wrong Dosage Form:

DRUG ORDER	ADMINISTERED	SIGNIFICANCE
Colace Liquid 100mg BID	Capsule	NS
Mellaril 10mg	Concentrate	NS*
Dilantin Kapseals 100 mg three Kapseals p.o. HS	Prompt Phenytoin 100 mg three capsules p.o. HS	S**

* If correct dose was given.

** Parke Davis Kapseals have an extended rate of absorption. Prompt phenytoin capsules do not.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		Wrong Drug:

DRUG ORDER	ADMINISTERED	SIGNIFICANCE
Tylenol 325 mg (Routinely)	Ascriptin	S

Wrong Time:

DRUG ORDER	ADMINISTERED	SIGNIFICANCE
Indocin 25mg PC	AC	NS
Periactin 4mg PC	AC	NS
Digoxin 0.25mg daily at 8 a.m.	At 9:15 am	NS
Tetracycline 250mg QID AC and HS	PC	S

Determining Medication Errors

Timing Errors. --If a drug is ordered before meals (AC) and administered after meals (PC), always count this as a medication error. Likewise, if a drug is ordered PC and is given AC, count as a medication error. Count a wrong time error if the drug is administered 60 minutes earlier or later than its scheduled time of administration, BUT ONLY IF THAT WRONG TIME ERROR CAN CAUSE THE RESIDENT DISCOMFORT OR JEOPARDIZE THE RESIDENT'S HEALTH AND SAFETY. Counting a drug with a long half-life (e.g., digoxin) as a wrong time error when it is 15 minutes late is improper because this drug has a long half-life (beyond 24 hours) and 15 minutes has no significant impact on the resident. The same is true for many other wrong time errors (except AC AND PC errors) in long term care facilities.

To determine the scheduled time, examine the facility's policy relative to dosing schedules. The facility's policy should dictate when it administers a.m. doses, or when it administers the first dose in a 4-times-a-day dosing schedule.

Physician's Orders. --The latest recapitulation of drug orders is sufficient for determining whether a valid order exists provided the physician has signed the "recap." The signed "recap" and subsequent orders constitute a legal authorization to administer the drug. Attempts to find original orders in the physician's handwriting are usually too time consuming.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		Procedures: §483.25(m) Medication Error Detection Methodology. --Use an observation technique to determine medication errors. This means that the survey team should observe the administration of drugs, on several different drug "passes", record what is observed; and reconcile the record of observation with the physician's drug orders to determine whether or not medication errors have occurred. Do not rely solely on a paper review to determine medication errors. Detection of blank spaces on a medication administration record does not constitute the detection of actual medication errors. Paper review only identifies possible errors. Experience has shown that facility staff are likely to correct the paper rather than correct the errors. Observation Technique. --The survey team must know without doubt, what drugs, in what strength, and dosage forms, are being administered. This is accomplished prior to drug administration and may be done in a number of ways depending on the drug distribution system used (e.g. unit dose, vial system, punch card). 1. Identify the drug product. There are two principal ways to do this. In most cases, they are used in combination: o Identify the product by its size, shape, and color. Many drug products are identifiable by their distinctive size, shape, or color. This technique is problematic because not all drugs have distinctive sizes, shapes, or color. o Identify the product by observing the label. When the punch card or the unit dose system is used, the survey team can usually observe the label and adequately identify the drug product. When the vial system is used, observing the label is sometimes more difficult. Ask the nurse to identify the medication being administered. 2. Observe and record the administration of drugs ("pass"). Follow the person administering drugs and observe residents receiving drugs (e.g., actually swallowing oral dosage forms). Be neutral and as unobtrusive as possible during this process. Make every effort to observe residents during several different drug "passes" so the survey team will have an assessment of the entire facility rather than one staff member on one drug pass. Note every detail on the surveyor's record of the drug administration. For example, "eye drops administered in both eyes" or "nurse took pulse," or "resident swallowed nitroglycerin" or "all drugs crushed and administered in apple sauce."

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		Identifying residents can present a problem. Some long-term care facilities do not use arm identification bands, so assume correctness of the resident by relying on the actions of the nurse and the response of the resident. 3. Reconcile the surveyor's record of observation with physician's orders. Compare the record of observation with the most current signed orders for drugs. This comparison involves two distinct activities: o For each drug on the surveyor's list: Was it administered according to the physician's orders? For example, in the correct strength, by the correct route? Was there a valid order for the drug? Was the drug the correct one? o For drugs not on surveyor's list: Are there orders for drugs that should have been administered, but were not? Examine the record for drug orders that were not administered and should have been. Such circumstances represent omitted doses - one of the most frequent types of errors. The surveyor should now have a complete record of what was observed and what should have occurred according to the physicians' orders. Determine the number of errors by adding the errors on each resident. Before concluding for certain that an error has occurred, discuss the apparent error with the nurse who administered the drugs. There may be a logical explanation for an apparent error. For example, the surveyor observed that a resident had received Lasix 20 mg, but the order was for 40 mg. This was an apparent error in dosage. But the nurse showed the surveyor another more recent order which discontinued the 40 mg order and replaced it with a 20 mg order. 4. Reporting Errors - Describe to the facility each error that the survey team detects (e.g., Mary Jones received digoxin in 0.125 instead of 0.25 mg). The survey team is not required to analyze the errors and come to any conclusions on how the facility can correct them. Do not attempt to categorize errors into various classifications (e.g., wrong dose, wrong resident). Stress that an error occurred and that future errors must be avoided. 5. Observe Morning "Pass" - It is preferable to watch the morning drug administration pass because that is when most doses are administered in long term care facilities and, hence, offers the greatest opportunity to observe errors and conserve survey time. 6. Observe Several Individuals - Strive to observe several individuals administering drugs in the facility so that an assessment of medication errors will be more broadly based. This requires observation of several "passes" at the same time or at different times of the day.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F333 Cont.		Dose Reconciliation Technique: Supplement to the Observation Technique. --When an omission error has been detected through the observation technique, the dose reconciliation technique can sometimes enable the survey team to learn how frequently an error has occurred in the past. Learning about the frequency of an error can assist in judging the significance of the error. (See Significant and Non Significant Medication Errors above.) The dose reconciliation technique requires a comparison of the number of doses remaining in a supply of drugs with the number of days the drug has been in use and the directions for use. For example, if a drug were in use for 5 days with direction to administer the drug 4 times a day, then 20 doses should have been used. If a count of the supply of that drug shows that only 18 doses were used (i.e., two extra doses exist) and no explanation for the discrepancy exists (e.g., resident refused the dose, or resident was hospitalized), then two omission errors may have occurred. Use the dose reconciliation technique in facilities that indicate the number of drugs received, and the date and the specific "pass" when that particular drug was started. Unless this information is available, do not use this technique. If this information is not available, there is no Federal authority under which the survey team may require it, except for controlled drugs.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F353	§483.30 Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. (a) Sufficient staff. (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel. (2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	Intent: §483.30 To assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. Procedures: §483.30 Fully review requirements of nursing services during an extended survey or when a waiver of RN and/or licensed nurse (RN/LPN) staffing has been requested or granted. Except as licensed nursing personnel are specifically required by the regulation (e.g., an RN for 8 consecutive hours a day, 7 days a week), the determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. The ability to meet the requirements of §§483.13, 483.15(a), 483.20, 483.25 and 483.65 determines sufficiency of nurse staffing. Guidelines: §483.30(a) and (b) At a minimum, "staff" is defined as licensed nurses (RNs and/or LPNs/LVNs), and nurse aides. Nurse aides must meet the training and competency requirements described in §483.75(e). "Full time" is defined as working 35 or more hours a week. Except for licensed staff noted above, the determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to resident care, even when adverse effects have not occurred, or there is a lack of residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat.
F354	(b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	The facility is required to designate an RN to serve as DON on a full time basis. This requirement can be met when RNs share the position. If RNs share the DON position, the total hours per week must equal 40. Facility staff must understand the shared responsibilities. The facility can only be waived from this requirement if it has a waiver under subsection (c) or (d). Probes: §483.30(a) and (b) Determine nurse staffing sufficiency for each unit: o Is there adequate staff to meet direct care needs, assessments, planning, evaluation, supervision? o Do work loads for direct care staff appear reasonable?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F354 Cont.	(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	o Do residents, family, and ombudsmen report insufficient staff to meet resident needs? o Are staff responsive to residents' needs for assistance, and call bells answered promptly? o Do residents call out repeatedly for assistance? o Are residents, who are unable to call for help, checked frequently (e.g., each half hour) for safety, comfort, positioning, and to offer fluids and provision of care? o Are identified care problems associated with a specific unit or tour of duty? o Is there a licensed nurse that serves as a charge nurse (e.g., supervises the provision of resident care) on each tour of duty (if facility does not have a waiver of this requirement)? o What does the charge nurse do to correct problems in nurse staff performance? o Does the facility have the services of an RN available 8 consecutive hours a day, 7 days a week (if this requirement has not been waived)? o How does the facility assure that each resident receives nursing care in accordance with his/her plan of care on weekends, nights, and holidays? o How does the sufficiency (numbers and categories) of nursing staff contribute to identified quality of care, resident rights, quality of life, or facility practices problems?
	(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if -- (1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;	Intent: §483.30(c) To give the facility flexibility, in limited circumstances, when the facility cannot meet nurse staffing requirements. Guidelines: §483.30(c) The facility may request a waiver of the RN requirement, and/or the 24-hour licensed nurse requirement. If the facility is Medicaid-certified only, the State has the authority to grant the waiver. If the facility is dually-participating, HCFA has the delegated authority to grant the waiver. (See guidelines for §483.30(d).) A survey of Nursing Services must be conducted if a waiver has been granted or requested.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F355	(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; (3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; (4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review; (5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel; (6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.	Probes: §483.30(c) Before granting a continuation of this waiver, or during the annual review, at a minimum, determine: o Is a continuing effort being made to obtain licensed nurses? o How does the facility ensure that residents' needs are being met? o Are all nursing policies and procedures followed on each shift during times when licensed services are waived? o Is there a qualified person to assess, evaluate, plan and implement resident care? o Is care being carried out according to professional practice standards on each shift? o Can the survey team ensure the State that the absence of licensed nurses will NOT endanger the health or safety of residents? o Are there trends in the facility, which might be indicators of decreased quality of care as a result of insufficient staffing to meet resident needs (e.g., increases in incident reports, the infection rate, hospitalizations)? o Are there increases in loss of function, pressure sores, tube feedings, catheters, weight loss, mental status? o Is there evidence that preventive measures (e.g., turning, ambulating) are taken to avoid poor quality of care outcomes and avoidable sudden changes in health status? o Is there evidence that sudden changes in resident health status and emergency needs are being properly identified and managed by appropriate facility staff and in a timely manner? o If the facility has a waiver of the requirement to provide licensed nurses on a 24-hour basis, have they notified the ombudsman, residents, surrogates or legal representatives, and members of their immediate families of the waiver, and are there services residents need that are not provided because licensed nurses are not available? o Is there an increase in hospitalizations because licensed personnel are not available to provide appropriate services? o Does the facility meet all applicable requirements to continue to receive a waiver? o Does the staff indicate that an RN or physician is available to respond immediately to telephone calls when licensed nurses are not available?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(d) *SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.* (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that -- (i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area; (ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and (iii) The facility either-- (A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or; (B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days	Guidelines: §483.30(d) HCFA is delegated the waiver authority for SNFs, including dually-participating facilities (SNF/NFs). The Medicare waiver authority is far more limited than is the States' authority under Medicaid since a State may waive any element of the nurse staffing requirement, whereas the Secretary may waive only the RN requirement. The requirements that a registered nurse provide services for 8 hours a day, 7 days a week (more than 40 hours a week), and that there be an RN designated as director of nursing on a full-time basis, may be waived by the Secretary in the following circumstances: o The facility is located in a rural area with an inadequate supply of SNF services to meet area needs. Rural is defined as "all areas not delineated as `urban` by the Bureau of Census, based on the most recent census; o The facility has one full-time registered nurse regularly working 40 hours a week. This may be the same individual, or part-time individuals. This nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires; and either; o The facility has only residents whose physicians have noted, in writing, do not need RN or physician care for a 48 hour period. This does not relieve the facility from responsibility for providing for emergency availability of a physician, when necessary, nor does it relieve the facility from being responsible for meeting all needs of the residents during those 48 hours; or o A physician or RN will spend the necessary time at the facility to provide care residents need during the days that an RN is not on duty. This requirement refers to clinical care of the residents that need skilled nursing services. If a waiver of this requirement has been granted, conduct a survey of nursing services during each certification survey. Dually-participating facilities must meet the waiver provisions of the SNF. Probes: §483.30(d) If the SNF has a waiver of the more than 40 hours a week RN requirement: o Is there an RN on duty 40 hours a week? o If more than one RN provides the 40 hour per week coverage, how is information exchanged that maintains continuity of resident care? o Does each clinical record have documentation by the physician that the resident does not need services of a physician or an RN for a 48 hour period each week. o Are there any emergency or routine services that should be, but are not, provided to residents during the days that a registered nurse is not on duty? o If specific skilled care is necessary for a resident during the time that an RN is not on duty, does an RN or physician provide that service on an "as needed" basis? o Did the facility notify residents (or their legal guardians) and their immediate families about the waiver and the ombudsman?

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	when the regular full-time registered nurse is not on duty; (iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver. (2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.	See also probes at §483.30(c). If the SNF requests continuation of the waiver to provide the services of a registered nurse for more than 40 hours a week, the survey team is to provide the Secretary with information needed to grant this continuation. o Does the SNF meet all requirements necessary for continuation of the waiver? Procedures: §483.30(a)-(d) If the facility has an approved nurse staffing waiver, it is not considered a deficiency. The facility does not need to submit a POC. The following procedure should be used to document that a facility has a waiver of nurse staffing requirements. When a facility does not meet the nurse staffing requirements, cite the appropriate tag. If the facility does have a waiver, reference the tag number based on the type of facility. The type of facility (SNF, NF, or SNF/NF) determines what type of waiver is granted: o For SNFs and SNF/NFs which may be waived from the requirement to provide more than 40 hours of registered nurse services a week, and for NFs which have been granted a waiver from the 56 hour registered nurse requirement, cite F354; o For NFs that have a waiver of the 24-hour licensed nursing requirement, cite F353; or o Both facility types could be waived for the requirement to designate a registered nurse as the director of nursing on a full-time basis. Cite F355. When the HCFA-2567 is entered into OSCAR, code the waived tag as a "W". Enter the tag number, leave the correction date blank, and enter a "W" in the CP field. This will indicate that this is not a deficiency--that the requirement has been waived.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F360	§483.35 Dietary Services. 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.	
F361	(a) Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. (1) 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. (2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	Intent: §483.35(a) The intent of this regulation is to ensure that a qualified dietitian is utilized in planning, managing and implementing dietary service activities in order to assure that the residents receive adequate nutrition. A director of food services has no required minimum qualifications, but must be able to function collaboratively with a qualified dietitian in meeting the nutritional needs of the residents. Guidelines: §483.35(a) A dietitian qualified on the basis of education, training, or experience in identification of dietary needs, planning and implementation of dietary programs has experience or training which includes: o Assessing special nutritional needs of geriatric and physically impaired persons; o Developing therapeutic diets; o Developing "regular diets" to meet the specialized needs of geriatric and physically impaired persons; o Developing and implementing continuing education programs for dietary services and nursing personnel; o Participating in interdisciplinary care planning; o Budgeting and purchasing food and supplies; and o Supervising institutional food preparation, service and storage. Procedures: §483.35(a) If resident reviews determine that residents have nutritional problems, determine if these nutritional problems relate to inadequate or inappropriate diet nutrition/assessment and monitoring. Determine if these are related to dietitian qualifications. Probes: §483.35(a) If the survey team finds problems in resident nutritional status: o Do practices of the dietitian or food services director contribute to the identified problems in residents' nutritional status? If yes, what are they?

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F361 Cont.		o What are the educational, training, and experience qualifications of the facility's dietitian?
F362	(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	Guidelines: §483.35(b) "Sufficient support personnel" is defined as enough staff to prepare and serve palatable, attractive, nutritionally adequate meals at proper temperatures and appropriate times and support proper sanitary techniques being utilized. Procedures: §483.35(b) For residents who have been triggered for a dining review, do they report that meals are palatable, attractive, served at the proper temperatures and at appropriate times? Probes: §483.35(b) (Sufficient staff preparation) Is food prepared in scheduled timeframes in accordance with established professional practices? Observe food service: Does food leave kitchen in scheduled timeframes? Is food served to residents in scheduled timeframes?
F563	(c) Menus and nutritional adequacy. Menus must-- (1) 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;	Intent: §483.35(c)(1)(2)(3) The intent of this regulation is to assure that the meals served meet the nutritional needs of the resident in accordance with the recommended dietary allowances (RDA's) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences. This regulation also assures that there is a prepared menu by which nutritionally adequate meals have been planned for the resident and followed. Procedures: §483.35(c)(1) o For sampled residents who have a comprehensive review or a focused review, as appropriate, observe if meals served are consistent with the planned menu and care plan in the amounts, types and consistency of foods served.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F363 Cont.		If the survey team observes deviation from the planned menu, review appropriate documentation from diet card, record review, and interviews with food service manager or dietitian to support reason(s) for deviation from the written menu. Probes: §483.35(c)(1) o Are residents receiving food in the amount, type, consistency and frequency to maintain normal body weight and acceptable nutritional values? o If food intake appears inadequate based on meal observations, or resident's nutritional status is poor based on resident review, determine if menus have been adjusted to meet the caloric and nutrient-intake needs of each resident. o If a food group is missing from the resident's daily diet, does the facility have an alternative means of satisfying the resident's nutrient needs? If so, does the facility perform a follow-up? (Menu adequately provides the daily basic food groups) Does the menu meet basic nutritional needs by providing daily food in the groups of the food pyramid system and based on individual nutritional assessment taking into account current nutritional recommendations? NOTE: A standard meal planning guide (e.g., food pyramid) is used primarily for menu planning and food purchasing. It is not intended to meet the nutritional needs of all residents. This guide must be adjusted to consider individual differences. Some residents will need more due to age, size, gender, physical activity, and state of health. There are many meal planning guides from reputable sources, i.e., American Diabetes Association, American Dietetic Association, American Medical Association, or U.S. Department of Agriculture, that are available and appropriate for use when adjusted to meet each resident's needs.
	(2) Be prepared in advance; and	Probes: §483.35(c)(2) (Menu prepared in advance) Are there preplanned menus for both regular and therapeutic diets?
	(3) Be followed.	Probes: §483.35(c)(3) (Menu followed) Is food served as planned? If not, why? There may be legitimate and extenuating circumstances why food may not be available on the day of the survey and must be considered before a concern is noted.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(d) Food. Each resident receives and the facility provides--	Intent: §483.35(d)(1)(2) The intent of this regulation is to assure that the nutritive value of food is not compromised and destroyed because of prolonged food storage, light, and air exposure; prolonged cooking of foods in a large volume of water and prolong holding on steam table, and the addition of baking soda. Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident's satisfaction. Refer to §483.15(e) and/or §483.15(a). Guidelines: §483.35(d)(1) "Food-palatability" refers to the taste and/or flavor of the food. "Food attractiveness" refers to the appearance of the food when served to residents. Procedures: §483.35(d)(1) Evidence for palatability and attractiveness of food, from day to day and meal to meal, may be strengthened through sources such as: additional observation, resident and staff interviews, and review of resident council minutes. Review nutritional adequacy in §483.25(i)(1). Probes: §483.35(d)(1)(2) Does food have a distinctly appetizing aroma and appearance, which is varied in color and texture? Is food generally well seasoned (use of spices, herbs, etc.) and acceptable to residents? (Conserves nutritive value) Is food prepared in a way to preserve vitamins? Method of storage and preparation should cause minimum loss of nutrients. (Food - temperature) Is food served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the resident and customary practice? Not to be confused with the proper holding temperature.
F364	(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature;	
F365	(3) Food prepared in a form designed to meet individual needs; and	Intent: §483.35(d)(3)(4) The intent of this regulation is to assure that food is served in a form that meets the resident's needs and satisfaction; and that the resident receives appropriate nutrition when a substitute is offered.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F366	(4) Substitutes offered of similar nutritive value to residents who refuse food served.	Procedures: §483.35(d)(3)(4) Observe trays to assure that food is appropriate to resident according to assessment and care plan. Ask the resident how well the food meets their taste needs. Ask if the resident is offered or is given the opportunity to receive substitutes when refusing food on the original menu. Probes: §483.35(d)(3)(4) Is food cut, chopped, or ground for individual resident's needs? Are residents who refuse food offered substitutes of similar nutritive value? Guidelines: §483.35(d)(4) A food substitute should be consistent with the usual and ordinary food items provided by the facility. For example, if a facility never serves smoked salmon, they would not be required to serve this as a food substitute; or the facility may, instead of grapefruit juice, substitute another citrus juice or vitamin C rich juice that the resident likes.
F367	(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.	Intent: §483.35(e) The intent of this regulation is to assure that the resident receives and consumes foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the treatment and plan of care. Guidelines: §483.35(e) "Therapeutic Diet" is defined as a diet ordered by a physician as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). "Mechanically altered diet" is one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' order. Procedures: §483.35(e) If the resident has inadequate nutrition or nutritional deficits that manifests into and/or are a product of weight loss or other medical problems, determine if there is a therapeutic diet that is medically prescribed. Probes: §483.35(e) Is the therapeutic diet that the resident receives prescribed by the physician?

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F367 Cont.		Also, see §483.25(i), Nutritional Status.
F368	(f) Frequency of meals. (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. (2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below. (3) The facility must offer snacks at bedtime daily. (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	Intent: §483.35(f)(1)(2)(3)(4) The intent of this regulation is to assure that the resident receives his/her meals at times most accepted by the community and that there are not extensive time lapses between meals. This assures that the resident receives adequate and frequent meals. Guidelines: §483.35(f)(1)(2)(3)(4) A "substantial evening meal" is defined as an offering of three or more menu items at one time, one of which includes a high-quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements. "Nourishing snack" is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the "nourishing snack" will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility, (e.g., Is the offered snack usually satisfying?) Procedures: §483.35(f)(1)(2)(3)(4) Observe meal times and schedules and determine if there is a lapse in time between meals. Ask for resident input on meal service schedules, to verify if there are extensive lapses in time between meals.
F369	(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.	Intent: §483.35(g) The intent of this regulation is to provide residents with assistive devices to maintain or improve their ability to eat independently. For example, improving poor grasp by enlarging silverware handles with foam padding, aiding residents with impaired coordination or tremor by installing plate guards, or providing postural supports for head, trunk, and arms.

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F369 Cont.		Procedures: §483.35(g) Review sampled residents comprehensive assessment for eating ability. Determine if recommendations were made for adaptive utensils and if they were, determine if these utensils are available and utilized by resident. If recommended but not used, determine if this is by resident's choice. If utensils are not being utilized, determine when these were recommended and how their use is being monitored by the facility and if the staff is developing alternative recommendations.
	(h) Sanitary conditions. The facility must--	Intent: §483.35(h)(2) The intent of this regulation is to prevent the spread of food borne illness and reduce those practices which result in food contamination and compromised food safety in nursing homes. Since foodborne illness is often fatal to nursing home residents, it can and must be avoided.
F370	(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities;	
F371	(2) Store, prepare, distribute, and serve food under sanitary conditions; and	Guidelines: §483.35(h)(2) "Sanitary conditions" is defined as storing, preparing, distributing, and serving food properly to prevent food borne illness. Potentially hazardous foods must be subject to continuous time/temperature controls in order to prevent either the rapid and progressive growth of infectious or toxigenic micro-organisms such as Salmonella or the slower growth of Clostridium Botulinum. In addition, foods of plant origin become potentially hazardous when the skin, husk, peel, or rind is breached, thereby possibly contaminating the fruit or vegetable with disease causing micro-organisms. Potentially hazardous food tends to focus on animal products, including but not limited to milk, eggs and poultry. Improper holding temperature is a common contributing factor of foodborne illness. The facility must follow proper procedures in cooking, cooling, and storing food according to time, temperatures, and sanitary guidelines. Improper handling of food can cause salmonella and E-coli contamination. The 1993 FDA Food Code advises the following precautions: NOTE: The 1993 FDA Food Code is not regulation and cannot be enforced as such. The food temperatures cited that are recommended in the 1993 FDA Food Code are target temperatures and give a margin of safety in temperature ranges and to avoid known harmful temperatures.

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F371 Cont.		Refrigerator storage of food to prevent food borne illness includes storing raw meat away from vegetables and other foods. Raw meat should be separated from cooked foods and other foods when refrigerated on its own tray on a bottom shelf so meat juices do not drip on other foods. Foods of both plant and animal origin must be cooked, maintained and stored at appropriate temperatures. o Foods of both plant and animal origin must be cooked, and maintained, and stored at appropriate temperatures. These temperatures are better utilized as food hold temperatures rather than the food temperatures as residents receive the food. o Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140° F, and cold foods at or below 41° F and freezer temperatures should be at 0° F or below. Refrigerator temperatures should be maintained at 41° F or below. The 1993 FDA Food Code can be used as an authoritative guide to clarify regulatory requirements on how to prepare and serve food to prevent foodborne illness. As the public becomes more informed and educated on how to prevent foodborne illness, this code will become the standard of practice the same as the 1976 Food Service Sanitation Manual did prior to 1993. Procedures: §483.35(h)(2) Observe storage, cooling, and cooking of food. Record the time and date of all observations. If a problem is noted, conduct additional observations to verify findings. Observe that employees are effectively cleaning their hands prior to preparing, serving and distributing food. Observe that food is covered to maintain temperature and protect from other contaminants when transporting meals to residents. Refrigerated storage: Check all refrigerators and freezers for temperatures. Use the facility's or the surveyor's own properly sanitized thermometer to evaluate the internal temperatures of potentially hazardous foods with a focus on the quantity of leftovers and the container sizes in which bulk leftovers are stored. Food preparation: Use a sanitized thermometer to evaluate food temperatures. In addition, how do kitchen staff process leftovers? Are they heated to the appropriate temperatures? How is frozen food thawed? How is potentially hazardous food handled during multi-step food preparation (e.g., chicken salad, egg salad)? Is hand contact with food minimized? Food service: Using a properly sanitized thermometer, check the temperatures of hot and cold food prior to serving. How long is milk held without refrigeration prior to distribution? Food distribution: Is the food protected from contamination as it is transported to the dining rooms and residents' rooms?

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F371 Cont.		Pest free: Is the area pest free? (See §483.70(h)(4).) Look for signs of pests such as mice, roaches, rats, flies. (Preventing Contamination) Are handwashing facilities convenient and properly equipped for dietary services staff use? (Staff uses good hygienic practices and staff with communicable diseases or infected skin lesions do not have contact with food if that contact will transmit the disease.) (Hazard Free) Are toxic items (such as insecticides, detergent, polishes) properly stored, labeled, and used separate from the food? Probes: §483.35(h)(2) Observe food storage rooms and food storage in the kitchen. Are containers of food stored off the floor and on clean surfaces in a manner that protects it from contamination? Are other areas under storage shelves monitored for cleanliness to reduce attraction of pest. Are potentially hazardous foods stored at 41° F or below and frozen foods kept at 0° F or below? Do staff handle and cook potentially hazardous foods properly? Are potentially hazardous foods kept at an internal temperature of 41° F or below in cold food storage unit, or at an internal temperature of 140° F or above in a hot food storage unit during display and service? Is food transported in a way that protects against contamination (i.e., covered containers, wrapped, or packaged)? Is there any sign of rodent or insect infestation. (Dishwashing) The current 1993 Food Code, DHHS, FDA, PHS recommends the following water temperatures and manual washing instructions: MACHINE: 1. Hot Water: a. 140° F Wash (or according to the manufacturer's specifications or instructions). b. 180° F Rinse (180°, 160° or greater at the rack and dish/utensils surfaces. 2. Low Temperature: a. 120° F + 25 ppm (parts per million) Hypochlorite (household bleach) on dish Surface.

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F371 Cont.		MANUAL: 1. 3 Compartment Sink (wash, rinse and sanitize): Sanitizing solution used according to manufacture's instructions. a. 75° F - 50 ppm Hypochlorite (household bleach) or equivalent, or 12.5 ppm of Iodine. b. Hot Water Immersion at 170° F for at least 30 seconds. (Dishwashing) Are food preparation equipment, dishes, and utensils effectively sanitized and cleaned to destroy potential disease carrying organisms and stored in a protected manner?
F372	(3) Dispose of garbage and refuse properly.	Guidelines: §483.35(h)(3) The intent of this regulation is to assure that garbage and refuse be properly disposed. Procedures: §483.35(h)(3) (Garbage/refuse) Observe garbage and refuse container construction, and outside storage receptacles. Probes: §483.35(h)(3) Are garbage and refuse containers in good condition (no leaks) and is waste properly contained in dumpsters or compactors with lids or otherwise covered? Are areas such as loading docks, hallways, and elevators used for both garbage disposal and clean food transport kept clean, free of debris and free of foul odors and waste fat? Is the garbage storage area maintained in a sanitary condition to prevent the harborage and feeding of pests? Are garbage receptacles covered when being removed from the kitchen area to the dumpster?

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F385	§483.40 Physician services. 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. (a) Physician supervision. The facility must ensure that-- (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable.	Intent: §483.40 The intent of this regulation is to ensure the medical supervision of the care of nursing home residents by a personal physician. Guidelines: §483.40 A physician's "personal approval" of an admission recommendation must be in written form. The physician's admission orders for the resident's immediate care as required in §483.20(a) will be accepted as "personal approval" of the admission. "Supervising the medical care of residents" means participating in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. It also includes, but is not limited to, prescribing new therapy, ordering a resident's transfer to the hospital, conducting required routine visits or delegating and supervising follow-up visits to nurse practitioners or physician assistants. Each resident should be allowed to designate a personal physician. (See §483.10(d)(1).) The facility's responsibility in this situation is to simply assist the resident, when necessary, in his or her efforts to obtain those services. For example, the facility could put the resident in touch with the county medical society for the purpose of obtaining referrals to practicing physicians in the area. Facilities should share MDS and other assessment data with the physician. Procedures: §483.40 If there is a deficiency in §483.10, Resident rights; §483.13, Resident behavior and facility practices; §483.15, Quality of life; or §483.25, Quality of care, fully review all of the tags under this requirement. Probes: §483.40(a) o How was the supervising physician involved in the resident's assessment and care planning? o If staff reported a significant change in medical status to the supervising physician, did the physician respond? o If the supervising physician was unavailable and could not respond, did the facility have a physician on call? Did this physician respond? o Are residents sent to hospital emergency rooms routinely because the facility does not always have a physician on call?

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	(b) Physician visits. The physician must--	Intent: §483.40(b) The intent of this regulation is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime.
F386	(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders.	Guidelines: §483.40(b) Total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status, as defined by the comprehensive assessment and plan of care. Care includes medical services and medication management, physical, occupational, and speech/language therapy, nursing care, nutritional interventions, social work and activity services that maintain or improve psychosocial functioning. The physician records residents' progress and problems in maintaining or improving their mental and physical functional status. The physician need not review the total plan of care at each visit, but must review the total plan of care at visits required by §483.40(c). There is no requirement for physician renewal of orders. In cases where facilities have created the option for a resident's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable. See Guidelines for §483.75(l)(1) for information on facility safeguards concerning electronic signatures. Physician orders may be transmitted by facsimile machine if the following conditions are met: o The physician should have signed and retained the original copy of the order from which the facsimile was transmitted and be able to provide it upon request. Alternatively, the original may be sent to the facility at a later time and substituted for the facsimile. o The facility should photocopy the faxed order since some facsimiles fade over time. The facsimile copy can be discarded after facility photocopies it. o A facility using such a system should establish adequate safeguards to assure that it is not subject to abuse. It is not necessary for a physician to re-sign the facsimile order when he/she visits the facility. When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.

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F386 Cont.		Probes: §483.40(b) o Do services ordered by a physician show a pattern of care to maintain or improve the resident's level of independent functioning? For example, how do physician orders reflect the resident's nutritional status and needs? o Does documentation reflect continuity of care in maintaining or improving a resident's mental and physical functional status? For example, do the attending physician's rehabilitation service orders show a pattern of consistent restorative programming?
	(c) Frequency of physician visits.	Guidelines: §483.40(c) "Must be seen" means that the physician must make actual face-to-face contact with the resident. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.
F387	(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	After the initial physician visit in SNFs, where States allow their use, a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA) may make every other required visit. (See §483.40(e) Physician delegation of tasks in SNFs.) In a NF, the physician visit requirement, in accord with State law, may be satisfied by NP, clinical nurse specialist or PA. (See §483.40(f).)
F388	(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. (4) 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	The timing of physician visits is based on the admission date of the resident. Visits will be made within the first 30 days, and then at 30 day intervals up until 90 days after the admission date. Visits will then be at 60 day intervals. Permitting up to 10 days slippage of a due date will not affect the next due date. However, do not specifically look at the timetables for physician visits unless there is indication of inadequate medical care. The regulation states that the physician (or his/her delegate) must visit the resident at least every 30 or 60 days. There is no provision for physicians to use discretion in visiting at intervals longer than those specified at §483.40(c). Policy that allows an NP, clinical nurse specialist, or PA to make every other required visit, and that allows a 10 day slippage in the time of the visit, does not relieve the physician of the obligation to visit a resident when the resident's medical condition makes that visit necessary. It is expected that visits will occur at the facility rather than the doctor's office unless office equipment is needed or a resident specifically requests an office visit. If the facility has established policy that residents leave the grounds for medical care, the resident does not object, and this policy does not infringe on his/her

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F388 Cont.	physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.	rights, there is no prohibition to this practice. The facility should inform the resident of this practice, in accordance with §483.10(b). Probes: §483.40(c) o How does the scheduling and frequency of physician visits relate to any identified quality of care problems? o When a PA, clinical nurse specialist, or NP performs a delegated physician visit, and determines that the resident's condition warrants direct contact between the physician and the resident, does the physician follow-up promptly with a personal visit?
F389	(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.	Guidelines: §483.40(d) If a resident's own physician is unavailable, the facility should attempt to contact that physician's designated referral physician before assuming the responsibility of assigning a physician. Arranging for physician services may include assuring resident transportation to a hospital emergency room/ward or other medical facility if the facility is unable to provide emergency medical care at the facility. Probes: §483.40(d) o Does the facility have a physician on call for medical emergencies? Does this physician respond? o For what reasons are residents sent to hospital emergency rooms? o Did medical management of the emergency affect the resident's maintaining or improving their functional abilities? o If the resident refused the physician's visit, what has the facility done to explain to the resident the results and alternatives that may be available?
F390	(e) Physician delegation of tasks in SNFs. (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who--	Guidelines: §483.40(e) "Nurse practitioner" is a registered professional nurse now licensed to practice in the State and who meets the State's requirements governing the qualification of nurse practitioners. "Clinical nurse specialist" is a registered professional nurse currently in practice in the State and who meets the State's requirements governing the qualifications of clinical nurse specialists.

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F390 Cont.	(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician. (2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	"Physician assistant" is a person who meets the applicable State requirements governing the qualifications for assistants to physicians. When personal performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. The tasks of examining the resident, reviewing the resident's total program of care, writing progress notes, and signing orders may be delegated according to State law. The extent to which physician services are delegated to physician extenders in SNFs will continue to be determined by the provisions of §483.40(e), while the extent to which these services are performed by physician extenders in NFs will be determined by the individual States under §483.40(f). Probes: §483.40(e) o Do the facility's attending physicians delegate to NPs, clinical nurse specialists, or PAs? o Do NP/clinical nurse specialist/PA progress notes and orders follow the scope of practice allowed by State law? o What evidence is there of physician supervision of NPs or PAs? For example, do physicians countersign NP/PA orders, if required by State law?
	(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF(including tasks which the regulations specify must be performed personally by the (physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.	Guidelines: §483.40(f) If delegation of physician tasks is permitted in your State and the physician extender does not meet the qualifications listed here, cite F388. Procedures: §483.40(f) If a nurse practitioner, clinical nurse specialist, or physician assistant is performing required physician tasks in a NF, is this allowed by the State? Is this person an employee of the facility? (Facility employees are prohibited from serving in this capacity.) Probes: §483.40(f) Is this person working in collaboration with the physician?

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	§483.45 Specialized rehabilitative services.	Intent: §483.45(a)(1)(2) The intent of this regulation is to assure that residents receive necessary specialized rehabilitative services as determined by the comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psycho-social well-being. "Specialized rehabilitative services" are differentiated from restorative services which are provided by nursing staff. Specialized rehabilitative services are provided by or coordinated by qualified personnel. Specialized rehabilitative services are considered a facility service and are, thus, included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services. A facility is not obligated to provide specialized rehabilitative services if it does not have residents who require these services. If a resident develops a need for these services after admission, the facility must either provide the services, or, where appropriate, obtain the service from an outside resource. For a resident with MI or MR to have his or her specialized needs met, the individual must receive all services necessary to assist the individual in maintaining or achieving as much independence and self-determination as possible. They are: "Specialized services for MI or MR" refers to those services to be provided by the State which can only be delivered by personnel or programs other than those of the NF (e.g., outside the NF setting), because the overall level of NF services is not as intense as necessary to meet the individuals needs. The Preadmission Screening and Annual Resident Review (PASARR) report indicates specialized services required by the resident. The State is required to list those services in the report, as well as provide or arrange for the provision of the services. If the State determines that the resident does not require specialized services, the facility is responsible to provide all services necessary to meet the resident's mental health or mental retardation needs. "Mental health rehabilitative services for MI and MR", refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff who come into contact with the resident who is mentally ill or who has mental retardation. These services are necessary regardless of whether or not they are required to be subject to the PASARR process and whether or not they require additional services to be provided or arranged for by the State as specialized services.
F406	(a) Provision of services. If specialized rehabilitative services such as, but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must-- (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	

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F406 Cont.		The facility should provide interventions which complement, reinforce and are consistent with any specialized services (as defined by the resident's PASARR) the individual is receiving or is required to receive by the State. The individual's plan of care should specify how the facility will integrate relevant activities throughout all hours of the individual's day at the NF to achieve this consistency and enhancement of PASARR goals. The surveyor should see competent interaction by staff at all times, in both formal and informal settings in accordance with the individual's needs. Mental health rehabilitative services for MI and MR may include, but are not limited to: o Consistent implementation during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors; o Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness; o Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal); o Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management, and maintenance of the living environment; o Crisis intervention services; o Individual, group, and family psychotherapy; o Development of appropriate personal support networks; and o Formal behavior modification programs. <u>Procedures: §483.45(a)(1)(2)</u> For sampled residents, whose comprehensive assessment indicates physical, psychosocial, and/or communications rehabilitation potential (See MDS Sections E, C, G, H. In version 2.0, sections G, C, F, E. References to version 2.0 of the MDS are effective when the State respecifies its RAI), observe for unmet needs for rehabilitative services. Determine the extent of follow through with comprehensive care plan using probes outlined below. Verify from the chart that resident is receiving frequency and type of therapy as outlined in the care plan. <u>Probes: §483.45(a)(1)(2)</u> 1. (For physical therapy) a. What did the facility do to improve the resident's muscle strength? The resident's balance? b. What did the facility do to determine if an assistive device would enable the resident to reach or maintain his/her highest practicable level of physical function? c. If the resident has an assistive device, is he/she encouraged to use it on a regular basis?

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F406 Cont.		d. What did the facility do to increase the amount of physical activity the resident could do (for example, the number of repetitions of an exercise, the distance walked)? e. What did the facility do to prevent or minimize contractures, which could lead to decreased mobility and increased risk of pressure ulcer occurrence? 2. (For occupational therapy) a. What did the facility do to decrease the amount of assistance needed to perform a task? b. What did the facility do to decrease behavioral symptoms? c. What did the facility do to improve gross and fine motor coordination? d. What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration? e.What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards? 3. For speech-language pathology a. What did the facility do to improve auditory comprehension such as understanding common, functional words, concepts of time and place, and conversation? b. What did the facility do to improve speech production? c. What did the facility do to improve expressive behavior such as the ability to name common, functional items? d. What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiologic evaluation? For example, did the facility instruct the resident how to effectively and independently use environmental controls to compensate for hearing loss such as eye contact, preferential seating, use of the better ear? e. For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication? 4. (For health rehabilitative services for MI and MR) a. What did the facility do to decrease incidents of inappropriate behaviors, for individuals with MR, or behavioral symptoms for persons with MI? To increase appropriate behavior? b. What did the facility do to identify and treat the underlying factors behind tendencies toward isolation and withdrawal? c. What did the facility do to develop and maintain necessary daily living skills? d. How has the facility modified the training strategies it uses with its residents to account for the special learning needs of its residents with MI or MR? e. (Questions to ask individuals with MI or MR:) (1)Who do you talk to when you have a problem or need something? (2)What do you do when you feel happy? Feel sad? Can't sleep at night? (3)In what activities are you involved, and how often?

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F406 Cont.		Intent: §483.45(b) The intent of this regulation is to assure that the rehabilitative services are medically necessary as prescribed by a physician and provided by qualified personnel to maximize potential outcomes. Specialized rehabilitative services are provided for individual's under a physician's order by a qualified professional. Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional. Once a resident has met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will follow to maintain functional and physical status.
F407	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	Guidelines: §483.45(b) "Qualified personnel" means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws. Health rehabilitative services for MI and MR must be implemented consistently by all staff unless the nature of the services is such that they are designated or required to be implemented only by licensed or credentialed personnel. Procedures: §483.45(b) Determine if there are any problems in quality of care related to maintaining or improving functional abilities. Determine if these problems are attributable in part to the qualifications of specialized rehabilitative services staff. Determine from the care plan and record that rehabilitative services are provided under the written order of a physician and by qualified personnel. If a problem in a residents rehabilitative care is identified that is related to the qualifications of the care providers, it may be necessary to validate the care providers qualification. Probes: §483.45(b) If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with MI or MR, how has the facility arranged for the necessary direct or staff training services to be provided?

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	§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	Intent: §483.55 The intent of this regulation is to ensure that the facility be responsible for assisting the resident in obtaining needed dental services, including routine dental services.
F411	(a) Skilled nursing facilities. A facility	Guidelines: §483.55 This requirement makes the facility directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents, i.e., employ a staff dentist or have a contract (arrangement) with a dentist to provide services.
	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; (2) May charge a Medicare resident an additional amount for routine and emergency dental services; (3) Must if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (4) Promptly refer residents with lost or damaged dentures to a dentist.	For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose an additional charge for the services. For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well-being. (See §483.15(g).) The facility is responsible for selecting a dentist who provides dental services in accordance with professional standards of quality and timeliness under §483.75(h)(2). "Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. "Emergency dental services" includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity, appropriately treated by a dentist that requires immediate attention. "Prompt referral" means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures. Probes: §483.55 Do residents selected for comprehensive or focused reviews, as appropriate, with dentures use them? Are residents missing teeth and may be in need of dentures? Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene? Are resident's dentures intact? Proper fit?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F412	(b) Nursing facilities. The facility	
	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (2) Must, if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (3) Must promptly refer residents with lost or damaged dentures to a dentist.	Guidelines: §483.55(b)(1)(i) For Medicaid residents, the facility must provide the resident, without charge, all emergency dental services, as well as those routine dental services that are covered under the State plan.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F425	§483.60 Pharmacy services. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	Guidelines: §483.60 The facility is responsible under §483.75(h) for the "timeliness of the services." A drug, whether prescribed on a routine, emergency, or as needed basis, must be provided in a timely manner. If failure to provide a prescribed drug in a timely manner causes the resident discomfort or endangers his or her health and safety, then this requirement is not met. Procedures: §483.60 During the surveyor's observation of the drug pass, are all ordered medications available?
F426	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	
F427	(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	Guidelines: §483.60(b)(2) and (3) A record of receipt and disposition of controlled drugs does not need to be proof of use sheets. The facility can use existing documentation such as the Medication Administration Record (MAR) to accomplish this record.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F427 Cont.	(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	Periodic reconciliations should be monthly. If they reveal shortages, the pharmacist and the director of nursing may need to initiate more frequent reconciliations. In situations in which loss of controlled drugs is evident, the facility may have to utilize proof of use sheets on all controlled drugs for all shifts. However, when the source of shortage is located and remedied, the facility may go back to periodic reconciliation by the pharmacist. Please note that the regulation does not prohibit shortages of controlled drugs - only that a record be kept and that it be periodically reconciled. If the survey reveals that all controlled drugs are not accounted for, refer the case to the State nursing home licensure authority, or to the State Board of Pharmacy.
	(c) Drug regimen review.	
F428	(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	Guidelines: §483.60(c)(1) It may be necessary to review more frequently (e.g., every week) depending on the residents' condition and the drugs they are taking. Procedures: §483.60(c)(1) Refer to Part One of Appendix N for detailed information concerning the survey of this requirement. If the survey team find one or more of the drug therapy circumstances in Part One of Appendix N and there is no documentation that the pharmacist has identified and notified the attending physician and the director of nursing of this circumstance, and that circumstance can cause or does cause significant harm to the resident, then document the observation on the Resident Review Worksheet (HCFA-805).

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F429 F430	(2) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.	Guidelines: §483.60(c)(2) The director of nursing and the attending physicians are not required to agree with the pharmacist's report, nor are they required to provide a rationale for their "acceptance" or "rejection" of the report. They must, however, act upon the report. This may be accomplished in many ways, i.e., indicating acceptance or rejection of the report and signing their names. The facility is encouraged to provide the medical director with a copy of drug regimen review reports and to involve the medical director in reports that have not been acted upon.
F431	(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	Guidelines: §483.60(d) This section imposes currently accepted labeling requirements on facilities, even though the pharmacies will be immediately responsible for accomplishing the task. The critical elements of the drug label in a long-term care facility are the name of the drug and its strength. The names of the resident and the physician do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right patient. All drugs approved by the Food and Drug Administration must have expiration dates on the manufacturer's container. "When applicable" means that expiration dates must be on the labels of drugs used in long term care facilities unless State law stipulates otherwise.
F432	(e) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	Guidelines: §483.60(e) Compartments in the context of these regulations include but are not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes. The provisions for authorized personnel to have access to keys must be determined by the facility management in accordance with Federal, State, and local laws and facility practices. "Separately locked" means that the key to the separately locked Schedule II drugs is not the same key that is used to gain access to the non-Schedule II drugs. Probes: §483.60(e) Are all drugs and biologicals stored properly, locked and at proper temperature?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F432 Cont.	(2) 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, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F425	§483.60 Pharmacy services. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	Guidelines: §483.60 The facility is responsible under §483.75(h) for the "timeliness of the services." A drug, whether prescribed on a routine, emergency, or as needed basis, must be provided in a timely manner. If failure to provide a prescribed drug in a timely manner causes the resident discomfort or endangers his or her health and safety, then this requirement is not met. Procedures: §483.60 During the surveyor's observation of the drug pass, are all ordered medications available?
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F427 Cont.	(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	Periodic reconciliations should be monthly. If they reveal shortages, the pharmacist and the director of nursing may need to initiate more frequent reconciliations. In situations in which loss of controlled drugs is evident, the facility may have to utilize proof of use sheets on all controlled drugs for all shifts. However, when the source of shortage is located and remedied, the facility may go back to periodic reconciliation by the pharmacist. Please note that the regulation does not prohibit shortages of controlled drugs - only that a record be kept and that it be periodically reconciled. If the survey reveals that all controlled drugs are not accounted for, refer the case to the State nursing home licensure authority, or to the State Board of Pharmacy.
	(c) Drug regimen review.	
F428	(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	Guidelines: §483.60(c)(1) It may be necessary to review more frequently (e.g., every week) depending on the residents' condition and the drugs they are taking. Procedures: §483.60(c)(1) Refer to Part One of Appendix N for detailed information concerning the survey of this requirement. If the survey team find one or more of the drug therapy circumstances in Part One of Appendix N and there is no documentation that the pharmacist has identified and notified the attending physician and the director of nursing of this circumstance, and that circumstance can cause or does cause significant harm to the resident, then document the observation on the Resident Review Worksheet (HCFA-805).

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F430	these reports must be acted upon.	
F431	(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	Guidelines: §483.60(d) This section imposes currently accepted labeling requirements on facilities, even though the pharmacies will be immediately responsible for accomplishing the task. The critical elements of the drug label in a long-term care facility are the name of the drug and its strength. The names of the resident and the physician do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right patient. All drugs approved by the Food and Drug Administration must have expiration dates on the manufacturer's container. "When applicable" means that expiration dates must be on the labels of drugs used in long term care facilities unless State law stipulates otherwise.
F432	(e) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	Guidelines: §483.60(e) Compartments in the context of these regulations include but are not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes. The provisions for authorized personnel to have access to keys must be determined by the facility management in accordance with Federal, State, and local laws and facility practices. "Separately locked" means that the key to the separately locked Schedule II drugs is not the same key that is used to gain access to the non-Schedule II drugs. Probes: §483.60(e) Are all drugs and biologicals stored properly, locked and at proper temperature?

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F432 Cont.	(2) 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, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
-	§483.65 Infection control.	Intent: §483.65(a) The intent of this regulation is to assure that the facility has an infection control program which is effective for investigating, controlling, and preventing infections. If infection control has been identified as an area of concern during Phase 1 of the survey, investigate aspects of the program, as appropriate, during Phase 2.
F441	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. (a) Infection control program. The facility must establish an infection control program under which it-- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	Guidelines: §483.65(a) The facility's infection control program must have a system to monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. A facility should, for example, maintain a separate record on infection that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of infection, and describes what cautionary measures were taken to prevent the spread of the infection within the facility. The system must enable the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. Surveillance data should be routinely reviewed and recommendations made for the prevention and control of additional cases. The written infection control program should be periodically reviewed by the facility and revised as indicated. Current standards for infection control program address the following. The following are not regulatory requirements but provide guidance for evaluating the facility's program. o Definition of nosocomial/facility acquired infections and communicable diseases. oRisk assessment of occurrence of communicable diseases for both residents and staff that is reviewed annually, or more frequently if indicated. o Methods for identifying, documenting and investigating nosocomial infections and communicable diseases. The infection control program should be able to identify new infections quickly, paying particular attention to residents at high risk of infection of infection (e.g. residents who are immobilized, have invasive devices or procedures, have pressure sores, have been recently discharged from a hospital to the long term care facility, have MI or MR, have decreased mental status, are nutritionally compromised or have altered immune systems). o Early detection of residents who have signs and symptoms of TB and a referral protocol to a facility where TB can be evaluated and managed appropriately. o Measures for prevention of infections, especially those associated with intravascular therapy, indwelling urinary catheters, tracheostomy care, stoma care, respiratory care, immunosuppression, pressures sores, bladder and bowel incontinence and any other factors which compromise a resident's resistance to infections.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F441 Cont.		o Measures for the prevention of communicable disease outbreaks, including tuberculosis, flu, hepatitis, scabies, MRSA. o Procedures to inform and involve a local or State epidemiologist, as required by the State for non-sporadic, facility-wide infections that are difficult to control. o Isolation procedures and requirements for infected and at risk or immunosuppressed nursing home residents. o Use of and inservice education regarding standard precautions, (e.g., universal precautions/body substance isolation). o Handwashing, respiratory protection, linen handling, housekeeping, needle and hazardous waste disposal, as well as other means for limiting the spread of communicable organisms. o Authority, indications, and procedures for obtaining and acting upon microbiological cultures from residents and for isolating residents. o Proper use of disinfectants, antiseptics and germicides in accordance with the manufacturers' instructions and EPA of FDA label specifications to avoid harm to staff, residents and visitors and to ensure its effectiveness. o Orientation of all new facility personnel to the infection control program and periodic updates for all staff. o Measures for the screening of the health care workers for communicable diseases, and for the evaluation of workers exposed to residents with communicable diseases including TB and Blood Borne Pathogens. o Work restriction guidelines for an employee that is infected or ill with a communicable disease. o Measures which address prevention of infection common to nursing home residents (e.g., vaccination for influenza and pneumococcal pneumonia as appropriate) TB screening and testing. o Sanitization of tubs, whirlpools and multiple use equipment to be performed according to manufacturer's recommendations. Observe whether staff including direct care, housekeeping, kitchen staff, use gloves in accord with aseptic principles. Determine if there is consistent use of aseptic technique for dressing changes. If breaks in technique are observed, verify that the facility has a system in place for routine monitoring of staff infection control practices. Ask direct care giver staff what do they do and who do they notify when an infection is noted.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F441 Cont.		Procedures: §483.65(a) Observe sanitation of tub, shower, multiple residents' whirlpool and care equipment, as necessary. Identify all residents in the sample who are currently on antibiotic therapy and verify that these residents are reported on the facility's infection control logs/records to ensure that infections are being identified timely and that these residents are being adequately monitored for infection. Review policies related to infection control if observation, record review, or staff interview indicate a problem with infection control. Observe direct care staff routinely washing their hands according to facility written protocols. Probes: §483.65(a) o Are there unexplained and/or similar infections? For sampled residents at high risk of infection, what has staff done to reduce residents' risk of infection? o Do surveillance data show a significant increase in the rate of infection from month to month? Over several months? How is this being addressed? o What infection control policies does the facility use for persons with AIDS, TB, or hepatitis B? Do these policies conform with Occupational Safety and Health Administration's requirements for protecting employees and current accepted standards of practice recommended by Centers for Disease Control and Prevention (CDC)? Does the staff follow its own procedures? o How does the facility define and dispose of its infectious waste?
	(b) Preventing spread of infection.	
F442	(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	Intent: §483.65(b) The intent of this regulation is to assure that the facility isolates residents appropriately to prevent the spread of infection. If infection control has been identified as an area of concern during Phase 1 of the survey, investigate aspects of the program, as appropriate, during Phase 2.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F442 Cont.		Guidelines: §483.65(b) Procedures must be followed to prevent cross-contamination, including handwashing and/or changing gloves after providing personal care, or when performing tasks among individuals which provide the opportunity for cross-contamination to occur. Facilities for handwashing must exist and be available to staff. The facility should follow the CDC's Guideline for Handwashing and Hospital Environmental Control, 1985 for handwashing. The facility should isolate infected residents only to the degree needed to isolate the infecting organism. The method used should be the least restrictive possible, while maintaining the integrity of the process. For example, the HIV virus is present in blood and other body fluids. The facility should take universal or standard blood and body fluid precautions related to HIV contamination for the following: o Blood; o Semen; o Vaginal secretions; o Cerebrospinal fluid; o Synovial fluid; o Pleural fluid; o Peritoneal fluid; o Pericardial fluid; o Amniotic fluid; and/or o Fluids with visible blood. Residents, visitors and employees should be protected from these fluids. Although the resident infected with HIV should not be isolated routinely, the resident should be isolated if he/she is in the communicable stages of an opportunistic infection, his/her body fluids cannot be contained or he/she has very poor hygiene and the likelihood of spillage is high. NOTE: TB isolation rooms are not needed if the facility does not provide care to active TB patients/residents. "Universal precautions" or "Standard blood and body fluid precautions" is an approach to infection control where all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens. Probes: §483.65(b) o For isolated residents, does the facility need to segregate them to control the infectious agent? o For residents who have been isolated appropriately, does staff use correct procedures consistently? For example, if isolation procedures require wearing gowns, do all staff put on and dispose of the gown in a way that lessens the spread of infection?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F442 Cont.		o How does the facility control the spread of infection by persons who visit infectious residents? Is there a written protocol? o Do persons with a communicable disease or infected skin lesions provide care to residents? o Have any residents developed a communicable disease as defined by State law while in the facility? If so, have appropriate barrier or isolation precautions been followed to control further spread of infection? Procedures: §483.65(b)(1) Verify that all residents who require isolation as determined by the infection control program are isolated. Observe residents that have been isolated. Determine what level of isolation they are required to have. Evaluate isolation procedures utilized by staff members. Determine if the facility has isolated the resident in the least restrictive environment possible.
F443	(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	Intent: §483.65(b)(2) The intent of this regulation is to prevent the spread of communicable diseases from employees to residents when the employee has a communicable disease or an infected skin lesion. State law defines communicable diseases for purposes of defining facility policies. Skin lesions should be considered infected if they have purulent drainage, or are red, hot, indurated without purulent drainage. Procedures: §483.65(b)(2) Determine if the facility prohibits employees with diseases communicable through direct contact or infected skin lesions from having direct contact with residents. To make this determination, observe residents' condition and treatments provided, interview facility staff, and review relevant facility policies and procedures for preventing the spread of infection.
F444	(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	Intent: §483.65(b)(3) The intent of this regulation is to assure that staff use appropriate handwashing techniques to prevent the spread of infection from one resident to another. Guidelines: §483.65(b)(3) Procedures must be followed to prevent cross-contamination, including handwashing or changing gloves after providing personal care, or when performing tasks among individuals which provide the opportunity for cross-contamination to occur. Facilities for handwashing must exist and be readily available to staff. The facility should follow the CDC's Guideline for Handwashing and Hospital Environmental Control, 1985 for handwashing.

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F444 Cont.		Procedures: §483.65(b)(3) Verify that the facility has policy that requires staff to wash their hands after each direct resident contact when indicated. Observe hand washing by staff after direct contact with residents. It is important for the surveyor to begin a thorough investigation of the facility's infection control program when poor resident outcomes and poor practices are observed. Probes: §483.65(b)(3) o Does the facility have a written protocol describing handwashing practices and is it consistent with the latest published standards? o Do staff follow the facility policy and protocol for handwashing?
F445	(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	Intent: §483.65(c) The intent of this regulation is to prevent the spread of infection through linens. Guidelines: §483.65(c) Soiled linens should be handled to contain and to minimize aerosolization and exposure to any waste products. Soiled linen storage areas should be well ventilated and maintained under a relative negative air pressure. The laundry should be designed to eliminate crossing of soiled and clean linen. Probes: §483.65(c) o Do staff handle linens on the resident care floors and in the laundry area to prevent the spread of infection? o Do staff follow the facility's protocols for handling linens? o Are linens processed, transported, stored, and handled properly?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F454	§483.70 Physical environment. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	Guidelines: §483.70(a) A waiver of specific provisions of the Life Safety Code is reviewed each time a facility is certified. The State fire authority will determine if the waiver continues to be justified, in that compliance with the requirement would result in an unreasonable hardship upon the facility and does not adversely affect the health and safety of residents or personnel. The State fire authority will forward its findings and recommendation as soon as possible to the State survey agency which will forward it to the HCFA RO for a decision on granting a waiver. Procedures: §483.70(a) The survey for safety from fire is normally conducted by the designated State fire authority. The State agency must establish a procedure for the State fire authority to notify them whether the facility is or is not in compliance with the requirement. If the survey team observes fire hazards or possible deficiencies in life safety from fire, they must notify the designated State fire authority or the RO.
	(a) Life safety from fire. Except as provided in paragraph (a)(1) or (a)(3) of this section, the facility must meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference). Incorporation of the 1985 edition of the National Fire Protection Association's Life Safety Code (published February 7, 1985; ANSI/NFPA) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51 that govern the use of incorporations by reference. The Code is available for inspection at the Office of the Federal Information Center, Room 8301, 1110 L Street N.W., Washington, D.C. Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, Mass. 02200. If any changes in this code are also to	

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	be incorporated by reference, a notice to that effect will be published in the Federal Register. (1) A facility is considered to be in compliance with this requirement as long as the facility-- (i) On November 26, 1982, complied with or without waivers, with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the Code; or (ii) On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code. (2) After consideration of State survey agency findings, HCFA may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in	

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	unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel. (3) The provisions of the Life Safety Code do not apply in a State where HCFA finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.	
F455	(b) Emergency power. (1) 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.	Guidelines: §483.70(b)(1) "Emergency electrical power system" includes, at a minimum, battery-operated lighting for all entrances and exits, fire detection and alarm systems, and extinguishing systems. An "exit" is defined as a means of egress which is lighted and has three components: an exit access (corridor leading to the exit), an exit (a door), and an exit discharge (door to the street or public way). We define an entrance as any door through which people enter the facility. Furthermore, when an entrance also serves as an exit, its components (exit access, exit, and exit discharge) must be lighted. A waiver of lighting required for both exits and entrances is not permitted. Procedures: §483.70(b)(1) Review results of inspections by the designated State fire safety authority that the emergency power system has been tested periodically and is functioning in accordance with the Life Safety Code. Check placement of lighting system to ensure proper coverage of the listed areas. Test all batteries to ensure they work.

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F455 Cont.		Probes: §483.70(b)(1) Is emergency electrical service adequate? Additional guidance is available in the National Fire Protection Association's Life Safety Code 99 and 101 (NFPA 99 and NFPA 101), 12-5.1.3 which is surveyed in tags K105 and K106 of the Life Safety Code survey.
	(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.	Guidelines: §483.70(b)(2) "Life support systems" is defined as one or more electro-mechanical device(s) necessary to sustain life, without which the resident will have a likelihood of dying (e.g., ventilators, suction machines if necessary to maintain an open airway). The determination of whether a piece of equipment is life support is a medical determination dependent upon the condition of the individual residents of the facility (e.g., a suction machine may be required "life support equipment" in a facility, depending on the needs of its residents). Procedures: §483.70(b)(2) If life support systems are used determine if there is a working emergency generator at the facility. A generator is not required if a facility does not use life support systems. Check that the emergency generator starts and transfers power under load conditions within 10 seconds after interruption of normal power. Where residents are on life support equipment, do not test transfer switches by shutting off the power unless there is an uninterruptable power supply available. Probes: §483.70(b)(2) Is there a working generator if the facility is using life support systems?
Refer to F246	(c) Space and equipment. The facility must-- (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and	Intent: §483.70(c)(1) The intent of this regulation is to ensure that dining, health services, recreation, activities and program areas are large enough to comfortably accommodate the needs of the residents who usually occupy this space. Therefore, if the survey team determines that there is a negative effect on a resident, refer to F246. Dining, health services, recreation, and program areas should be large enough to comfortably accommodate the persons who usually occupy that space, including the wheelchairs, walkers, and other ambulation aids used by the many residents who require more than standard movement spaces. "Sufficient space" means the resident can access the area, it is not functionally off-limits, and the resident's functioning is not restricted once access to the space is gained.

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		Program areas where resident groups engage in activities focused on manipulative skills and hand-eye coordination should have sufficient space for storage of their supplies and "works in progress." Program areas where residents receive physical therapy should have sufficient space and equipment to meet the needs of the resident's therapy requirement. Recreation/activities area means any area where residents can participate in those activities identified in their plan of care. Procedures: §483.70(c)(1) In the use of space, consider if available space allows residents to pursue activities and receive health services and programs as identified in their care plan. If the team determines that there is inadequate space and equipment to enable staff to provide residents with needed services, refer to F246.
F456	(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	Probes: §483.70(c)(2) Is essential equipment (e.g., boiler room equipment, nursing unit/medication room refrigerators, kitchen refrigerator/freezer and laundry equipment) in safe operating condition? Is equipment maintained according to manufacturers recommendations.
Refer to F252	(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.	Guidelines: §483.70(d) If the survey team determines that the facility does not provide rooms designed and equipped for adequate care, comfort and privacy, refer to F252.
	(1) Bedrooms must--	
F457	(i) Accommodate no more than four residents;	Guidelines: §483.70(d)(1)(i) See §483.70(d)(3) regarding variations. Probes: §483.70(d)(1)(i) Unless a variation has been applied for and approved under §483.70(d)(3), do the residents' bedrooms accommodate no more than four residents?

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F458	(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;	Guidelines: §483.70(d)(1)(ii) See §483.70(d)(3) regarding variations. The measurement of the square footage should be based upon the useable living space of the room. Therefore, the minimum square footage in resident rooms should be measured based upon the floor's measurements exclusive of toilets and bath areas, closets, lockers, wardrobes, alcoves, or vestibules. However, if the height of the alcoves or vestibules reasonably provides useful living area, then the corresponding floor area may be included in the calculation. The space occupied by movable wardrobes should be excluded from the useable square footage in a room unless it is an item of the resident's own choice and it is in addition to the individual closet space in the resident's room. Non-permanent items of the resident's own choice should have no effect in the calculation of useable living space. Protrusions such as columns, radiators, ventilation systems for heating and/or cooling should be ignored in computing the useable square footage of the room if the area involved is minimal (e.g., a baseboard heating or air conditioning system or ductwork that does not protrude more than 6 to 8 inches from the wall, or a column that is not more than 6 to 8 inches on each side) and does not have an adverse effect on the resident's health and safety or does not impede the ability of any resident in that room to attain his or her highest practicable well-being. If these protrusions are not minimal they would be deducted from useable square footage computed in determining compliance with this requirement. The swing or arc of any door which opens directly into the resident's room should not be excluded from the calculations of useable square footage in a room. Procedures: §483.70(d)(1)(ii) The facility layout may give square footage measurements. Carry a tape measure and take measurements if the room appears small. Probes: §483.70(d)(1)(ii) Unless a variation has been applied for and approved under §483.70(d)(3), are there at least 80 square feet per resident in multiple resident rooms and at least 100 square feet for single resident rooms?
F459	(iii) Have direct access to an exit corridor;	Guidelines: §483.70(d)(1)(iii) There is no authority under current regulations to approve a variation to this requirement. Additional guidance is available in the National Fire Protection Association's Life Safety Code 101 (NFPA 101), 12-2.5.1, which is tag K41 of the Life Safety Code survey.

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P460	(iv) Be designed or equipped to assure full visual privacy for each resident; (v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;	Guidelines: §483.70(d)(1)(iv) "Full visual privacy" means that residents have a means of completely withdrawing from public view while occupying their bed (e.g., curtain, moveable screens, private room). The guidelines do not intend to limit the provisions of privacy to solely one or more curtains, movable screens or a private room. Facility operators are free to use other means to provide full visual privacy, with those means varying according to the needs and requests of residents. However, the requirement explicitly states that bedrooms must "be designed or equipped to assure full visual privacy for each resident." For example, a resident with a bed by the window cannot be required to remain out of his or her room while his/her roommate is having a dressing change. Room design or equipment must provide privacy. Surveyors will assess whether the means the facility is using to assure full visual privacy meets this requirement without negatively affecting any other resident rights. Procedures: §483.70(d)(1(iv) There are no provisions for physician statements to be used as a basis for variation of the requirements for full visual privacy. Probes: §483.70(d)(1)(iv) Observe whether each resident selected for a comprehensive or focused review has a means to achieve full visual privacy. Guidelines: §483.70(d)(1)(v) The term "initially certified" is defined as all newly certified nursing facilities (NFs) or SNFs as well as NFs and SNFs after March 31, 1992, which re-enter the Medicare or Medicaid programs, whether they voluntarily or involuntarily left the program. It is not necessary for the bed to be accessible from both sides when the privacy curtain in pulled. Additional guidance is available in the National Fire Protection Association's Life Safety Code 101 (NFPA 101), 31-1.4.1, 31-4.5, which is tag K74 of the Life Safety Code survey.
P461	(vi) Have at least one window to the outside; and	Guidelines: §483.70(d)(1)(vi) A facility with resident room windows, as defined by section 13-3.8.1 of the 1985 edition of the Life Safety Code, that open to an atrium in accordance with Life Safety Code 6-2.2.3.5 can meet this requirement for a window to the outside.

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F461 Cont.		In addition to conforming with the Life Safety Code, this requirement was included to assist the resident's orientation to day and night, weather, and general awareness of space outside the facility. The facility is required to provide for a "safe, clean, comfortable and homelike environment" by deemphasizing the institutional character of the setting, to the extent possible. Windows are an important aspect in assuring the homelike environment of a facility. Probes: §483.70(d)(1)(vi) Is there at least one window to the outside?
	(vii) Have a floor at or above grade level.	Guidelines: §483.70(d)(1)(vii) "At or above grade level" is defined as a room in which the floor is at or above ground level. Probes: §483.70(d)(1)(vii) Are the bedrooms at or above ground level? Additional guidance is available in the National Fire Protection Association's Life Safety Code 101 (NFPA 101), 12-2.5.1, 12-2.5.7, which is tag K41 of the Life Safety Code survey.
Refer to F246	(2) The facility must provide each resident with--	Procedures: §483.70(d)(2)(i)(ii)(iii) If the survey team determines that these requirements are not met, refer to F246.
	(i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding appropriate to the weather and climate; and	Probes: §483.70(d)(2)(i), (ii) and (iii) Are mattresses clean and comfortable? Is bedding appropriate to weather and climate?

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Refer to F246	(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	Guidelines: §483.70(d)(2)(iv) "Functional furniture appropriate to the residents' needs" means that the furniture in each resident's room contributes to the resident attaining or maintaining his or her highest practicable level of independence and well-being. In general, furnishings include a place to put clothing away in an organized manner that will let it remain clean, free of wrinkles, and accessible to the resident while protecting it from casual access by others, a place to put personal effects such as pictures and a bedside clock, and furniture suitable for the comfort of the resident and visitors (e.g., a chair). There may be instances in which individual residents determine that certain items are not necessary or will impede their ability to maintain or attain their highest practicable well-being (e.g., Both the resident and spouse use wheelchairs. They visit more easily without another chair in the room.) In this case, the resident's wishes should determine the furniture needs. "Shelves accessible to the resident" means that the resident, if able, or a staff person at the direction of the resident, can get to their clothes whenever they choose. Probes: §483.70(d)(2)(iv) Functional furniture Is there functional furniture, appropriate to residents' needs? Closet space Is there individual closet space with accessible clothes racks and shelves?
	(3) HCFA, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and	Guidelines: §483.70(d)(3) A variation must be in accordance with the special needs of the residents and must not adversely affect the health or safety of residents. Facility hardship is not part of the basis for granting a variation. Since the special needs of residents may change periodically, or different residents may be transferred into a room that has been granted a variation, variations must be reviewed and considered for renewal whenever the facility is certified. If the needs of the residents within the room have not changed since the last annual inspection, the variance should continue if the facility so desires. Guidelines: §483.70(d)(1)(i): As residents are transferred or discharged from rooms with more than four residents, beds should be removed from the variance until the number of residents occupying the room does not exceed four.

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	(ii) Will not adversely affect residents' health and safety.	
F462	(e) Toilet facilities. Each resident room must be equipped with or located near toilet facilities.	Guidelines: §483.70(e) "Toilet facilities" is defined as a space that contains a lavatory and a toilet. If the resident's room is not equipped with an adjoining toilet facility, then "located near" means residents who are independent in the use of a toilet, including chairbound residents, can routinely use a toilet in the unit. Probes: §483.70(e) Are resident rooms equipped with or located near toilet and bathing facilities?
F463	(f) Resident call system. The nurses' station must be equipped to receive resident calls through a communication system from-- (1) Resident rooms; and (2) Toilet and bathing facilities.	Intent: §483.70(f) The intent of this requirement is that residents, when in their rooms and toilet and bathing areas, have a means of directly contacting staff at the nurse's station. This communication may be through audible or visual signals and may include "wireless systems". Guidelines: §483.70(f) This requirement is met only if all portions of the system are functioning (e.g., system is not turned off at the nurses' station, the volume too low to be heard, the light above a room or rooms is not working). Probes: §483.70(f) Is there a functioning communication system from rooms, toilets and bathing facilities?
F464	(g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities.	Guidelines: §483.70(g)(1) "Well lighted" is defined as levels of illumination that are suitable to tasks performed by a resident. Probes: §483.70(g)(1) Are there adequate and comfortable lighting levels? Are illumination levels appropriate to tasks with little glare? Does lighting support maintenance of independent functioning and task performance?

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F464 Cont.	These rooms must-- (1) Be well lighted; (2) Be well ventilated, with nonsmoking areas identified;	Guidelines: §483.70(g)(2) "Well ventilated" is defined as good air circulation, avoidance of drafts at floor level, and adequate smoke exhaust removal. "Nonsmoking areas identified" is defined as signs posted in accordance with State law regulating indoor smoking policy and facility policy. Probes: §483.70(g)(2) How well is the space ventilated? Is there good air movement? Are temperature, humidity, and odor levels all acceptable? Are non-smoking areas identified?
	(3) Be adequately furnished; and	Guidelines: §483.70(g)(3) An "adequately furnished" dining area accommodates different residents' physical and social needs. An adequately furnished organized activities area accommodates the specific activities offered by the facility. Probes: §483.70(g)(3) How adequate are furnishings? Are furnishings structurally sound and functional (e.g., chairs of varying sizes to meet varying needs of residents, wheelchairs can fit under the dining room table)?
	(4) Have sufficient space to accommodate all activities.	Guidelines: §483.70(g)(4) "Sufficient space to accommodate all activities" means that the space available is adaptable to a variety of uses and residents' needs. Probes: §483.70(g)(4) How sufficient is space in dining, health services, recreation and program areas to accommodate all activities? Are spaces adaptable for all intended uses? Is resident access to space limited? Do residents and staff have maximum flexibility in arranging furniture to accommodate residents who use walkers, wheelchairs, and other mobility aids? Is there resident crowding?
F465	(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

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	The facility must--	
F466	(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	Guidelines: §483.70(h)(1) The facility should have a written protocol which defines the source of water provisions for storing the water, both potable and non-potable, a method for distributing water, and a method for estimating the volume of water required. Procedures: §483.70(h)(1) During the entrance conference, ask the administrator the facility's procedure to ensure water availability.
F467	(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	Probes: §483.70(h)(2) How well is the space ventilated? Is there good air movement? Are temperature, humidity, and odor levels all acceptable?
F468	(3) Equip corridors with firmly secured handrails on each side; and	Guidelines: §483.70(h)(3) "Secured handrails" means handrails that are firmly affixed to the wall. Probes: §483.70(h)(3) Are handrails secure?
F469	(4) Maintain an effective pest control program so that the facility is free of pests and rodents.	Guidelines: §483.70(h)(4) An "effective pest control program" is defined as measures to eradicate and contain common household pests (e.g., roaches, ants, mosquitoes, flies, mice, and rats). Procedures: §483.70(h)(4) As part of the overall review of the facility, look for signs of vermin. Evidence of pest infestation in a particular space is an indicator of noncompliance. Probes: §483.70(h)(4) Is area pest free?

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F490	§483.75 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	Procedures: §483.75 If there is a deficiency in §483.13, Resident behavior and facility practices; §483.15, Quality of life; or §483.25, Quality of care, which has the scope and/or severity to be defined as substandard quality of care, fully review for compliance all the tags within this section (§483.75).
F491	(a) Licensure. A facility must be licensed under applicable State and local law.	Guidelines: §483.75(a) Applicable licenses, permits and approvals must be available to you for inspection upon request. Procedures: §483.75(a) If there are problems with care provided or supervised by licensed personnel, verify applicable licenses, permits and approvals.
F492	(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	Intent: §483.75(b) The intent of this regulation is to ensure that a facility is in compliance with Federal, State, and local laws, regulations, and codes relating to health, safety, and sanitation. Guidelines: §483.75(b) The State is responsible for making decisions about whether there are violations of State laws and regulations. Licenses, permits and approvals of the facility must be available to you upon request. Current reports of inspections by State and/or local health authorities are on file, and notations are made of action taken by the facility to correct deficiencies.

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	(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.	Procedures: §483.75(b) If resident/family interviews reveal possible problems with admission contracts, review these contracts for violations of requirements at §§483.10 and 483.12. As appropriate, refer problems to an ombudsman or other agencies, e.g., Office for Civil Rights. Some State or local laws are more stringent than the Federal requirement on the same issue. Failure of the facility to meet a Federal, State or local law may be cited at this tag only when the authority having jurisdiction has both made a determination of noncompliance and has taken a final adverse action as a result. Accepted professional standards and principles include the various practice acts and scope of practice regulations in each State, and current, commonly accepted health standards established by national organizations, boards and councils. If interviews with residents suggest that the facility may have required deposits from Medicare residents at admission, review the facility's admissions documents. Procedures: §483.75(c) If during the survey you identify problems relating to one or more of these requirements, which are under the purview of another Federal agency, forward the information to the RO, who will forward it to the appropriate Federal agency.

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F493	(d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and (2) The governing body appoints the administrator who is-- (i) Licensed by the State where licensing is required; and (ii) Responsible for the management of the facility.	Guidelines: §483.75(d)(2)(i) The administrator must be licensed where required by the State.
	(e) Required training of nursing aides-- (1) Definitions. Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker. Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.	Guidelines: §483.75(e) Volunteers are not nurse aides and do not come under the nurse aide training provisions of these requirements. Unpaid students in nursing education programs who use facilities as clinical practice sites under the direct supervision of an RN are considered volunteers. Private duty nurse aides who are not employed or utilized by the facility on a contract, per diem, leased or other basis, do not come under the nurse aide training provisions.

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F494	(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:	Guidelines: §483.75(e)(2 - 4) Facilities may use, as nurse aides, any individuals who have successfully completed either a nurse aide training and competency evaluation program or a competency evaluation program. However, if an individual has not completed a program at the time of employment, a facility may only use that individual as a nurse aide if the individual is in a nurse aide training and competency evaluation program (not a competency evaluation program alone) and that individual is a permanent employee in his or her first four months of employment in the facility.
	(i) That individual is competent to provide nursing and nursing related services; and	Facilities may not use non-permanent employees as nurse aides unless they have either completed a training and competency evaluation program, or a competency evaluation program.
	(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).	Probes: §483.75(e)(2 - 4) During an extended or partial extended survey: o Have all nurse aides completed a nurse aide training and competency evaluation program or a competency evaluation program? If not, are those nurse aides permanent employees enrolled in a training and competency evaluation program who have worked in the facility for 4 months or less? o Ask nurse aides where they received their training, how long the training was and how long they have worked in the facility as a nurse aide. During all surveys: o If incorrect nurse aide work performance is observed during the survey, check to see if the nurse aide received training and licensed nurse supervision to correctly carry out the task. A "permanent employee" is defined as any employee you expect to continue working on an ongoing basis.
	(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.	Procedures: §483.75(e)(2-4) Review competency requirements for nurse aides if you identify potential deficient care practices in quality of care, resident rights, resident behavior and facility practice or quality of life which may be related to nurse aide competency. Is there evidence that the nurse aide has successfully completed the competency evaluation program, or has the individual been grandfathered in by the State?

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F495	(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).	If you identify deficient care practices by nurse aides who do not have evidence of having successfully completed a competency evaluation program, determine: o if the aide is currently receiving training an a State approved Nurse Aide Training Program; o if the aide is under the supervision of a licensed nurse; and o if the aide has been trained and determined to be proficient for the tasks to which he or she is assigned. See §483.152 for specific training that the aide is to receive. This training includes: o at least 16 hours of training in the following subjects before any direct contact with the resident: - communication and interpersonal skills; - infection control; - safety and emergency procedures, including the Heimlich Maneuver; - promoting resident's independence; and - respecting resident's rights. o Basic nursing skills; o Personal care skills; o Mental health and social services of residents; o Care of cognitively impaired residents; o Basic restorative services; and o Resident's rights.
F496	(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or	

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F496 Cont.	(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	Guidelines: §483.75(e)(7) If an individual does not wish to be retrained, the individual must establish that he or she performed nursing or nursing-related services for monetary compensation for at least one documented day (i.e., 8 consecutive hours) during the previous 24 months. The State is required to remove the individual's name from the registry if the services are not provided for monetary compensation during the 24-month period. Thus, in the absence of any evidence to the contrary, you can assume that the retraining requirement does not apply to an individual whose name appears on the registry.

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F497	(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must-- (i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; (ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and (iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	Guidelines: §483.75(e)(8) The adequacy of the in-service education program is measured not only by documentation of hours of completed in-service education, but also by demonstrated competencies of nurse aide staff in consistently applying the interventions necessary to meet residents' needs. If there has been deficient care practices identified during Phase 1 of the survey, review as appropriate training received by nurse aides in that corresponding subject area. For example, if the facility has deficiencies in infection control, review the infection control unit in the facility's inservice nurse aide training program. Each nurse aide must have no less than twelve hours of in-service education per year. Calculate the date by which a nurse aide must receive annual in-service education by the employment date rather than the calendar year. Probes: §483.75(e)(8) During an extended or partial extended survey, or during any survey in which nurse aide performance is questioned. (See §483.75(f).) o Does the facility review the performance of its nurse aides? o How has in-service education addressed areas of weakness identified in performance reviews, special resident needs, and needs of residents with cognitive impairments? o How has in-service education addressed quality of care problems including those of special care needs and resident rights?

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F498	(f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	Guidelines: §483.75(f) "Competency in skills and techniques necessary to care for residents' needs" includes competencies in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services and resident rights. Procedures: §483.75(f) During the Resident Review, observe nurse aides. Probes: §483.75(f) Do nurse aides show competency in skills necessary to: maintain or improve the resident's independent functioning, e.g., performing range of motion exercises, assisting the resident to transfer from the bed to a wheelchair, reinforcing appropriate developmental behavior for persons with MR, or psychotherapeutic behavior for persons with MI; observe and describe resident behavior and status and report to charge nurse; follow instructions; carry out appropriate infection control precautions and safety procedures.
F499	(g) Staff qualifications. (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	Procedures: §483.75(g) *If there is reason to doubt the qualifications of temporary agency personnel working in* the facility, check with the appropriate registry or professional licensing board.
F500	(h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have	

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F500 Cont.	that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.	
F501	(i) Medical director. (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for-- (i) Implementation of resident care policies; and	*Guidelines: §483.75(i)* "Resident care policies" include admissions, transfers, and discharges; infection control; use of restraints; physician privileges and practices; and responsibilities of non-physician health care workers, (e.g., nursing, rehabilitation therapies, and dietary services in resident care, emergency care, and resident assessment and care planning). The medical director is also responsible for policies related to accidents and incidents; ancillary services such as laboratory, radiology, and pharmacy; use of medications; use and release of clinical information; and overall quality of care. The medical director is responsible for ensuring that these care policies are implemented.

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F501 Cont.	(ii) The coordination of medical care in the facility.	The medical director's "coordination role" means that the medical director is responsible for assuring that the facility is providing appropriate care as required. This involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and the medical care of residents. It also includes having a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate. When the medical director identifies or receives a report of possible inadequate medical care, including drug irregularities, he or she is responsible for evaluating the situation and taking appropriate steps to try to correct the problem. This may include any necessary consultation with the resident and his or her physician concerning care and treatment. The medical director's coordination role also includes assuring the support of essential medical consultants as needed. A medical director whose sole function is to approve resident care policies does not meet this requirement. Probes: §483.75(i) o What does the medical director do to coordinate medical care services for residents of the facility? o How does the medical director identify and confirm problems of inadequate care?
F502	(j) Laboratory services. (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	Intent: §483.75(j)(1) The intent of this regulation is to assure that laboratory services are accurate and timely so that the utility of laboratory testing for diagnosis, treatment, prevention or assessment is maximized. The facility is responsible for quality and timely laboratory services whether or not services are provided by the facility or an outside agency. Guidelines: §483.75(j)(1) A "laboratory service or test" is defined as any examination or analysis of materials derived from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings. Services provided must be both accurate and timely. Timely means that laboratory tests are completed and results are provided to the facility (or resident's physician) within timeframes normal for appropriate intervention. All laboratories providing services for facility residents must meet applicable requirements of 42 CFR Part 493. The purpose of this requirement is to assist in assuring quality of laboratory services.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F503	(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. (ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.	Procedures: §483.75(j)(1) Verify that laboratory services are provided to meet the needs of the residents. If a problem in quality of care leads you to suspect a problem in laboratory services, timeliness or quality, refer to the interpretive guidelines for laboratory testing found in Appendix C. Probes: §483.75(j)(1) Are problems attributable to: o An inability to order laboratory tests in a timely manner, including delays in transporting the resident to and from the source of service, if needed? o A delay of treatment due to untimely receipt of lab results? o A large lag time between an order for a test and the recording of the results that may have resulted in poor care? Intent: §483.75(j)(1)(i) - (iv) The intent of this regulation is to assure that laboratory services, bloodbank and transfusion services are obtained from an entity that meets the requirements of 42 CFR Part 493 in order to provide a standard of quality for laboratory and transfusion services. If the long term care facility does not provide laboratory services on site, there must be an agreement to obtain these services from a laboratory that meets the same requirements. Guidelines: §483.75(j)(1)(i) - (iv) If a facility provides its own laboratory services, the provisions of 42 CFR Part 493 apply. The facility must have a Clinical Laboratory Improvement Amendments (CLIA) certificate appropriate for the level of testing performed. An application for a certificate of waiver may be made if the facility performs only those tests categorized as waived under CLIA. Direct questions concerning the application of these requirements to your State laboratory consultant or the HCFA RO. Procedures: §483.75(j)(1)(i) - (iv) Determine if all laboratory services provided for the facility are provided by a laboratory that meets the requirements of 42 CFR Part 493. The surveyor should determine if the facility has an arrangement in writing to assume responsibility for (a) obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (b) the timeliness of the services.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F503 Cont.		Probes: §483.75 (j)(1)(i) - (iv) Are problems attributable to: o Lack of an arrangement to provide or obtain clinical laboratory services from a source that meets the applicable conditions for coverage of the services? o Delays in interpreting the results of laboratory tests?
	(2) The facility must--	Intent: §483.75(j)(2)(i) The intent of this regulation is to assure that only medically necessary laboratory services are ordered.
F504	(i) Provide or obtain laboratory services only when ordered by the attending physician;	Procedures: §483.75(j)(2)(i) Verify that all laboratory services received were ordered by the attending physician.
F505	(ii) Promptly notify the attending physician of the findings;	Intent: §483.75(j)(2)(ii) The intent of this regulation is to assure that the physician is notified of all lab results so that prompt, appropriate action may be taken if indicated for the resident's care. Procedures: §483.75(j)(2)(ii) If you have reason to believe that a physician(s) may not have been notified of laboratory results in a timely manner, determine if the facility has a policy/procedure for routine notification of physicians and if the procedure is implemented. Probes: §483.75(j)(2)(ii) o Are any problems identified as relating to lack of prompt notification of the attending physician, contributing to delays in changing the course of treatment or care plan?
F506	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and	Intent: §483.75(j)(2)(iii) The intent of this regulation is to assure that residents are able to get to and receive necessary laboratory testing when the testing is conducted outside of the facility. Probes: §483.75(j)(2)(iii) o Does the resident ever have to cancel lab service appointments due to difficulties with transportation?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F507	(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	Intent: §483.75(j)(2)(iv) The intent of this regulation is to assure that the laboratory performing the tests is Medicare approved, and that test results are accurate and are available for clinical management.
F508	(k) Radiology and other diagnostic services. (l) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	Intent: §483.75(k)(1) The intent of this regulation is to assure that the resident receives quality radiologic and diagnostic services in a timely manner to meet his/her needs for diagnosis, treatment, and prevention. Probes: §483.75(k)(1) If problems are identified in radiology or other diagnostic services, are problems attributable to: o An inability to order radiological and diagnostic services in a timely manner, including delays in transporting the resident for these services? o Delays in interpreting the results of X-rays and other tests? o Lack of prompt notification, in writing, of test results to the attending physician, contributing to delays in changing care plans or the course of treatment?
F509	(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide it's own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.	
	(2) The facility must--	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F510	(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;	
F511	(ii) Promptly notify the attending physician of the findings;	
F512	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and	
F513	(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	
F514	(l) Clinical records. (l) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are-- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.	Intent: §483.75(l)(l) To assure that the facility maintains accurate, complete and organized clinical information about each resident that is readily accessible for resident care. Guidelines: §483.75(l)(l) A complete clinical record contains an accurate and functional representation of the actual experience of the individual in the facility. It must contain enough information to show that the facility knows the status of the individual, has adequate plans of care, and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition, and changes in treatment. The facility determines how frequently documentation of an individual's progress takes place apart from the annual comprehensive assessment, periodic reassessments when a significant change in status occurs, and quarterly monitoring assessments. Good practice indicates that for functional and behavioral objectives, the clinical record should document change toward achieving care plan goals. Thus, while there is no "right" frequency or format for "reporting" progress, there is a unique reporting schedule to chart each resident's progress in maintaining or improving functional abilities and mental and psychosocial status. Be more concerned with whether the staff has sufficient progress information to work with the resident and less with how often that information is gathered.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F515	(2) Clinical records must be retained for-- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or, (iii) For a minor, three years after a resident reaches legal age under State law.	In cases in which facilities have created the option for an individual's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable. In cases when such attestation is done on computer records, safeguards to prevent unauthorized access, and reconstruction of information must be in place. The following guideline is an example of how such a system may be set up: o There is a written policy, at the health care facility, describing the attestation policy(ies) in force at the facility. o The computer has built-in safeguards to minimize the possibility of fraud. o Each person responsible for an attestation has an individualized identifier. o The date and time is recorded from the computer's internal clock at the time of entry. o An entry is not to be changed after it has been recorded. o The computer program controls what sections/areas any individual can access or enter data, based on the individual's personal identifier (and, therefore his/her level of professional qualifications). Procedures: §483.75(l)(1) In reviewing sampled residents' clinical records: o Is there enough record documentation for staff to conduct care programs and to revise the program, as necessary, to respond to the changing status of the resident as a result of interventions? o How is the clinical record used in managing the resident's progress in maintaining or improving functional abilities and mental and psychosocial status?
F516	(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;	
Refer to F164	(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by-- (i) Transfer to another health care institution; (ii) Law;	Intent: §483.75(l)(3)(4) To maintain the safety and confidentiality of the resident's record. Guidelines: §483.75(l)(3) and (4) "Keep confidential" is defined as safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative. If there is information considered too confidential to place in the record used by all staff, such as the family's financial assets or sensitive medical data, it may be retained in a secure place in the facility, such as a locked cabinet in the administrator's office. The record should show the location of this confidential information. Procedures: §483.75(l)(3) and (4) Determine through observations and interviews with staff, the policy and implementation of that policy, for maintaining confidentiality of residents' records.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(iii) Third party payment contract; or (iv) The resident.	Probes: §483.75(1)(3) and (4) o How does the facility ensure confidentiality of resident records? o If there is a problem with confidentiality, is it systemic, that is, does the problem lie in the recordkeeping system, or with a staff person's use of records, e.g., leaving records in a place easily accessible to residents, visitors, or other unauthorized persons?
Refer to F514	(5) The clinical record must contain-- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The plan of care and services provided; (iv) The results of any preadmission screening conducted by the State; and (v) Progress notes.	
	(m) Disaster and emergency preparedness.	Guidelines: §483.75(m) The facility should tailor its disaster plan to its geographic location and the types of residents it serves. "Periodic review" is a judgment made by the facility based on its unique circumstances. Changes in physical plant or changes external to the facility can cause a review of the disaster plan. The purpose of a "staff drill" is to test the efficiency, knowledge, and response of institutional personnel in the event of an emergency. Unannounced staff drills are directed at the responsiveness of staff, and care should be taken not to disturb or excite residents.
F517	(1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	
F518	(2) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff,	Procedures: §483.75(m) Review disaster and emergency preparedness plan, including plans for natural or man-made disasters. Probes: §483.75(m) Ask two staff persons separately (e.g., nurse aide, housekeeper, maintenance person) and the charge nurse: o If the fire alarm goes off, what do you do? o If you discover that a resident is missing, what do you do?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F518 Cont.	and carry out unannounced staff drills using those procedures.	o What would you do if you discovered a fire in a resident's room? Where are fire alarms and fire extinguisher(s) located on this unit? o How do you use the fire extinguisher? Note: : Also, construct probes relevant to geographically specific natural emergencies (e.g., for areas prone to hurricanes, tornadoes, earthquakes, or floods, each of which may require a different response). Are the answers to these questions correct (staff answers predict competency in assuring resident safety)?
F519	(n) Transfer agreement. (1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that-- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and (ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F519 Cont.	(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	
	(o) Quality assessment and assurance.	Intent: §483.75(o) The intent of this regulation is to ensure the facility has an established quality assurance committee in the facility which identifies and addresses quality issues, and implements corrective action plans as necessary. Guidelines: §483.75(o) The quality assessment and assurance committee is responsible for identifying issues that necessitate action of the committee, such as issues which negatively affect quality of care and services provided to residents. In addition, the committee develops and implements plans of action to correct identified quality deficiencies. The medical director may be the designated physician who serves on this committee pursuant to §483.75(o)(1)(ii). Procedures: §483.75(o) This requirement is reviewed only after completion of phase 2 sampling. There are two phases to the quality assurance review. During phase 1 for all facilities: o The survey team should review how the quality assurance committee functions. Determine through interviews with administrative staff and Quality Assessment and Assurance Committee members if the facility has a Quality Assurance Committee which meets the requirements in §483.75(o). o Determine if the committee has a formal method to identify issues in the facility which require quality assessment and assurance activities. The facility should also have a method to respond to identified issues and a means to evaluate the response to these issues. Phase 2 of the review should be conducted if the survey team has identified quality issues. During Phase 2: o Verify, through interviews with committee members and, as necessary, direct care staff that the committee has established a protocol or method for addressing specific quality problems in the facility that the facility believes have now been resolved.
F520	(1) A facility must maintain a quality assessment and assurance committee consisting of-- (i) The director of nursing services; (ii) A physician designated by the facility; and (iii) At least 3 other members of the facility's staff.	
	(2) The quality assessment and assurance committee--	
F521	(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F521 Cont.	(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies. (3) A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	Do not review committee records identifying details of the specific quality deficiencies. Surveyors should not focus on if the quality assurance committee has identified and addressed deficiencies which the survey team identifies. Concentrate on verifying that the facility has a quality assurance committee which addresses quality concerns and that staff know how to access that process. Probes: §483.75(o) When conducting interviews: o How are facility policies and clinical policies revised based on quality assurance findings? See Task 5F for detailed information concerning survey procedures.
F522	(p) Disclosure of ownership. (1) The facility must comply with the disclosure requirements of §§420.206 and 455.104 of this chapter. (2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in-- (i) Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter; (ii) The officers, directors, agents, or managing employees; (iii) The corporation, association, or other company responsible for the management of the facility; or	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F522 Cont.	(iv) The facility's administrator or director of nursing. (3) The notice specified in the paragraph (p)(2) of this section must include the identity of each new individual or company.	

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PHILADELPHIA NURSING HOME

Inter-disciplinary Environmental Rounds Process

Purpose:

The purposes of performing environmental rounds are as follows:

1. Develop a process to ensure compliance with State survey requirements with regard to environmental standards relating to Resident dignity and quality of life issues.
2. Develop a process to maintain routine compliance through internal monitoring.
3. Provide and encourage involvement of every clinical and non-clinical department.

Participants:

The rounds will be initiated by inter-disciplinary teams, composed of members from the following departments:

1. Nursing
2. Infection Control
3. Administration
4. Plant Operations
5. Environmental Services
6. Recreation Therapy
7. Fiscal Department
8. Human Resources
9. Central Supply
10. Quality Improvement
11. Admissions Office
12. Physical Therapy
13. Social Service
14. Medical Records

Team Development:

1. Every resident and non-resident unit(except a dietary department) has a team composed of at least four to five team members, a team leader and if possible, one alternate team member.
2. Team leaders are individuals from Administration &/or management.

Audit Tool:

A standardized audit tool will be utilized during team rounds. The audit tool is composed of those items which evaluate key environmental and infection control practices. The audit tool will indicate which area did not meet institutional standards and provide space to incorporate action to correct those noncompliant areas. (see copy of audit tool attached)

Rounding process:

Rounding will be done daily on each unit. By the end of every week, all units will have been completely evaluated. The specifics of the process are as follows:

1. Each day, one team member conducts rounds on every unit.
2. Resident rooms on each unit are divided among unit team members. Team members visit community areas and assigned rooms/residents, on assigned day.
3. Before beginning rounds, the team member asks the Unit Manager or licensed staff on the resident floors or the director/manager of the non-resident floors, to select one person working on the unit to accompany and assist with rounds.
4. Any item that can be easily fixed on the rounds is corrected(example: towel on a bathroom floor is picked up and placed in dirty linen).
5. Following rounds, all staff available on theunit along with a Unit Manager or licensed personnel on resident units and manager/director on non-resident units, will gather for a 3-5 minute meeting to discuss findings. The Unit Manager or licensed personnel &/or director/manager will assign corrective actions and document actions on rounds form. The Unit Manager/licensed personal/director/manager will communicate concerns, corrective actions and system changes with all shift supervisors and unit staffs.
6. One copy of the rounds form is kept on the floor. Other copies will go to Administration, team leaders, Director of Nurses, Director of Housekeeping, Director of Plant Operations and Director of Quality Improvement, for follow-up.
7. Team leaders will meet weekly for the first two months to discuss system issues identified. Team leaders will explore systems improvement ideas with unit staff.
8. Tracking of areas for improvement will be aggregated quarterly and presented to the Quality Improvement Committee.

ELTC Philadelphia Nursing Home **UNIT ROUNDS CHECKLIST**

NAME:_____ UNIT:_____ AREA:_____ DATE:_____

Circle item # if out of compliance with regulation. Comment below, if necessary. All suggestions for system improvement are welcome!

	ITEM NUMBER	WHO/WHAT/WHERE	ACTION TAKEN
RESIDENTS	1. Evidence of privacy and dignity maintained.		
	2. Resident personal care: hair, nails, mouth, clean, shaven		
	3. Clothing: clean, neat, footwear appropriate		
RESIDENT ROOMS	4. Call lights accessible and operational		
	5. Bathroom area clean, no personal items or housekeeping cleaners present.		
	6. Oxygen set-ups dated, cannula covered when not in use. Filters clean. Suction machines in working condition.		
	7. Gloves are appropriately dispensed and disposed.		
	8. Resident rooms neat, clean, no dust. Working overbed lights, spreads on bed. Overbed tables, chests and closets clean. Privacy curtain clean and operational.		
	9. Resident rooms: personal care items appropriately labeled and stored. Linen handled appropriately. Food in appropriate containers.		
	10. Water cups with fresh water and appropriately dated.		
	11. Feeding pumps exterior clean & feedings appropriately dated.		
	12. Foley catheters in appropriate placement for drainage and appropriately covered, if resident out of bed.		
	13. Irrigation trays dated and marked with name.		
	14. Furniture appropriately labeled with Resident name.		
	15. Wheelchairs/ger-chairs clean and in good repair.		
COMMUNITY & ENVIRONMENT	16. Halls clean, free of obstacles, equipment to one side of hall. Emergency doors clear.		
	17. Water fountains clean and operational.		
	18. Unit free from odor.		
	19. Floors clean. No dirt build-up in corners or around edges.		
	20. Staff complies with dress code. Identification badge visible.		
	21. Dirty/clean carts are covered and emptied on timely basis. Dirty carts are at least 4 ft. from clean linen carts.		
	22. Medication carts locked if unattended and clean in & out.		
	23. **MEDICATION ROOM:** clean, neat, locked. Refrigerator clean, temperature 35-45, no food. Approp. items dated.		
	24. **NURSES STATION:** Desk and floor clean. Chart rack free of dust. No food at station.		
	25. **EMERGENCY STORAGE:** Floor clean, shelves appropriately stocked. Check sheet appropriately labeled.		
	26. **TUB AND SHOWER ROOMS:** Floors and walls clean. No resident care items available. Thermometer present.		
	27. **DINING ROOM:** Tables/chairs clean and free of spills.		
	28. **PANTRY:** Door closed, trash container with lid. Ice machine clean and operational. Floor and cabinet clean. Refrigerator clean, temperature 35-40. Approp. items dated.		
	29. **SUPPLY ROOMS:** Linen, wheelchairs clean and area neat. 18" clearance from items to ceiling. Door locked.		
	30. **DIRTY UTILITY ROOM:** Floor, counter clean. Door locked. Trash in carts with covered lids. Bio-hazard label on appropriate cans. Soap and paper towels available. No trash build-up.		
	31. **CLEAN UTILITY ROOM:** Floor, counter clean. Door locked. Sterile items with appropriate expiration date. Treatment carts locked, if unattended and clean inside & outside. Soap and paper towels available.		
	32. Residents smoking in appropriate lounge with appropriate monitoring by staff.		
	33. **PLANT OPERATIONS:** No loose toilet seats. Ceiling, walls, floors in good repair. Heat, electric, air condition units and plumbing operational and in good repair. Call light operational with appropriate length pull string.		

ROUTING— Administration, Team Leader, Unit Manager

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

Revised
IA 8

DEPARTMENT OF NURSING

RESIDENT ACCOUNTABILITY

POLICY:

It is the intention of Episcopal Long Term Care/Philadelphia Nursing Home to provide residents with as much access to self determination concerning movement as possible. Within that intent, we have developed a monitoring program which provides for resident accountability.

PURPOSE:

To provide a system which assumes and communicates that residents are present in the facility.

PROCEDURE:

1. Census must be utilized every shift by the Unit Manager or Charge Nurse to account for each resident on each unit. (See attached sample)

2. Census rounds will be done at 3:00 p.m. , 11:00 p.m. and 7:00 a.m. with the Charge Nurse going off-duty and the Charge Nurse coming on duty. During these rounds resident whereabouts are to be accounted for by noting a checkmark (✔) in the appropriate column on the resident identification log. The checkmark (✔) means that the resident is physically present on his/her assigned unit.

   If the resident is in a location in the facility, other than their assigned unit, or at another facility for doctors appointments, programs, procedures, etc., their location is to be recorded in the log.

   For example:

   - If the resident is on the Patio record **PATIO**
   - if the resident is in the X-ray Department record **X-RAY**
   - If the resident is at Einstein Program record **EINSTEIN**
   - If the resident is at Episcopal Hospital Emergency Room record **EH/ER**
   - If the resident was admitted to a hospital record **ADMITTED**
   - If the resident was transferred to another unit record **TRANSFER/UNIT**
   - if the resident was discharged record **DISCHARGED**
   - If the resident expired record **EXPIRED**

When rounds arr completed, the Charge Nurse coming on-duty and the Charge Nurse going-off duty are to affix their signature at the bottom of the log labeled **"SIGNATURES"** in the appropriate column.

3. Unit Managers/Shift Supervisor are responsible to verify that the resident census and presence in the facility is accurate.

   The census report and resident identification log will be utilized by Unit Manager/Shift Supervisor each shift as a check that rounds are conducted and each resident is accounted for on each unit.

   Unit Manager and Shift Supervisor are also responsible to conduct room-to-room rounds. At the completion of rounds the Unit Manager/Shift Supervisor will affix their signtures on the bottom of the log labeled "UM/SUP" in the appropriate column.

4. Any resident not accounted for will be reported to the Unit Manager or Supervisor and a search of the building and grounds will be conducted immediately.

5. Once it has been determined that the resident is not in the building nor on the grounds, the Unit manager or nursing Supervisor will contact the following: from the hours of 7:00 a.m. - 3:30 p.m.; Administrator, Director of Nursing, attending physician, responsibile relative and from the hours of 3:00 p.m. - 11:30 p.m. and 11:00 p.m. - 7:30 a.m.; Administrator on call, Nurse Administrator on call, attending physician, responsible relative. If the resident is determined to be AWOL, the Department of Health and police are notified.

6. An incident report will be completed and an investigation as to the causes will be conducted. Trending reports will be completed and presented to Quality Assurance committee on a quarterly basis.

7. The census report and resident identification log are to be retained on each unit attached to assignment sheets.

The Unit Manager is responsible for maintaining these records in an orderly fashion.

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

BEHAVIORAL UNIT
Program Outline and Implementation Schedule

Goal:

- Focus facility resources in one wing to meet the complex needs of residents with problematic behavior

- Provide the least restrictive, home-like environment for residents with problematic behaviors while ensuring the safety of all residents and staff.

Location: 2 East (25 beds)

Admission Criteria

- Males who are current residents of PNH or after admission to PNH demonstrate problematic behavior who have been deemed appropriate by the Admissions Team. The problematic behaviors include:

  - Difficulty in relating to other residents or staff, including verbal and physical outbursts

  - Non-compliant in participating in routine activities of daily living including bathing, dressing, etc.

  - Non-compliant with interdisciplinary plan of care which contributes/exacerbates problematic behavior

  - Requires behavior intervention when in contact with other residents' personal belongings

- Need for coordinated, consistent behavioral modification program in order to minimize problem behavior.

- Demonstrates ability to respond to behavioral intervention and redirection.

Admission Process:

- Interdisciplinary team will recommend psychiatric consult and/or neuropsychology testing to confirm residents appropriateness for the behavioral unit.

- The Admissions Committee, comprised of the Director of Nursing or designee, Medical Director, Director of Social Work, Director of Admission, Unit Manager and Psychiatric Nurse Specialist will review all medical information including psychiatric consult in determining a resident's appropriateness for admission to the Behavioral Unit.

Discharge Criteria:

- Residents of the Behavioral Unit who care needs necessitate transfer to a more appropriate unit. These care needs include:

  - Compliant in participating in routine activities of daily living for sixty (60) days.
  - No episodes of verbal or physical outbursts for ninety (90) days.
  - Significant changes in medical status which eliminates either non-compliant and/or verbal or physical outbursts.

- Interdisciplinary team will recommend a resident's discharge from the behavioral unit.
- The Admissions Committee will review all medical information and determine resident's appropriateness for discharge from the behavioral unit.

Staffing:

- Nursing 2 East @ 4.0 hours PPD

  - Under the supervision of an ADON, the unit will be managed by a unit manager who with the Psychiatric Nurse Specialist and IDT will define and conduct an educational program consistent with the behavioral interventions that will be utilized.

- Social Service

  - .5 FTE MSW with demonstrated skill in group dynamics and behavioral interventions
    - complete in depth psychosocial history for each resident.
    - participate in therapeutic regimen including support groups and individual/family counseling.
    - act as a liaison between family, facility and resident.
    - act as a liaison between facility and community mental health system.
    - coordinate all discharge planing for the unit.
    - educate other disciplines regarding the psychosocial needs of residents.

- Recreation Therapy

  - .25 FTE Recreation Therapists with demonstrated skill in behavioral intervention
  - .50 FTE Recreation Aide

- Psychiatric Services

  - Psychiatrist
    - participate in development of behavioral plan
    - monitor medications
    - educate team as to underlying causes for problematic behavior

  - Psychiatric Nurse Specialist
    - participate in development of behavioral plan
    - provide initial and ongoing staff education
    - monitor behavioral approaches for each resident
    - monitor resident reaction to medication regimen

  - Clinical Psychologist
    - provide neuropsychological testing as required
    - provide individual and small group counseling

- Interdisciplinary Team

  - Interdisciplinary Team will include Nursing, Psychiatric Nurse Specialist, Social Worker, Recreational Therapist, Clinical Dietitian, Respiratory Therapy and Rehabilitation Services as appropriate.

  - Interdisciplinary Care Conferences will occur on a weekly basis.

    - Stand-up IDT meetings with follow-up documentation will occur daily to develop and/or assess current interventions.

    - Schedule for daily and weekly care conferences will be determined by the Unit Manager in cooperation with the team.

Action	Responsible Party	Target Date
• Resident Pre-Relocation screening		
• Psychiatric consults	PNH Medical Staff and AEMC Psychiatry	10/20/95
• Neuropsychologicals if indicated	AEMC Psychiatry	11/03/95
• Complete recommendations to Admissions Committee including roommate matches.	AEMC Psychiatry/Interdisciplinary Team	11/03/95
• Relocation of Current Residents to Other ICF Units (16)	Admissions/Social Service/Nursing	11/10/95
• Maximum - 2-3 residents/week		
• AEMC Psychiatric Team in place		
• Psychiatric Nurse Specialist	AEMC Psychiatry	10/16/95
• Psychiatry 24 hour/In House	AEMC Psychiatry	10/02/95
• Clinical Psychology Available for pre-screening and consultations	AEMC Psychiatry	09/25/95
• Unit Staffing		
• Psychiatric Nurse Specialist	AEMC Psychiatry	10/16/95
• assessment of residents with problematic behaviors	AEMC Psychiatry	11/03/95
• in conjunction with Interdisciplinary Team develop behavior interventions as indicated.	AEMC Psychiatry/Interdisciplinary Team	11/10/95 and ongoing
• Inservicing of all Interdisciplinary staff on behavioral interventions/approaches.	AEMC Psychiatry/Interdisciplinary Team department directors	10/16/95 and ongoing

Action	Responsible Party	Target Date
• Recreational Therapy		
• assignment of appropriate therapist and aide	Recreational Therapy/Assistant Administrator	11/10/95
• development resident specific and unit programming with input from Recreational Therapy consultant and Interdisciplinary Team	Recreational Therapy/Consultant Assistant Administrator	11/03/95 and ongoing
• initiation of new programming	Recreational Therapy/Assistant Administrator	11/17/95 and ongoing
• attendance at all appropriate inservices	Recreational Therapy/Assistant Administrator	10/16/95 and ongoing
• participate in IDT conferences	Recreation Therapy/Assistant Administrator	11/03/95
• Social Services		
• assignment of MSW with demonstrated skill in group dynamics and behavioral interventions	Director of Social Services	9/25/95
• participation in Interdisciplinary Team conferences	Director of Social Services	11/03/95
• attendance at all appropriate inservices	Director of Social Services	11/03/95

Action	Responsible Party	Target Date
• Nursing		
• Recruitment and/or reassignment of appropriate licensed and ancillary nursing staff	Director of Nursing and/or designee	9/21/95 and ongoing
• Staffing appropriate for: - eight residents	Director of Nursing and/or designee	11/13/95
- ten residents		11/20/95
- twelve residents		11/27/95
- fourteen residents		12/04/95
- see unit phase in schedule		
• attendance at all appropriate inservices	Director of Nursing and/or designee	10/16/95 and ongoing
• participation in Interdisciplinary Team conferences	Director of Nursing and/or designee	11/03/95
Unit Phase-In		
• Problematic Resident to 2 East	Interdisciplinary Team	
• 8 relocated residents		11/13/95
• 8 residents plus 2 relocated residents		11/20/95
• 10 residents plus 2 relocated residents		11/27/95
• 12 residents plus 2 relocated residents		12/04/95
• 14 residents plus 2 relocated residents		12/11/95
• 16 residents plus 2 relocated residents		12/18/95
• 18 residents plus 2 relocated residents		12/25/95
• 20 residents plus 2 relocated residents		01/01/96
• 22 residents plus 2 relocated residents		01/08/96

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

ADULT UNIT

Program Outline and Implementation Schedule

Mission: To provide the least restrictive home-like environment for young or middle aged residents, while focusing facility resources on wing/unit to meet the complex psychosocial needs of this group of residents.

Location: 5 East

Admission Criteria

Young/Middle Aged Adults who are current residents of PNH or after admissions have demonstrated the following:

- psychological need for interpersonal interaction and activities consistent with unit
- ability and interest in participating in specially developed activities and groups
- ability to communicate needs and wishes
- willingness to attend facility based substance abuse program if active personal substance abuse history exists
- proven record of complying with facility rules
- care needs can be appropriately met by the unit's interdisciplinary team and nursing staff

Admission Process

- Interdisciplinary teams will recommend residents for the unit based on the admission criteria.
- Social Worker will interview all potential residents for interest/willingness to relocate to the unit.
- Resident must agree via behavioral contract to comply with rules of the unit and participate in appropriate counseling and groups.
- The admissions team comprised of Assistant Director of Nursing, Social Worker, Unit Manager and Medical Director or designee will review all information and determine resident's appropriateness for admission.

Discharge Criteria

- Unit interdisciplinary team will recommend resident for transfer off the unit based on one or more of the following:
  - significant change in medical condition which decreases resident's ability to participate in unit's psychosocial programs.
  - significant change in resident's care needs that unit's interdisciplinary team are unable to provide.
  - unwillingness to participate in facility-based programs.
  - physical or verbal outbursts.
  - failure to comply with units' rules.

- The admission team will review all information and determine resident's appropriateness for transfer from the unit.

Staffing

- Nursing 5 East @ 3.5 hours PPD
  - Under the supervision of an Assistant Director, the wing will be managed by a unit manager who with the social worker and recreational therapist will define or conduct a program consistent with these residents physical and complex psychosocial needs.

- Social Service
  - .5 FTE MSW with demonstrated skill in group dynamics, substance abuse and young adult disabilities.
    - complete update indepth psychosocial history for each resident
    - negotiates behavioral contract for all residents appropriate for admission
    - acts as a liaison between family, facility and resident
    - coordinates all discharge planning for the unit
    - participates in staff education of other disciplines regarding the psychosocial needs of these residents

- Recreation Therapy
  - .25 FTE Recreation Therapists with demonstrated skill in program development which includes interactive groups, recreational and educational activities

- Rehabilitation Services
  - .2 FTE Exercise _____ to coordinate exercise program consistent with physical disabilities

- Space
  - Expand common space available for informal and formal activities
  - Discuss conversion of large three bed room to second lounge
  - Increased use of Pavilion for large group activities
  - Discussion location of smoking areas

- Equipment
  - Exercise equipment
  - Video games (? donation)
  - Expand cable potential on 5 East
  - Activity Supplies
  - Library

- Interdisciplinary Team
  - Interdisciplinary Care Conferences will occur on a weekly basis. Residents will be encouraged to attend.

Action	Responsible Party	Target Date
• Resident relocation screening to include – willingness to relocate and behavioral contract to abide by rules of unit.	Social Worker	1/5/96
• Relocation of Current Residents to Other ICF Units (6 residents/week)	Admissions/Social Service/Nursing	2/2/96
• Adult Unit Task Force will meet weekly to continue program development.	Executive Director/ Social Worker/Recreational Therapists/Residents	Ongoing - Thursdays, 4PM Auditorium
• Activity Programming Presentation to Adult Unit Task Force	Recreational Therapist	12/7/95
– Programming revisions supplies/ equipment requirements		12/21/95
– Program implementation		1/15/96
• Substance Abuse Counseling		
– 1 on 1	Social Worker	Ongoing
– AA community group	Social Worker	1/15/96
– group counseling	Social Worker	1/08/96

Action	Responsible Party	Target Date
• Educational Programs		
– development of program	Social Worker/	1/15/96
– recruitment of tutors/training	Recreation Therapist	1/29/95
– implementation		2/12/96
• Space requirements determined; evaluate need for renovation; determine need for second floor smoking area	Specialty Unit Task Force and Plant Operations	1/5/96
• Assess area electrical requirements due to concentration of motorized wheelchairs		1/5/96
Unit Phase - In		
• Adult Resident to 5 East		
– 6 relocated residents		1/08/96
– 6 relocated residents		1/15/96
– 6 relocated residents		1/22/96
– 4 relocated residents		1/29/96

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEMENTIA UNIT
Program Outline

Goal:

- Focus facility resources in one wing to meet the complex needs of residents with dementia related behavioral problems

- Provide the least restrictive, home-like environment for residents dementia-related problems while ensuring the safety of all residents and staff.

Location: 5 West (49 beds)

Admission Criteria

- Current residents of PNH or after admission to PNH who demonstrate dementia - related behavioral problems and who have been deemed appropriate by the Interdisciplinary Team. Dementia - related behaviors include:

  - Wandering which results in disruption of other residents
  - Difficulty in relating to other residents or staff, including verbal and/or physical outbursts
  - Requires behavioral intervention when in contact with other residents personal belongings

Admission Process:

- Interdisciplinary team will review resident's medical record including all consults to confirm the resident's appropriateness for the dementia unit.

Discharge Criteria:

- Residents of the Dementia Unit whose care needs necessitate transfer to a more appropriate unit. These care needs include:

  - Significant changes in medical status which eliminates either non-compliant and/or verbal or physical outbursts and wandering.

The Interdisciplinary Team will recommend a resident's discharge from the dementia unit. The team will communicate the need for a room change to the Admission's department.

Staffing:

- Nursing 5 West @ 3.7 hours PPD

  - Under the supervision of an ADON, the unit will be managed by a unit manager and with the cooperation with behavioral health professionals conduct an educational program consistent with the behavioral interventions that will be utilized.

- Social Service

  - .5 FTE Social Work with demonstrated skill in group dynamics and behavioral interventions
    - complete in depth psychosocial history for each resident.
    - participate in therapeutic regimen including support groups and individual/family counseling.
    - act as a liaison between family, facility and resident.
    - act as a liaison between facility and community mental health system.
    - coordinate all discharge planning for the unit.
    - educate other disciplines regarding the psychosocial needs of residents.

- Recreation Therapy

  - .50 FTE Recreation Therapists with demonstrated skill in behavioral intervention
  - .50 FTE Recreation Aide

- Mental Health Services

  - Psychiatrist
    - provide consultant function as required
    - monitor medication in accordance with accepted standards of care
    - assist IDT in identification of underlying causes of behavior .

  - Psychiatric Nurse Specialist
    - participate in development implementation of IDT plan of care
    - monitor resident's responses to behavioral approaches
    - monitor resident responses to medication regimen when indicated

  - Psychotherapist
    - provide individual and group psychotherapist
    - participate in development implementation of IDT plan of care

- Interdisciplinary Team

  - Interdisciplinary Team will include Attending Physician, Physician Assistant, Nursing, Psychiatric Nurse Specialist, Social Worker, Psychotherapist, Recreational Therapist, Clinical Dietitian, Respiratory Therapy and Rehabilitation Services as appropriate.

Action	Responsible Party	Target Date
• Develop Program Outline	Speciality Unit Task Force	09/20/96 and revised 12/97
• Educate clinical interdisciplinary staff re: behavioral care planning and interventions	Departments: Medicine, Nursing, Social Work, Therapeutic Recreation, Food Service, Rehabilitation	11/96 and 12/96 reeducate 3/98
• Review of resident safety systems - surveillance cameras - code alert system	Executive Director, Director of Plant Operations and Security	Surveillance System: 10/97 Code Alert: 12/97
• Facility - Unit based Interdisciplinary Teams will initiate recommendations for meet admission criteria	Unit-based Interdisciplinary teams	1/98
• Resident Admission Screening and Approval - review of medical record - communications with both sending and admitting IDT	Five West Interdisciplinary Team Unit-based Interdisciplinary teams	3/98 and ongoing
• Nursing - all staff assigned - attend all appropriate education programs - participate and implement inter-disciplinary plan of care - participation in interdisciplinary therapeutic activity programs	Assistant Director of Nursing	11/96, 12/96 and 3/98 3/98 and ongoing 12/98
• Recreational Therapy - assignment of therapist and recreation aide - attend all appropriate education programs - participate and implement	Director of Therapeutic Recreation Director of Social Work and Community Relations	3/98 11/96, 12/96, 3/98 3/98 and ongoing

Action	Responsible Party	Target Date
interdisciplinary plan of care		
- design resident-specific therapeutic recreation programs		3/98 and ongoing
- develop unit-based recreation programs to be coordinated by the unit certified nursing aide		12/98
• **Social Work**		
- assignment of social worker with demonstrated skill in behavioral interventions	Director of Social Work	3/98
- participation and implementation of Interdisciplinary Team Care Plans	Director of Social Work	3/98 and ongoing
- attendance at all appropriate education sessions	Director of Social Services	11/96 and 12/96, 3/98
- discharge planning as appropriate		

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EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

MDS/RAP
THE RESIDENT ASSESSMENT INSTRUMENT

POLICY:

The MDS and RAP is completed for each resident within fourteen (14) days of admission/readmission and is completed according to the **Minimum Data Set 2.0 Manual.**

PURPOSE:

The Resident Assessment Instrument (RAI) is used in order to maintain timely and comprehensive resident assessments as a basis for problem identification and care plan development and to assist the resident to attain and/or maintain the highest practicable physical, mental and psychosocial functioning possible.

PROCEDURE:

1, The Minimum Data Set 2.0 User's Manual is maintained on every unit.

2. The Unit Manager/Charge Nurse is responsible to review the MDS 2.0 Manual and to follow the procedures for completing the MDS and RAPs.

3. The Unit Manager/Charge Nurse is responsible to review the monthly MDS Report in order to identify those residents whose quarterly or yearly MDS is due.

4. The Unit Manager/Charge Nurse is responsible to initiate a complete MDS within fourteen (14) days of admission or readmission, every ninety (90) days (quarterly), and when there is a significant change in the resident's condition.

5. The Unit Manager/Charge Nurse is responsible to complete those sections of the MDS and RAPS that involve nursing (see attached flow chart).

6. The Unit Manager/Charge Nurse is responsible, through the Inter-Disciplinary Care Conference, to coordinate the completion of the MDS and RAPs within a timely manner. However, it is the ultimate responsibility of each discipline to complete their sections of the MDS/RAPs within the appropriate time frames.

   a. The Resident Care Plan is initiated within two (2) weeks and is completed within 21 days of resident admission and is maintained, reviewed and revised throughout the resident's stay.

   b. The Resident Care Plan is reviewed and revised at least once every three (3) months at the time of the Quarterly and/or Yearly MDS/RAPs review and is revised when the resident has a significant change.

   c. The Resident Care Plan is interdisciplinary; therefore, each resident problem is addressed by all disciplines involved.

   d. A new Resident Care Plan is initiated only when the resident has been out of the facility for more than thirty (30) days and returns as a new admission.

SEE CARE PLAN POLICY AND PROCEDURE

Resident Admission

Basic Assessment Tracking Form
(Admissions)

MA Tracking Form
(Admissions)

New Admission

No

Yes

MA Tracking Form - - - - Proceed with regular MDS schedule

(Date of Admission unless otherwise specified)
(Transfer OFF MA to Non-MA ie: Medicare)
(Date of discharge to hospital or other setting)
(Date of reentry to facility if on MA)

Quarterly MDS

Basic Assessment Tracking Form
(AA # 8, #9)
Section A = Nursing
Section B = Nursing
Section C = Nursing
Section E = Social Work
Section G = Nursing
Section H = Nursing
Section I = Nursing
Section J = Nursing
Section K = Dietary
Section M = Nursing
Section N = T. Recreation
Section O = Nursing
Section P
1a = Nursing
1b = Therapies (individual)
P2 = Social Work
P3 to 9 = Nursing
Section Q = Nursing
Section R = ALL
Section S # 1 thru 3 = Admissions
Section S # 4 = Nursing

→ Transfer/Discharge

Discharge Tracking Form
(Admissions)

Reentry Tracking Form
MA Tracking Form
(Admissions)

Annual MDS

Basic Assessment Tracking Form
(AA #8, #9)
Complete Full MDS 2.0

Merger Form
(MDS Office)

→→ **Reassess MDS**
(Nursing)

MDS 2.0 Face Sheet (Section AB)
(Admissions)

Customary Routine (Section AC)
(Admissions Case Manager)

MDS 2.0

Section A = Nursing
Section A # 6, # 7 = Admissions/ Business Office
Section B = Nursing
Section C = Nursing
Section D = Nursing
Section E = Social Work
Section F = Social Work
Section G = Nursing
Section H = Nursing
Section I = Nursing
Section J = Nursing
Section K = Dietary
Section L = Nursing
Section M = Nursing
Section N = T. Recreation
Section O = Nursing
Section P
1a = Nursing
1b = Therapies (individual)
P2 = Social Work
P3 to 9 = Nursing
Section Q = Social Work
Section R = ALL
Section S #1 thru 3 = Admissions
Section S #4 = Nursing

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

INTERDISCIPLINARY RESIDENT PLAN OF CARE

POLICY:

A comprehensive and individualized plan of care is maintained in an ongoing basis for each resident. The Plan of Care includes measurable objectives and time tables to meet resident's medical, nursing, mental and psycho-social needs.

The PNH Resident Care Plan is interdisciplinary and addresses problems identified through a comprehensive assessment (See the Resident Assessment Instrument, MDS/RAPs). The Resident Care Plan is addressed by all disciplines involved in the resident's care. The Resident Care Plan becomes a permanent part of the resident's chart.

PURPOSE:

To plan individualized and appropriate care in order to address identified problems and to promote the highest practicable physical, mental and psycho-social functioning as possible.

PROCEDURE:

A. The Interdisciplinary Resident Care Plan is initiated within fourteen (14) days of the resident's admission.

B. The initial Interdisciplinary Resident Care Plan is completed within twenty-one (21) days of the resident's admission/readmission and continues until discharge by review and revision as necessary.

C. Information about the resident is completed on the first page of The Resident Care Plan Form, and includes:

1. Resident name
2. Room number
3. Admission date
4. Admission number
5. Admission location
6. Age

7. Sex
8. Allergies
9. Doctor's name
10. Admission diet
11. Medical diagnosis on admission
12. Additional diagnosis with date of onset
13. The name, telephone number, relationship and availability of the relative or significant other involved in the resident's care planning.
14. Any updates or changes in the above information
15. Advance Directives review dates

EXAMPLE:

RESIDENT CARE PLAN

ADVANCE DIRECTIVES REVIEW DATES

RESIDENT John Doe ROOM 201 — 9/1/96

ADMISSION DATE 9/1/96 ADM. DX CVA ADM. DX. HBP

AGE 70 SEX M ALLERGIES NKA

DOCTOR Burden ADM. DIET Mechanical Soft

MEDICAL DIAGNOSIS ON ADMISSION

S/P CVA — Seizure Disorder

Rt sided hemiparesis

S/P Pneumonia

ADDITIONAL DIAGNOSES - ONSET DATE:

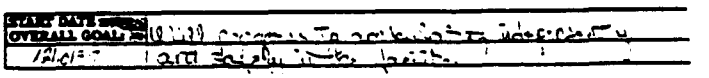
RELATIVE SIGNIFICANT OTHER INVOLVED IN CARE PLANNING

NAME Jane Doe TEL 123-4567

RELATIONSHIP wife AVAILABILITY Mon-Fri 8-5 Work # 456-7890

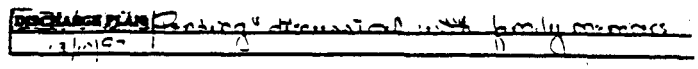
UPDATES/CHANGES IN ABOVE INFORMATION

D. The start date and overall goal (Long Term Goal) is documented, using the identified individual problems or needs of the resident.



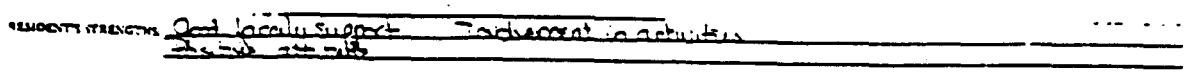
E. The discharge plan is documented (usually by Social Service)

EXAMPLE:



F. The resident's strengths are documented.

EXAMPLE:



G. The identified problem or need is documented. All items triggered on the RAP sheet, and found to be valid, will be addressed on the Resident Care Plan. If the team does not act on an item triggered, they must document the reason for no intervention. This can be accomplished on the RAP Sheet in the space provided. or explained in the RAP Summary.

H. The interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, develops quantifiable objectives (short term goals) based on the identified needs.

1. Selected short term goals:

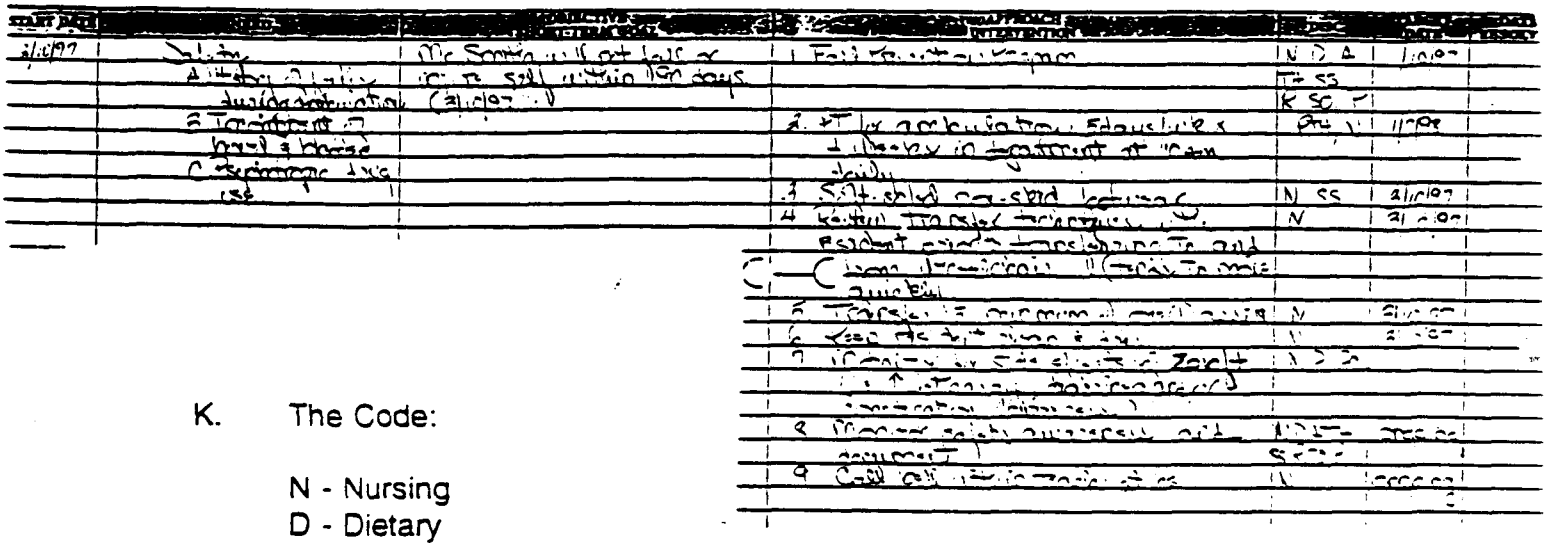
EXAMPLES

NOTE: Examples are designed to assist in the development of the plan of care, however, the plan of care should be personal and individualized to the resident.

I. Care planning interventions are developed for all RAPs triggered by the MDS.

J. The Interdisciplinary Resident Care Plan will reflect intermediate steps for each outcome objective (short term goal).

SEE EXAMPLES:



K. The Code:

N - Nursing
D - Dietary
A - Activities
TH - therapy
SS - Social Service
R - Resident
SO - Significant Other
P - Physician
PC - Pharmacy Consultant

will be used to document involvement in specific intervention

EXAMPLE:

APPROACH INTERVENTION	DISC	TARGET DATE	DATE RESOLVED
- Allow resident to verbalize. Listen to resident	SS, N, SO, P, A, D, Th.	12/6/96	
- Allow for grieving process to occur. (Consider the stages of grieving: Denial, Anger, Bargaining, Depression and acceptance. Remember the resident may fluctuate from one stage to another)	SS, N, SO, P, A, D,		

L. A reasonable target date for the accomplishment of the goal and/or intervention will be documented in the space provided.

1. When the care plan is revised it may be necessary to add a revised target date.

M. The date of resolution is documented in the space provided.

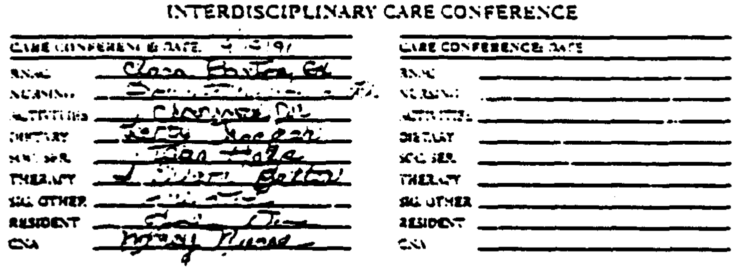
1. When the need is resolved, it is highlighted with yellow highlighter and is no longer carried as a problem.

N. The Resident Care Plan is revised at least every three (3) months at the time of the Quarterly or Yearly MDS/RAP review, but may be revised more frequently if necessary.

O. The date of the Care Conference is documented in the space provided.

P. The Resident Care Plan is signed by all disciplines involved.

EXAMPLE:


INTERDISCIPLINARY CARE CONFERENCE

CARE CONFERENCE DATE	[illegible]	CARE CONFERENCE DATE	
R.N./C	[illegible]	R.N./C	
NURSING	[illegible]	NURSING	
ACTIVITIES	[illegible]	ACTIVITIES	
DIETARY	[illegible]	DIETARY	
SOC. SER.	[illegible]	SOC. SER.	
THERAPY	[illegible]	THERAPY	
SOC. OTHER	[illegible]	SOC. OTHER	
RESIDENT	[illegible]	RESIDENT	
CNA	[illegible]	CNA	

Q. In addition, Respiratory Therapy and/or the Einstein Program are members of the interdisciplinary team when resident's treatments involve those disciplines.

B:\POLICY.PRO\RESCARE.PLN
Revised: 11/4/97

5. In the event of a positive alcohol/drug screen, physician will:

   A) Counsel the resident regarding positive screen and encourage cooperation with substance abuse evaluation/Tx.

   B) Document resident's response to counseling and referral in medical record.

   C) Work with resident, Social Work (Psychiatry if necessary) and IDCT to develop and implement a treatment plan

Social Work Department:

1. Arrange evaluation of resident by Certified Addiction Counselor (CAC) within 24 -72 hours of event.

2. CAC will:

   A) Complete substance abuse history.

   B) Provide addiction education for resident.

   C) Work collaboratively with Psychiatry/Psychotherapy in situations of dual diagnosis.

   D) Assess resident's motivation for Tx.

   E) Recommend treatment regimen and assist unit social worker with referral process.

   F) Document assessment and Tx recommendation in Medical Record.

3. Unit Based Social Worker will:

   a) Arrange IDCT conference to review Tx. plan

   b) Initiate referrals for Tx Programs as defined by CAC

   c) Work with transport coordinator to ensure transportation.

   d) Monitor resident's compliance with and progress in Tx. program.

   e) Keep IDCT abreast of resident's progress in Tx. Program.

f) Counsel resident as appropriate regarding compliance issues.

g) As appropriate and with residents permission, keep family/significant others abreast of situation.

h) Arrange for safe and appropriate discharge of residents when necessary

TLASA

DRAFT	PHILADELPHIA NURSING HOME	EFF. DATE
TITLE:	ASSESSMENT OF RESIDENT WITH ACUTE MENTAL STATUS CHANGE OR SUSPECTED INTOXICATION	PAGE 1 Of 4

I. PURPOSE:

To provide a consistent and predictable response to behavioral changes due to substance abuse and other violations of PNH policies/regulations.

II. POLICY STATEMENT:

A resident's use of any non-prescribed drugs or illicit psychoactive substance, including alcohol, shall be considered substance abuse. Such use places the resident at grave risk for unpredictable medical and/or behavioral reactions and endangers the well-being of that resident, other residents and/or PNH staff.

III. PROCEDURE/RESPONSIBILITY:

1. Any resident with an acute change in mental status, behavior, or in whom acute intoxication is suspected will have a prompt Nursing and Physician assessment, including appropriate diagnostic tests.

2. Any resident who is being treated for chemical dependency or substance abuse, or who is suspected of being intoxicated, who refuses to comply with physician orders for drug or alcohol screening will be considered to be noncompliant with medical evaluation and therapy. She/He may be subject to continued stay assessment with potential for discharge.

3. A resident confirmed to be intoxicated or who refuses a drug screen will be referred to the Social Work Department. The Administrator and Nursing Administrator will be notified.

IV. NURSING STAFF:

1. Will perform an assessment which will minimally include level of consciousness, vital signs, respiratory status, orientation and behavior.

2. Will then immediately notify the Attending or on-call physician and provide the results of the nursing assessment.

3. Will document assessment information or resident's chart, and initiate steps to ensure resident safety

4. When appropriate, due to resident related behavior problems, will complete an incident report.

5. In the event that a urine sample is required for drug screeing a physicians' order must be obtained. Nursing staff will remain with the resident during process of urine collection and insure safe delivery of specimen to the lab.

Physician:

1. Will perform an evaluation minimally including review of resident's history, medication, mental status examination and physical examination. The physician will document evaluation information in the resident's chart. After normal working hours and on weekends, the physician will be notified by phone and the evaluation/ exam will take place the next day.

2. Will order diagnostic tests, with screening for alcohol or other drugs of abuse as appropriate. On evenings, nights, weekends and holidays, urine is to be collected and refrigerated until the next business day.

3. The physician will order treatments including medicaions as appropriate and re-evaluate the resident as appropriate (in not less than 24 hours).

4. If intoxication is suspected and the resident refuses alcohol/drug screening, the Physician will:

   A) Counsel resident that substance abuse services are available

   B) Counsel resident that refusal of medical evaluation may lead to continued stay assessment with potential for discharge

   c) Document resident's response in medical record

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	No. III A 1-4 Eff. Date 1/96 Pages 1 of 2
Title:	Mental Health Services	

PURPOSE: To ensure the provision of adequate and appropriate psychiatric and mental health services in accordance with accepted professional standards to facility residents who require such services.

POLICIES AND RESPONSIBILITIES:

1. Each consultant psychiatrist will have medical staff appointments approved by the Governing Board of Episcopal Long Term Care/Philadelphia Nursing Home to provide psychiatric services to residents of the facility. ELTC/PNH shall procure adequate psychiatric consult hours sufficient to meet the mental health care needs of the residents.

2. The psychiatric fellow, psychiatric nurse practitioners and psychiatric social workers are qualified by academic and practical training and maintain a current license in the Commonwealth of Pennsylvania. The psychiatric fellow delivers care to residents under the supervision of an attending consultant psychiatrist.

Consultant Psychiatrist Responsibilities

1. Each psychiatrist will be assigned specific resident units and be responsible to provide consultant services to residents who require psychiatric services including a comprehensive assessment and/or cognitive examination of resident who present with any or all of the following

   a. Existing diagnosis of mental illness
   b. Currently receiving psychotropic medication
   c. Presenting signs and symptoms of mental illness

   and establish a diagnosis of mental illness consistent with DSM-IV codes as indicated.

2. Each psychiatrist will participate in the development and implementation of a treatment plan consistent with the interdisciplinary care plan for each resident with a diagnosis of mental illness or behavioral symptoms due to dementia and/or delirium. Treatment plans may include any following mental health services consistent with individual resident needs.

   a. Psychopharmacologic therapy
   b. Behavioral interventions
   c. Psychotherapy (group/individual)
   d. Partial Day Psychiatric Hospital Program
   e. Inpatient Hospitalization

3. Each psychiatrist will monitor the effectiveness of the treatment plan on each resident with diagnosis of mental illness consistent with acceptable standards of practice but not less than twice a year.

4. Each psychiatrist will review the use of psychotropic medications consistent with accepted professional standards and adjust medications as indicated by individual resident needs including decrease and/or increase in behavioral symptoms; presence of side effects and gradual dose reductions.

5. The consultant psychiatrist, in cooperation with the interdisciplinary team and the Office of Mental Health as appropriate, will timely evaluate and develop an emergency treatment plan for residents who have recently exhibited violent or threatening behaviors.

Reviewed/Revised
: 12/97

III B4-1

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	Eff. Date 6/95 No. Pages 1 of 3
Title:	Medical Services	

PURPOSE: To ensure that quality medical services are provided to each resident the Philadelphia Nursing Home by a qualified primary care physician and physician assistant.

POLICIES AND RESPONSIBILITIES:

1. Each physician and physician assistant will have medical staff appointments approved by the Governing Board of Episcopal Long Term Care/Philadelphia Nursing Home to provide medical services to residents of the facility.

2. All physicians will meet the appointment criteria as outlined in the physician credential policy.

3. The physician assistant is qualified by academic and practical training and maintains a current license in the state of Pennsylvania. The physician assistant delivers care to residents under the supervision of a licensed physician.

PRIMARY CARE PHYSICIANS RESPONSIBILITIES:

1. Each physician will be assigned specific residents and be responsible for the resident's comprehensive medical care including supervising each residents daily care, prescribing the medical regimen, and establishing appropriateness of consulting and ancillary services. The residents retains the right to be seen or treated by a physician of their own choice. A list of physicians and physician assistants and their resident assignment will be maintained by the Medical Director and Unit Managers and updated as appropriate.

2. Residents will be seen minimally every 30 days and as often as indicated by the residents medical condition.

3. The scope of physician services should include:

A. Recommend that resident be admitted to the facility and document, in own handwriting, initial visit of each new admission.

B. Review the total program of care including medications and treatments at least every thirty (30) days:

C. Sign all orders.

D. Write, sign, and dates progress notes of each visit.

E. Verbal orders may be given by the physician to the registered nurse and must be countersigned within 48 hours.

F. Review resident advance directive status with resident and/or responsible party at time of admission and annually.

G. Countersign all physician assistant/nurse practioners progress notes and orders.

H. Review and sign monthly computer-generated physician orders.

I. Provide 24 hours physician coverage in case of emergency. A schedule of the name of the physician on call will be writing and posted at telephone operators' desk, Medical Director, Assistant Administrator, Director of Nursing, Nursing Office, and each nursing station on a monthly basis.

K. To ensure continuity of care for residents requiring speciality medical services, the primary care will request a consultation for speciality services consistent with resident's medical condition, i.e., Dental Services, Surgical Services, Rehabilitation, etc.

L. Participate in the development and implementation of a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs with the interdisciplinary team.

M. Attend bi-weekly medical staff meetings and participate in ongoing peer review and Quality Assurance programs.

Physician Assistant:

The ~~physical~~ physician will have communication and technical support of designate Physician Assistants.

The Physical Assistant will be responsible for transmitting patient-oriented information to the physical as well as preparing chart entries with reference to progress notes, emergency encounters, admission, and annual histories; some physicals problem lists, transfer notes, and laboratory results. In addition, Physician Assistants and physicians will prepare monthly clinical summaries, review monthly orders and prepare physician interim notes when indicted. In accordance with the Pennsylvania Board of Medical Education and Licensure, the physician assistant will inform the resident that he/she is not a physician and will wear an identification tag using the term "Physician Assistant".

The physician assistants may perform the following duties as delegated by the physician:

1. Obtain a complete medical history.

2. Perform a general physical examination, including accurate measurement of blood pressure and other vital signs.

3. Perform a rectal examination.

4. After data gathering, organize the information and present it to the physician so that the physical can perceive the medical problem and determine the treatment.

5. Draw blood by finger stick and venipuncture.

6. Obtain culture specimens such as sputum, blood, stool, urine, and from the throat and wound for bacteriological examinations.

7. Take an electrocardiogram, reading it for technical accuracy and identifying basic abnormal cardiac rhythms.

8. Test stool specimens for occult blood.

9. Provide patient care information on such matters as specific diagnoses, diets, and other therapy.

10. Catherize the urinary bladder, insert supra pubic tube.

11. Perform cardiopulmonary resuscitation.

12. Write into the medical record.

13. Attend bi-weekly medical staff meeting.

revised
III B 3-3

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

VERBAL ORDER POLICY

POLICY:

Verbal (telephone) orders may be taken only by licensed nursing personnel when the physician is not present on the unit.

(Note: Verbal orders may be taken in a Cardiopulmonary Code situation when the physician is at the bedside.)

PURPOSE:

To ensure the accurate and appropriate provision of care.

PROCEDURE:

1. Verbal (telephone) orders may be taken only by the licensed Registered Nurse in accordance with state law.

2. The nurse taking the order writes as follows:

   EXAMPLE:
   - 9/24/96 1pm v.o. Dr. Burden/Florence Nightingale, RN

3. As the nurse writes the order, she/he will repeat the order to the physician for confirmation.

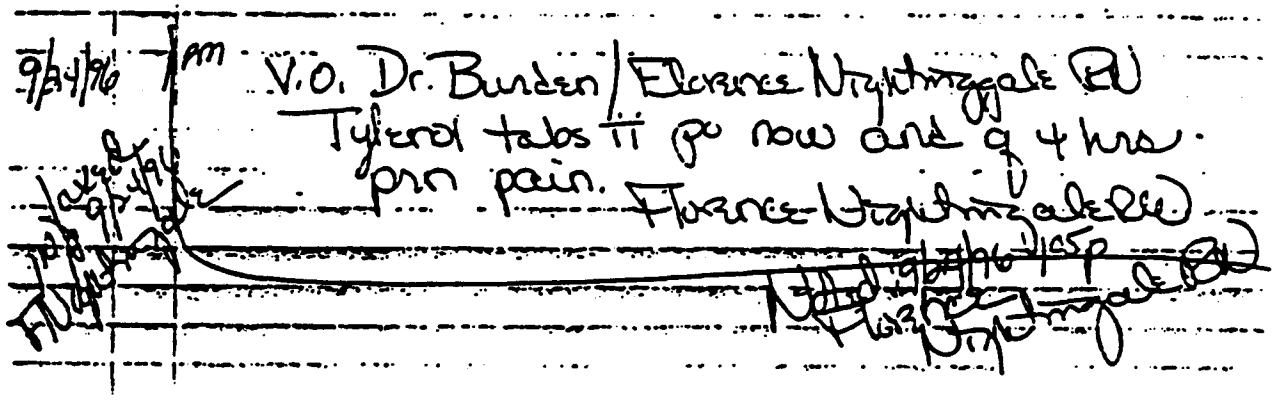
4. The order is written exactly as the physician verbalizes it.

5. The order is signed by the nurse taking the order.

6. The order is then transcribed and noted by the RN who has taken the verbal order.

   a. The RN transcribing the order shall draw a line around the order and sign, time and date the notation of the order.

EXAMPLE:



NOTE: Remember the order must be faxed and the order sheet is marked "faxed" with the date, time and signature of the person faxing the order. Orders are faxed by the pharmacy technician on Mondays to Fridays from 9:30am to 6:30pm, with the exception of holidays that fall within those days.

III B 2-1A

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

TWENTY-FOUR HOUR REPORT FORM

PURPOSE:

The Twenty-Four Hour Report Form is used to communicate pertinent information regarding the condition of the resident who has experienced:

- Admission/discharge for 3 days (5 days on skilled units)
- Change in mental status/behavior changes - as needed
- Change in physical status - as needed
- Change in skin condition - 24 hours
- Incidents - 3 days or until resolved
- Fall or injury - 3 days or until resolved
- Fractures/alleged abuse - 3 days or until resolved
- Medication/treatment error - 3 consecutive days
- Medication refusal, one or more times - as needed
- Transfer to hospital for medical treatment or evaluation - as needed
- Return from hospital following med. treatment or eval. - as needed-
- Change in vital signs, including temperature evaluation - 24 hours
- An invasive procedure - 3 days
- Attempted or successful elopement - as needed
- 1:1 or 1:2 nursing care status - as needed
- Suicidal ideation - as needed
- Death - as needed
- The use of a condom catheter - initial 5 days
- Accu checks, including normal an abnormal values - as needed
  NOTE: All values <60 or> 250 require intervention; notification of MD, written order and nurses' note.
- Significant changes in lab values - 24 hours
- Altercations or abuse - 3 days or until resolve
- Family concerns - as needed
- 302 or 201 - as needed
- Appointment for study or procedure on the following days and the prep for the study or procedure - as needed
- Resident's who are NPO(not to include tube feeding residents)-full course

- Antibiotic Therapy - full course
- Vaccines administered - 24 hours
- Out on pass - until returned
- Calorie Count - full course
- Behavioral outburst - for duration of occurrences of behavioral symptoms
- Any other condition or incident which is reportable to the following shift, supervision, physician or administration - as needed
- Residents in restraint reduction program - initial 7 days

Equipment:

1. 24 Hour Report Form
2. Ball point pen **only**. (Write heavily so that information is clear on all four(4) copies)

A. The 24 Hour Report is a four-part (NCR) form

1. Day shift
2. Evening shift
3. Night shift
4. 24 Hour copy to be retained

B. The 7-3^{30} Charge Nurse will initiate the form by writing the Unit Name and Date in the top margin. (All documentation)

Example:

EPISCOPAL LONG-TERM CARE
PLEASE USE BALL POINT PEN ONLY

1 West : July 9, 1996

24-HOUR REPORT OF PATIENTS CONDITION AND NURSING UNIT ACTIVITIES

C. Pertinent information will be documented on the following:

- Admission/discharge for 3 days (5 days on skilled units)
- Change in mental status/behavior changes - as needed
- Change in physical status - as needed
- Change in skin condition - 24 hours
- Incidents - 3 days or until resolved
- Fall or injury - 3 days or until resolved
- Fractures/alleged abuse - 3 days or until resolved
- Medication/treatment error - 3 consecutive days
- Medication refusal, one or more times - as needed
- Transfer to hospital for medical treatment or evaluation - as needed

- Return from hospital following med. treatment or eval. - as needed
- Change in vital signs, including temperature evaluation - 24 hours
- An invasive procedure - 3 days
- Attempted or successful elopement - as needed
- 1:1 or 1:2 nursing care status - as needed
- Suicidal ideation - as needed
- Death - as needed
- The use of a condom catheter - initial 5 days
- Accu checks, including normal an abnormal values - as needed
  NOTE: All values <60 or> 250 require intervention; notification of MD, written order and nurses' note.
- Significant changes in lab values - 24 hours
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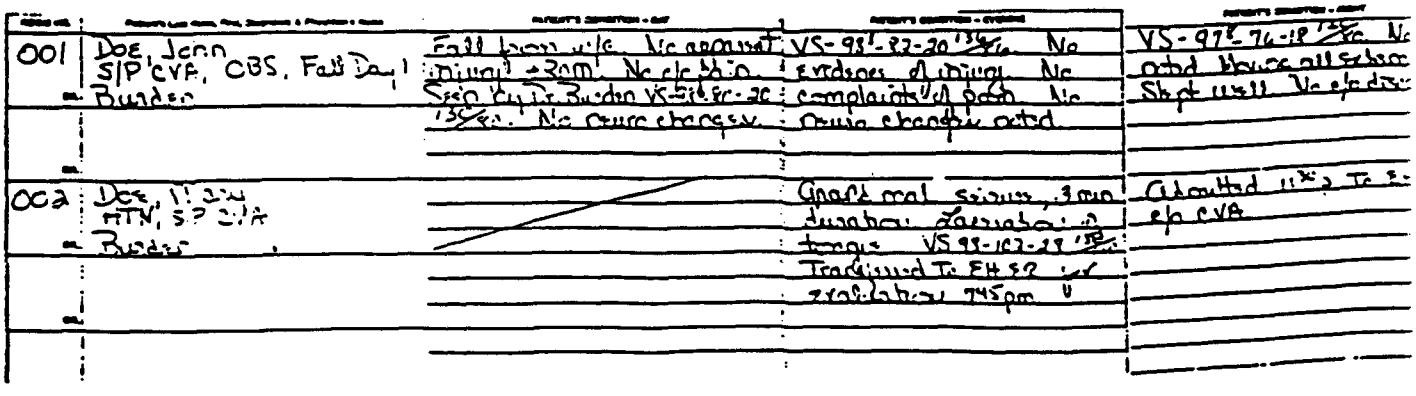
- Antibiotic Therapy - full course
- Vaccines administered - 24 hours
- Out on pass - until returned
- Calorie Count - full course
- Behavioral outburst - for duration of occurrences of behavioral symptoms
- Any other condition or incident which is reportable to the following shift, supervision, physician or administration - as needed
- Residents in restraint reduction program - initial 7 days

D. Document Resident Information (Use ballpoint pen <u>only</u>)

1. The resident's room number in the space provided
2. The resident's full name (last name, first name)
3. The resident's diagnosis
4. The attending physician's name
5. Pertinent information regarding the resident's condition in the space provided.

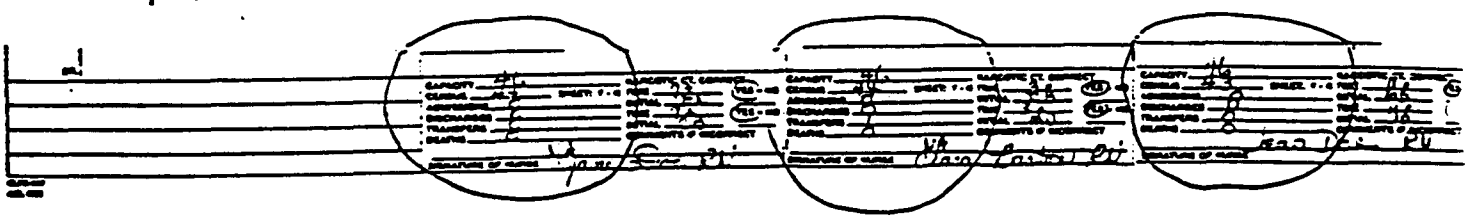
Example:



E. Document logistical Information (use ballpoint pen **only**)

1. Capacity of the unit
2. Census
3. Number of Admissions
4. Number of discharges
5. Number of transfers
6. Number of deaths

Example:



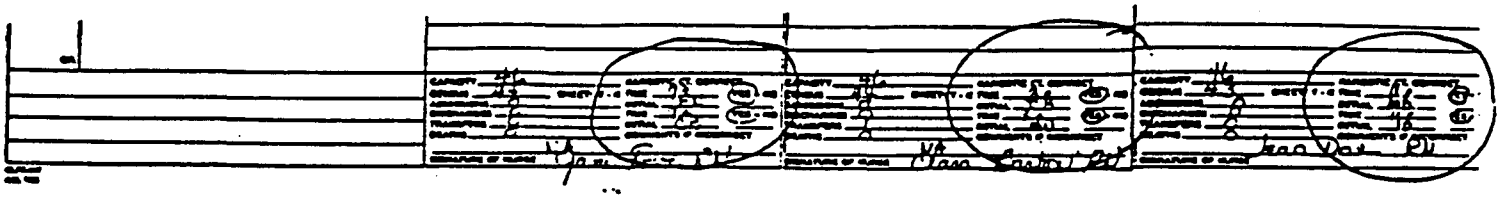
NOTE: When a resident is transferred to the hospital for evaluation, sutures, etc., he/she remain a part of the census. When the resident is admitted to the hospital, he/she is taken off the census, but is not considered a discharge until after he/she has been in the hospital for fifteen (15) days.

F. Document Information regarding narcotic count (use ballpoint pen **only**)

1. Time of narcotic count
2. If narcotic count was correct, circle the word "yes".
3. If narcotic count was incorrect, circle the word "no".
4. The initials of the licensed person from the off-going shift who has counted the narcotics.
5. Time of narcotic count (NOTE: The off-going shift will count narcotics together, so the times of narcotic count will be the same).
6. The initials of the licensed person from the on-coming shift who has counted the narcotics.
7. Comments if incorrect.

NOTE: If the narcotic count is incorrect, it must be reported to the Unit Manager, Supervisor, or Nursing Administration prior to the departure of the charge person/medication nurse from the off-going shift.

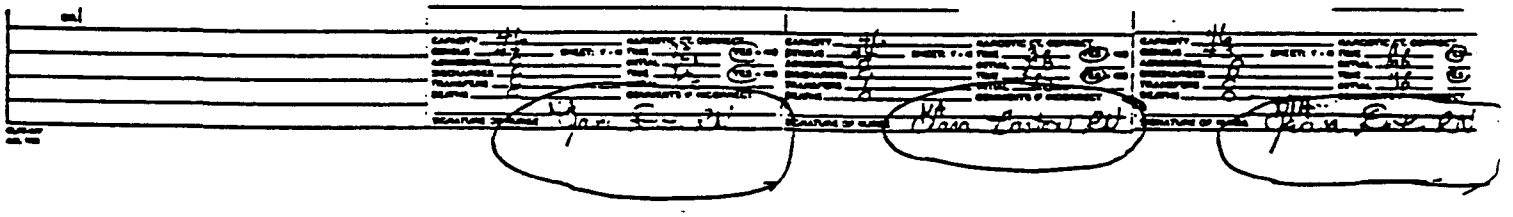
Example:



G. Responsibility

1. The signature of the charge nurse/licensed person documenting data will be placed in the space provided.

Example:



H. Communication

1. The documentation will be reviewed with the staff, including licensed staff and CNA's of the time of report and rounds.

2. The Unit Manager/Supervisor will remove the appropriate sheet at the end of the shift and will review the information with the on-coming supervisory staff at the time of report.

3. The 11^{pm} - $7^{30\ am}$ Supervisory staff will retain the 11^{pm} - $7^{30\ am}$ copy for review by Nursing Administration.

4. The Unit Manager/Charge Nurse will retain the final copy with attached Assignment Forms for the same 24 Hour period and the Resident Accountability Form for that date.

5. The above forms will be maintained in the envelope provided and designated for that calendar month and year.

6. These forms will be retained for seven (7) years.

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

RESIDENTS WHO NEED TO BE ON 24 HOURS REPORT

REASON	PERIOD
Admission/discharge	3 days/5 days on skilled units
Change in Mental status/behavior changes	as needed
Change in physical status	as needed
Change in skin condition	24 hours
Incidents	3 days or until resolved
Fall or Injury	3 days or until resolved
Fractures/alleged abuse	3 days or until resolved
Medication/treatment error	3 consecutive days
Medication refusal, one or more times	as needed
Transfer to hospital for medical treatment or evaluation	as needed
Return from hospital following medical treatment or evaluation	as needed
Change in vital signs, including temperature evaluation	24 hours
An invasive procedure	3 days
Attempted or successful elopement	as needed
1:1 or 1:2 nursing care status	as needed
Suicidal ideation	as needed
Death	as needed
The use of a condom catheter	initial 5 days
Accu-check, including normal and abnormal values	as needed
Significant changes in lab values	24 hours
Altercations or abuse	3 days or until resolved
Family concerns	as needed
302 or 201	as needed
Appointment for study or procedure on the following days and the prep for the study or procedure	as needed
Resident's who are NPO (excluding those getting tube feedings)	full course
Antibiotic Therapy	full course
Vaccines administered	24 hours
Out on pass	until returned
Calorie Count	full course
Behavioral outburst	for duration of behavioral symptoms
Any other condition or incident which is reportable to the following shift, supervision, physician or administration	as needed
Residents on restraint reduction program	initial 7 days

PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

MEDICATION PROCEDURES

I. Medication Ordering Procedures

A. New medication ordering procedure: written and oral

1.) All new drug orders, including new admissions orders, shall be transcribed from the physician's order sheet to the Medication Administration Record by the nurse taking the order from the physician. (All readmission orders will be transcribed to a new Kardex.)

2.) From Monday to Friday (excluding holidays) from 9^{30}AM to 8^{30}PM. The order sheet is placed in the Pharmacy bin at the Nurses' Station and is picked up by the Pharmacy Tech, who faxes the orders to the Pharmacy and takes the order sheet to the in-house pharmacy. The Pharmacy Tech then returns the order sheet to the unit.

On weekends, holidays and from 6^{30}PM to 9^{30}AM, the order sheet is faxed to APS Pharmacy by the Nursing Supervisor or designee and is replaced in the resident's chart.

In all instances for new orders, signed physician order sheets are to go to the pharmacy on the 8th day and the 20th day of the month. (see Recap procedure).

3.) Noting or implementation of the Medication order:

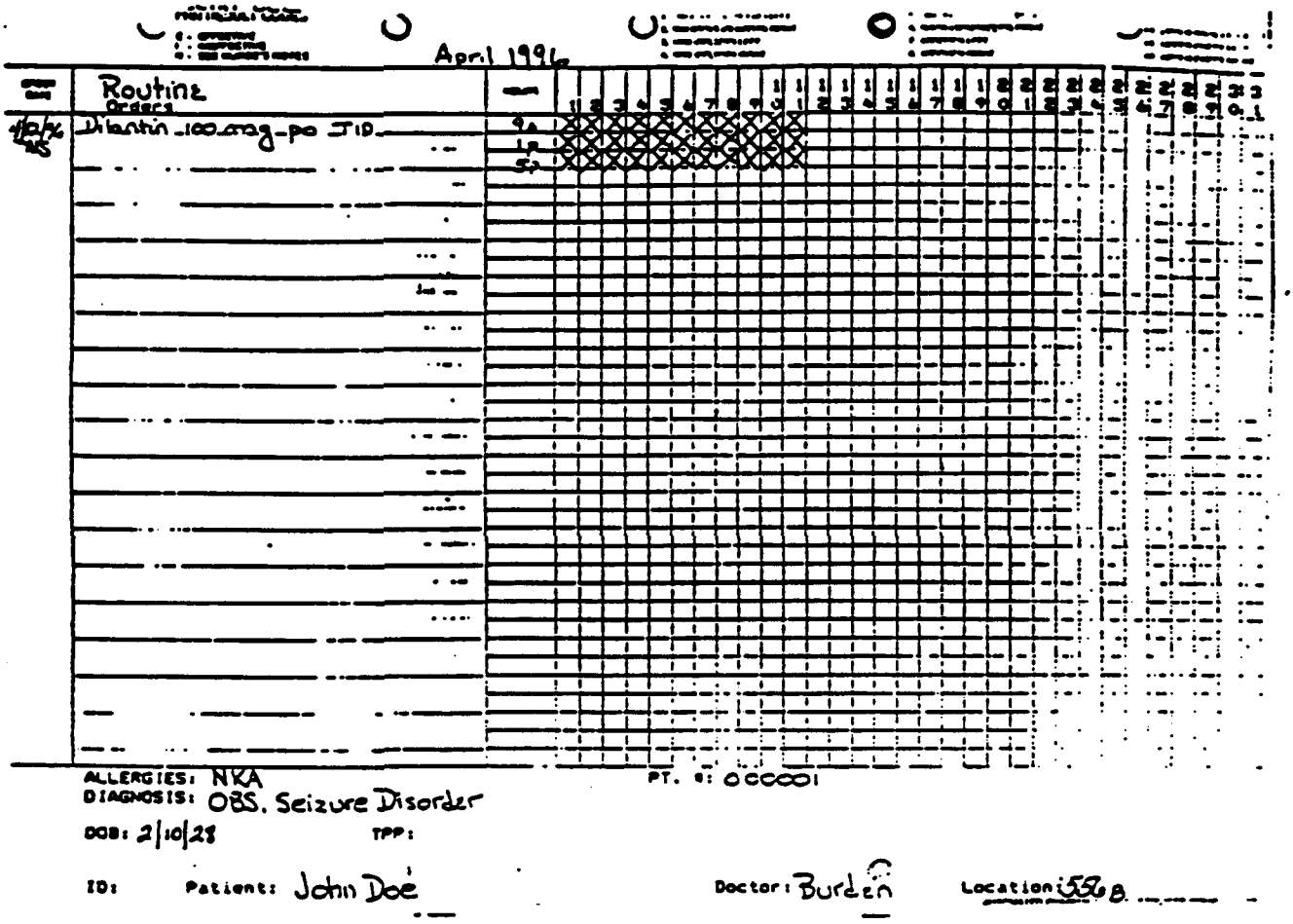
a. The licensed nurse will read the order. IF THE ORDER IS NOT CLEAR TO THE NURSE, THE ATTENDING OR THE ON CALL PHYSICIAN WILL BE CONTACTED FOR CLARIFICATION.

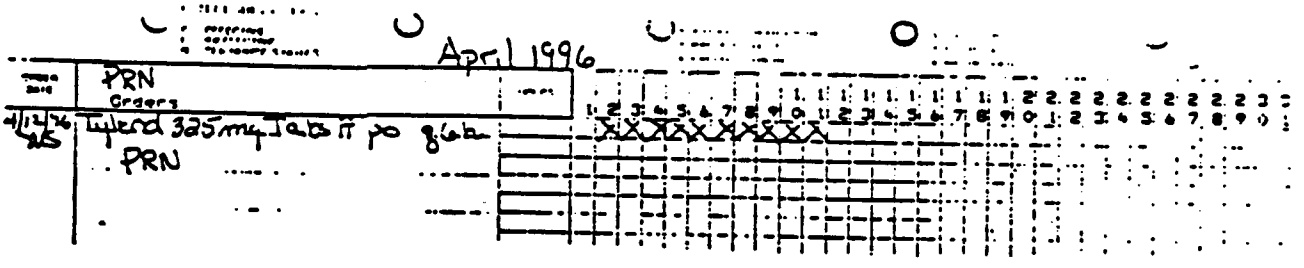
b. The nurse then communicates the medication order to the pharmacy via fax, or by placing the order in the pharmacy bin.

c. The medication order is then listed on the medication administration record of the resident.

d. The spacing and arrangement takes into consideration whether the order is a routine or a PRN medication. Note: There are separate Kardexes for:

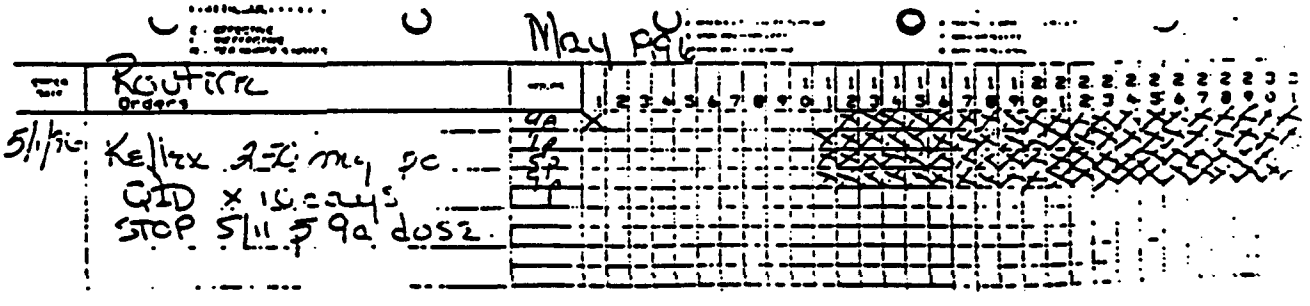
- Routine medications
- PRN medications
- Nutritional supplements





e. If the order is time limited or is limited to a certain number of doses, the nurse shall so indicate on the administration record.

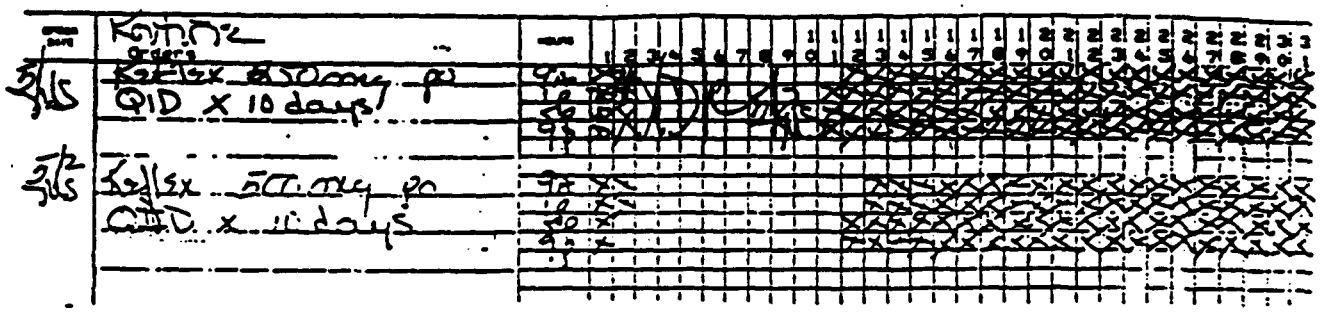
EXAMPLE:



4.) Change in Order:

a. When a new order changes in dosage or intervals of doses on a current medication, the previous listing is discontinued on the medication administration record and the new order is entered in a new space on the form.

EXAMPLE:



5.) For new admissions, medication orders may be added to the pre-printed admission physician's order and faxed to the pharmacy. The word "faxed", date, time and initials of the person faxing the orders are to be written beside the orders.

EXAMPLE:

PHILADELPHIA NURSING HOME DATE: 4/12/96

PATIENT NAME: John Doe
DOB: 2/10/29
IPP:
ALLERGIES: NKA
DIAGNOSIS: CBS, Seizure Disorder

DOCTOR: Burden
LOCATION: 556B
ADM DATE: 4/12/96
PT. #: ccccc

ADMISSION ORDER SHEETS

1: DIET: House
2: ACTIVITIES PLAN ACCEPTED AS RECOMMENDED
3: MAY GO OUT ON PASS WITH FAMILY. MEDICAL CONDITIONS PERMITTING
4: OUT OF BED WITH ASSISTANCE AS TOLERATED
5: EKG. U/A. CBC. CX RAT UPON ADMISSION AND YEARLY THEREAFTER
6: DENTAL CONSULT WITHIN 6 MONTHS THEN PRN
7: PODIATRY CONSULT PRN
8: LAB:
9: PT. OT. ST. SCREENED ON ADMISSION
10: PATIENT SOCIAL SECURITY NUMBER ccc-cc-cccc
11: Dilantin Level in am
12: Dilantin 100 mg po TID.
13: Tylenol 325 mg Tabs II po q 6 h prn

faxed 4/12/96 pm JDoe

PHYSICIAN ACCEPTS PLAN OF CARE..YES....NO
REHAB POTENTIAL - EXCELLENT....GOOD..✓..FAIR....POOR....NONE....
RESIDENT REQUIRES SNF..... HEAVY ICF..✓..... ICF..... LEVEL D
REVIEWED BY ...Jane Doe. RN..... DATE 4/12/96
PHYSICIAN SIGNATURE..... DATE 4/12/96
NOTED BY ...Jane Doe. RN..... DATE 4/12/96

6.) When the entire procedure is completed, the nurse shall write "noted", date, time and signature on the physician's order sheet.

EXAMPLE:

PATIENT NAME: John Doe
DOB: 2/10/96
ALLERGIES: NKA
DIAGNOSES: CBS, Seizure Disorder
DATE: 4-13-96
DOCTOR: Burden
LOCATION: 556B
ADM DATE: 4/12/96
PT. #: 000001

Physician's Order

GENERIC SUBSTITUTION PERMISSIBLE UNLESS PHYSICIAN STIPULATES DO NOT SUBSTITUTE

4/13/96 5P Change dilantin to 100mg po QID
J. Burden
4/13/96 5P
Jane Doe RN
4/13/96 5P
5 QDoeRN

7.) a. When a resident is admitted to the hospital, the medication and treatment Kardexes are marked "Resident admitted to hospital" and the date's entered.

b. The Medication and Treatment Kardexes are placed in the resident's chart in the area designated for medications.

c. When the resident returns to the facility, <u>new</u> Kardexes are written, according to the new orders, and are placed in the Medication Kardex holder.

8.) ORDERING FOR REFILL OF MEDICATION SUPPLY NO UNIT DOSE

a.) Drug orders are to be refilled when a three day supply of the prescription remains. The nurse shall list the medication on the Medication Order Sheet/Action Request Form, being careful to note any change in dosage or interval which has occurred since the original drug order date.

EXAMPLE:

AUTOMATED PHARMACEUTICAL SERVICES
MEDICATION ORDER SHEET
ACTION REQUEST SHEET
UNIT: PNH
ROOM: 556
NURSE: Jane Doe RN
DATE: 4/12/96

Room #	Bed Desig	Patient Name	Drug Name	Strength	Direction	Doctor	Progress Notes
556A	A	John Doe	Trusopt	2%	Tattood Burden		
			Ophthalmic Soln.		TID, monitor		
					BP closely		

Key Codes: A - Add/Order; D - Change; C - Discontinue; E - Other

Note: This form is also used to communicate new allergies, room changes, discrepancies noted in medications received from pharmacy and any other communication that cannot be accomplished by faxing the order (see Recap Policy and Procedure).

b.) Emergency refills may be telephoned to the pharmacy to expedite delivery.

8.) Obtaining missing doses of medication:

a.) See Section Titled "Drug Administration Procedures" Subsection A3g. "Replacement of missing doses".

9.) Receiving drug orders from the pharmacy:

a.) Any shortage or other problem with the order is to be documented on the daily medication order sheet and communicated to pharmacy.

b.) Before using any prescribed drug, the nurse shall verify the label content with the order in the resident's health record.

10.) Use of resident's previously acquired personal medication:

The facility prohibits the use of previously acquired medications from home or other facilities.

II. Drug Administration Procedures

NO MEDICATION IS TO BE ADMINISTERED TO A RESIDENT WITHOUT A VALID ORDER ON THE PHYSICIAN'S ORDER SHEET.

A. Procedures for the Administration of Medications

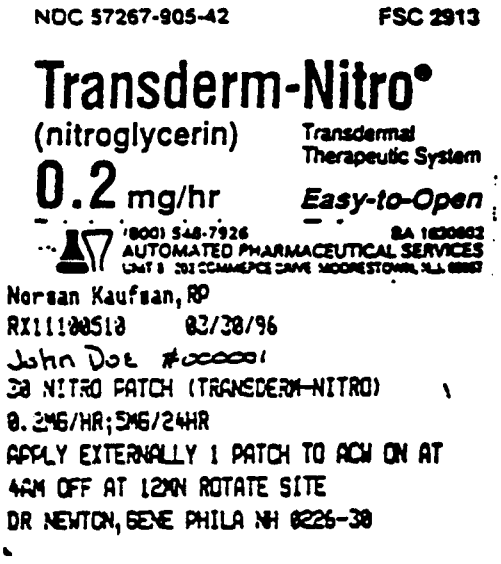
Note: Before any medications are administered, the nurse must positively identify the resident by reading the resident's ID bracelet and by the photograph on the Medication Administration Record.

1.) When Administering oral medication the following procedures apply:

a.) The medication name, dosage and interval will be read from the medication administration record.

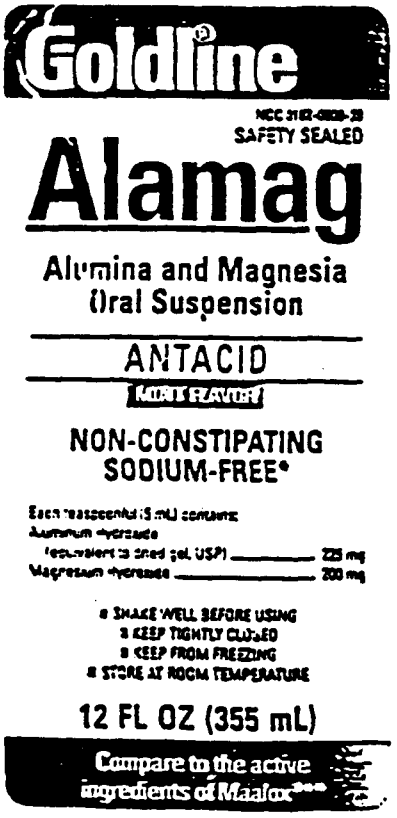
b.) The label on each unit-dose medication container will be read twice, when taking it from the drawer of the cassette, and before opening the package, and compare this package to the medication sheet.

EXAMPLE:



c.) The label on each non-unit dose medication will be read three times, when taking it from the shelf, drawer or cart, before pouring it and when putting it back in the cart.

EXAMPLE:



d.) When it is necessary to calculate a dosage, the licensed person will refer any questions to the supervisor or pharmacist.

e.) To assure administration accuracy, the nurse will cross check the following reference points:

Physician's order - Medication Administration record
Medication Administration Record - label on drug container
Label on drug container - Physician Order

f.) If the medication is suspension or emulsion, the bottle shall be shaken before each measurement of a dose.

g.) To pour a liquid medication dose, the bottle is held with the label in the palm of the hand in order to avoid spilling on the label.

h.) When measuring liquid medications, the medicine cup is held at eye level and desired volume on the cup is marked with the thumb and the volume is read at the LOW LEVEL OF THE MENISCUS.

I.) Tablets and capsules are handled so that the fingers do not touch them.

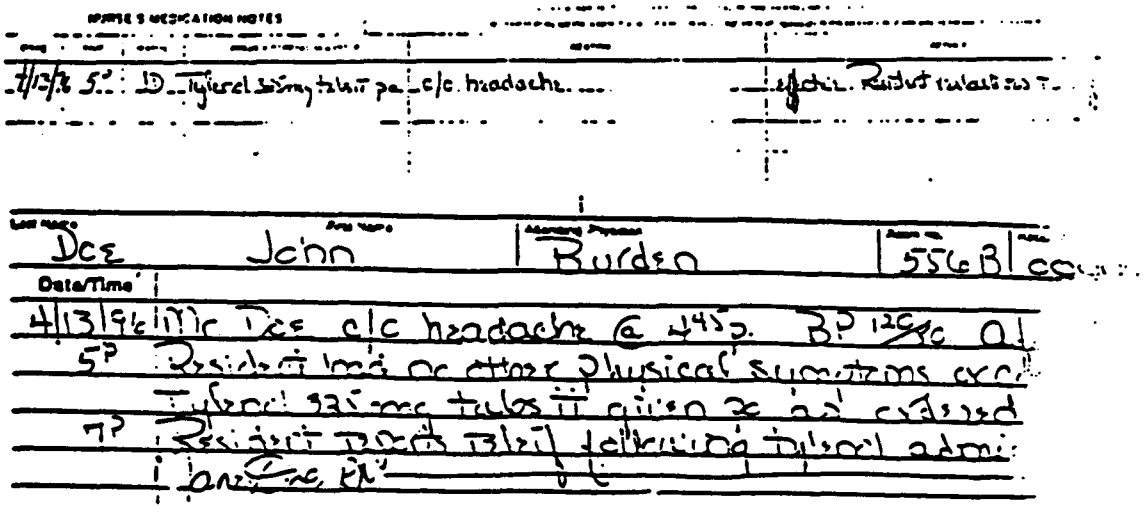
j.) Medications are given at the time or within 60 minutes on either side of the designated time.

k.) The nurse administering the medication remains with the resident until medicine is swallowed.

l.) The medication is charted IMMEDIATELY after administration.

m.) When charting administration of any PRN medications, the nurse will include full details including resident's symptoms, method, route and time of administration, affect of medication and signature in the nurse's notes. If the resident 's condition warrants, a nurse's note is entered in the Nurse's Progress Notes.

EXAMPLE:



NURSE'S MEDICATION NOTES

4/13/96 5P | D Tylenol 325 mg tabs II po | c/o headache | effect: Resident relates no

Last Name	First Name	Attending Physician	Room #
Doe	John	Burden	556 B

Date/Time	
4/13/96 11P	Dr Doe c/c headache @ 4:45p. BP 129/80 A
5P	Resident has no other physical symptoms exc. Tylenol 325 mg tabs II given & as ordered
7P	Resident reports relief following Tylenol admin. [illegible]

2.) Administering Hypodermic Medications, the following instructions apply:

a.) Only medications for which a doctor's order will be given.

b.) The hands are to be washed before preparing the hypodermic medications.

c.) The gauge of the needle is elected according to the consistency of the drug to be administered (i.e., 21G for heavy suspensions, 25G for light suspensions).

d.) The standard length for an IM needle is 1½ inches, however for very thin residents, a 1 inch needle may be better.

e.) The length of the needle is determined according to the site to be used, the weight and tissue turgor of the individual resident and the drug to be given.

f.) The label of the medication to be administered is checked three times.

g.) The procedure is explained to the resident and the injection is administered in privacy.

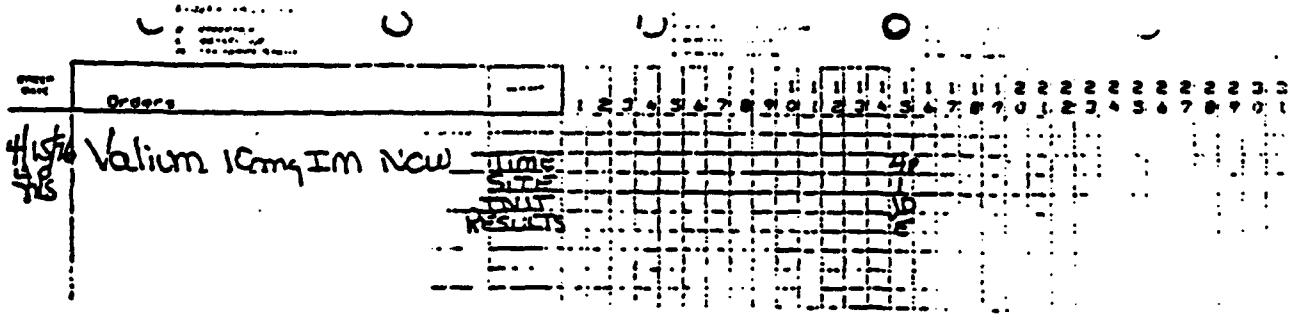
h.) If a series of injections are being given to the same resident the injection sites are rotated to ensure adequate absorption and lessen discomfort.

l.) The different injection sites are indicated when charting the medication.

EXAMPLES:

INJECTION OR APPLICATION SITE NUMBERS

1. BUTTOCKS (GLUTEUS) LEFT
2. BUTTOCKS (GLUTEUS) RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. THIGH (QUADRICEPS) LEFT
6. THIGH (QUADRICEPS) RIGHT
7. ABDOMEN LEFT
8. ABDOMEN RIGHT
9. UPPER BACK LEFT
10. UPPER BACK RIGHT
11. UPPER CHEST LEFT
12. UPPER CHEST RIGHT



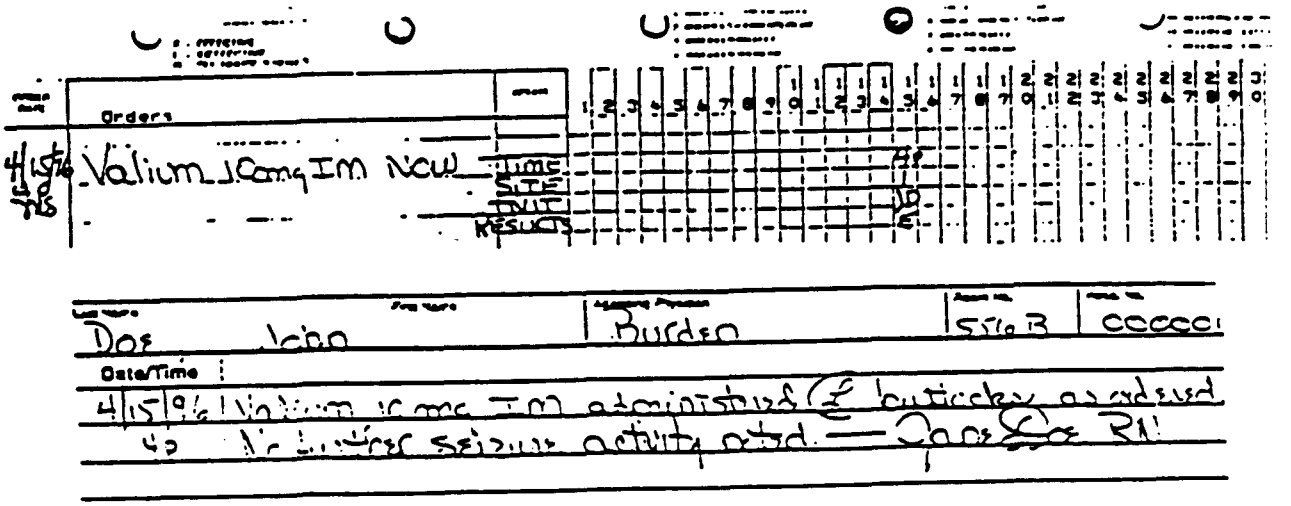
j.) The site for injection is selected and exposed according to the route or administration (i.e., IV, IM, SQ). Upon completion of the injection, the needle is withdrawn from the injection site and the area massaged very gently.

k.) For policies on the administration of IV medications, refer to the nursing manual.

l.) After administration of the hypodermic injections, the syringe is disposed of in accordance with State regulations (see section "Syringe Inventory and Control".).

j.) The injection is charted by recording the time, site, results if applicable and the name and title of the person administering the injection. When the resident's condition warrants, a note is entered on the Nurse's Progress Notes.

EXAMPLE:



3.) Insulin injection - insulin is measured in units and available in 100 units per cc.

a.) Insulin is given subcutaneously rotating the site of injection (i.e. arm-area, thighs-anterior, abdomen).

b.) Time of onset and duration of the commonly used insulin are as follows:

Preparation	*Action*	*On-set*	*Peak*	*Duration*
Regular Insulin	Short	1/2hr. - 1 hr.	2-4hrs.	6-8 hrs.
Semilente Insulin	Short	1/2 hr - 1 hr.	2-8hrs.	8-16 hrs.
Lente Insulin	Intermediate	1-3 hrs.	6-12 hrs.	13-16 hrs.
NPH Insulin	Intermediate	1-2 hr.	6-12 hrs.	13-16 hrs.
Ultra Lente Insulin	Long	4-6 hrs.	14-24 hrs.	36 hrs.
70 % NPH, 30% Regular	Premixed	1/2 hr.	2-12 hrs.	18-24 hrs.

4.) Charting

a.) The nurse administering a medication is responsible for charting the drug.

b.) Charting of medication will be kept current and is completed IMMEDIATELY following the administration of the drug.

c.) The nurse responsible for medications will not report off duty without first checking his/her charting of the medications which he/she administrated. Subsequent administration intervals depend on his/her recordings.

d.) Each dose of medication will initiated on the daily medication report after administration of the drug. The nurse verifies her initial with full signature and title in the space provided on the individual Medication Administration Record Sheet.

EXAMPLE:

INITIALS	FULL SIGNATURE	TITLE
JD	Jane Doe	RN

e.) Medications that are given on an as needed basis, PRN, will be recorded in the nurse's notes on the reverse of the Medication Administration Record. Charting shall include:

- The resident's subjective symptoms or complaints.
- The results of the medication given.
- The nurse's initials.

EXAMPLE:

PRN RESULT CODES

E - EFFECTIVE
I - INEFFECTIVE
N - SEE NURSE'S NOTES

JD Jane Doe RN

NURSE'S MEDICATION NOTES

DATE	TIME	GIVEN	SIGN - TITLE	REASON	RESULT
4/15/96	2p	JD	Demerol 50mg po	pain in left shoulder	effective within 1 hour. JD

5.) Refused, withheld or regurgitated medications.

a.) If a dose of regular interval medication is withheld, refused or regurgitated, the nurse's initials are circled.

b.) A full explanatory note is written on the nurse's notes in back of the medication sheet.

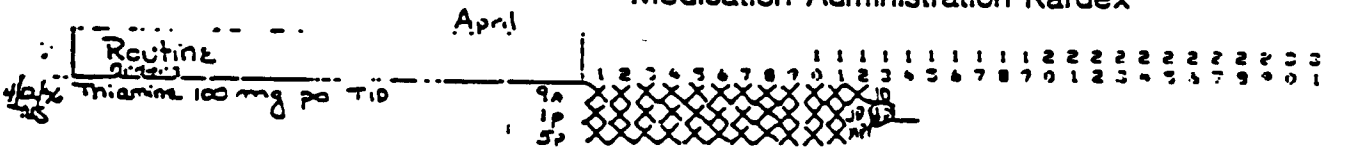
c.) If medication is refused or withheld, the physician will be called and his/her responsive orders will be recorded in the doctor's orders, in the nurse's notes and on the 24 hour Report Sheet.

1. Include on the 24 hour Report Sheet

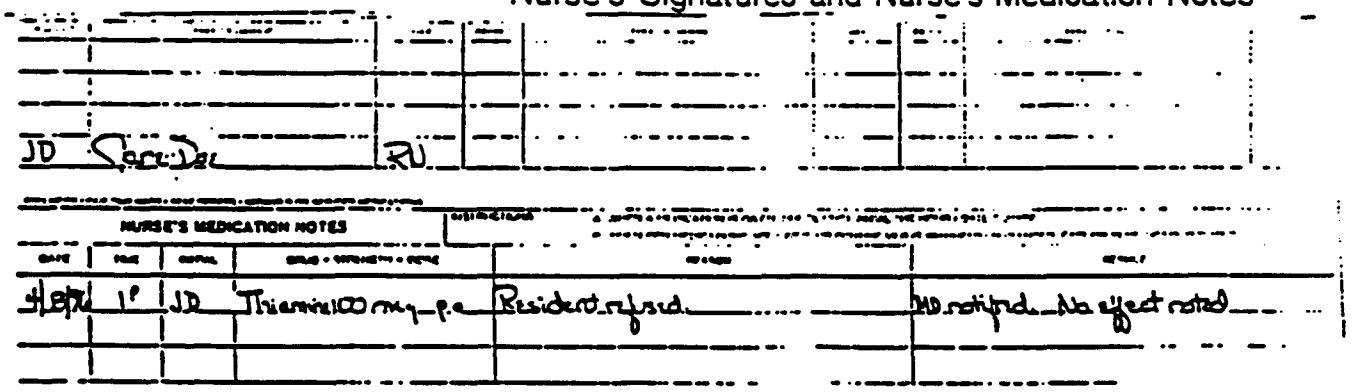
- Drug
- Dose
- Physician notified

EXAMPLES:

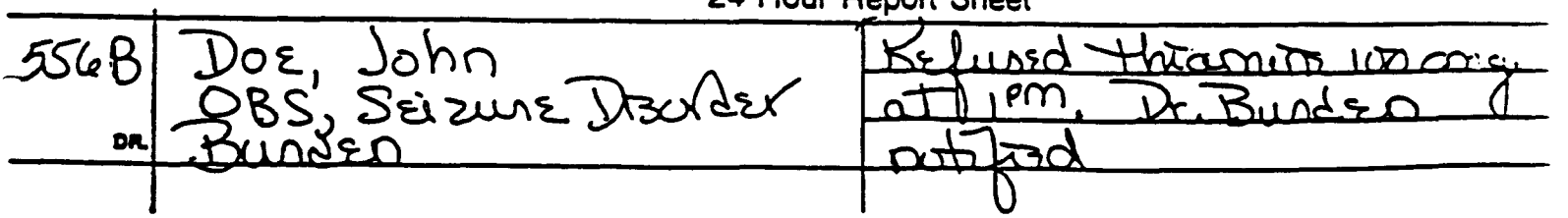
Medication Administration Kardex



Nurse's Signatures and Nurse's Medication Notes



24 Hour Report Sheet

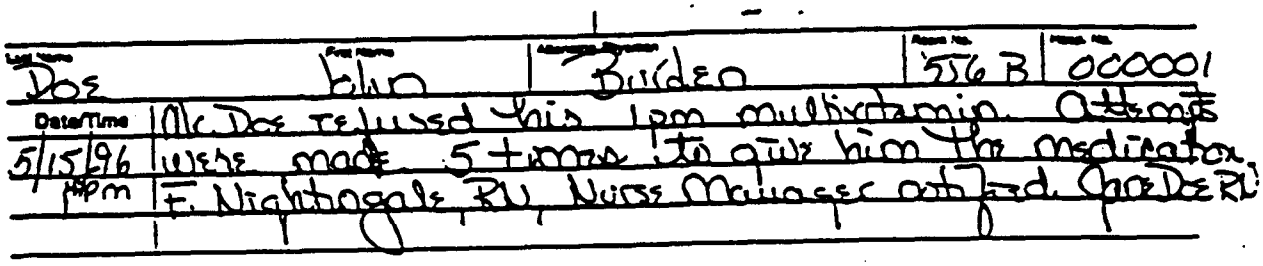


d.) In the Nurse Notes, document:

1. The number if attempts made to give the resident his medication.

2. The notification of the Nurse Manger/Nursing Supervisor.

EXAMPLE:



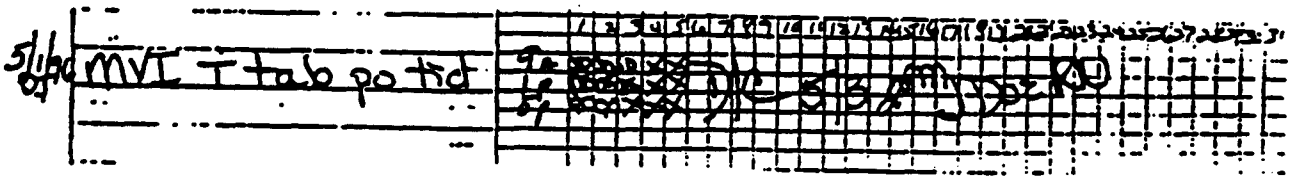
6. When a drug is discontinued, the following procedure will be followed:

a.) An "x" will be placed in the spaces designated for administration for the next two days.

b.) The word "D/C", the date, time and initials of the nurse will be placed after the "x"s.

c.) The entire entry will be highlighted with yellow highlighter.

EXAMPLE:

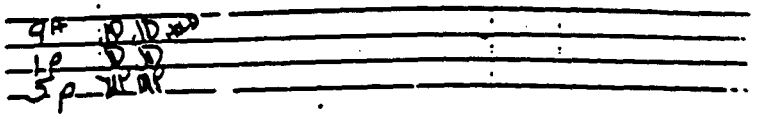


7. When the physician orders a drug to be held, the word"HOLD" will be placed in the box designated for administration.

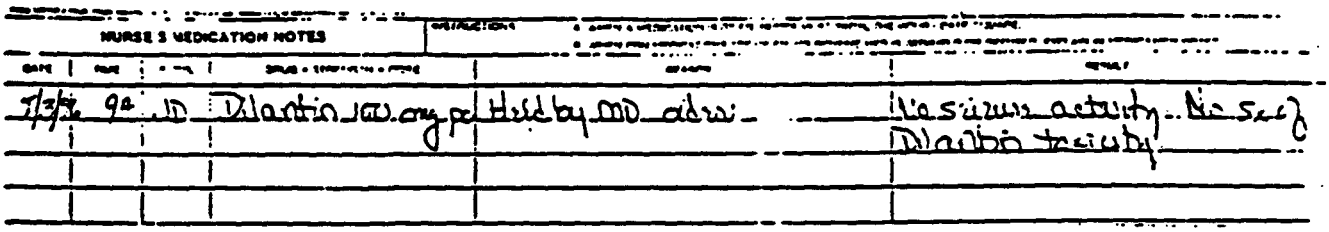
EXAMPLES:

ORDER - "Hold AM dose of Dilantin 100 mg on 5/3/96."

5/1/96 MS Dilantin 100 mg po tid



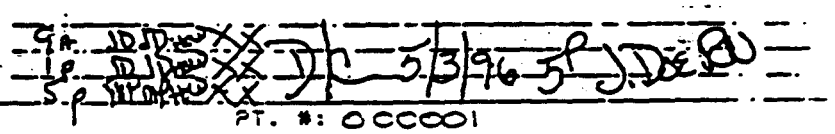
And a notation will be made in the nurses' medication notes on the reverse side of the medication Kardex.



a.) If a medication is held for 24 hours, it is automatically discontinued and a new order must be written.

EXAMPLE:

5/1/96 MS Dilantin 100 mg po tid



ALLERGIES: NKA
DIAGNOSIS: OBS. Seizure Disorder
PT. #: 000001

8. In the event that the pharmacy has not sent a prescribed medication or has sent an incorrect medication, the following steps should be taken to ensure that the resident receives his/her required dose:

a.) Notify the Nurse Manager/Nursing Supervisor

b.) Retrieve the medication from the back up pharmacy. If the medication is not available from this source, the nurse must:

c.) Call APS, who will contact the satellite pharmacy.

d.) Charting that the medication was "Not Available" is **not acceptable.** (There is always a mechanism to secure medications on a 24 hour basis.)

B. The following are policy statements covering the administration non-controlled drugs:

1.) Only licensed personnel are assigned responsibility for preparing,

administering and recording of medication, or have access to drug storage areas at each nursing station.

2.) Medication will always be prepared and administered by the same licensed personnel. Medications are to be administered promptly after being prepared.

3.) Only licensed personnel, (i.e. RN, LPN) are allowed to pass medications to residents.

4.) Medications supplied for one resident are not administered to another resident.

5.) Medication errors and untoward drug reactions are immediately reported to the attending physician, charted in detail on the nurse's notes and described on an incident report and a medication error report (see attached), and documented on the 24 hour Report Sheet.

6.) Personnel administering drugs will refer to the PDR or its equal when unfamiliar with the pharmacology of the drugs, its potential toxic effect and contraindications.

7.) There is a current PDR or its equivalent for convenient drug reference available at each nursing station. The provider or consultant pharmacist is responsible for providing additional drug information as needed.

8.) There is an adequate supply of disposable containers provided by the facility for the administration of drugs. No disposable container used in the administration of drugs will be re-used.

9.) When measuring dosage of non-unit dose concentrates (i.e. Haldol OR Thorazine) and the required dose does not appear on the calibrated dropper, the dose will be obtained by filling the dropper to a higher dose and dropping it to a lower dose (i.e., for ½ mg. of Haldol, fill dropper to 1½ mg. And drop it into a medication cup , to 1 mg.). The drug in the medication cup will be ½mg.

10.) Hours of administration:

OD	=	9:00AM
BID	=	9:00AM, 5:00PM
TID	=	9:00AM, 1:00PM, 5:00PM
QID	=	9:00AM, 1:00PM, 5:00PM, 9:00PM
HS	=	9:00PM
AC	=	No longer than ½ hour **before** meals
PC	=	No longer than ½ hour **after** meals

Q12H = 9:00AM, 9:00PM
Q8H = 1:00AM, 9:00AM, 5:00PM
Q6H = 12:00AM, 6:00AM, 12:00PM 6:00PM
Q4H = 1:00AM, 5:00AM, 9:00AM, 1:00PM, 5:00PM, 9:00PM
Insulin Daily = 7:00AM
Insulin Bid = 7:00AM, 4:00PM

11.) The nurse has the right to adjust the time of drug administration up to 60 minutes to avoid drug interactions.

12.) Respiratory medication - respiratory therapist will be giving the respiratory treatments at the following times:

QID = 7:00AM, 11:00AM, 3:00PM, 6:30PM
TID = 7:00AM, 12:00PM, 6:00PM
BID = 7:00AM, 6:00PM

At the end of the 12 hour shift, respiratory will give meds, (previously dispensed by APS pharmacy), to nursing for the residents who receive around the clock therapy.

C. The following are policy statements concerning the administration of controlled drugs:

1.) In addition to the policies and procedures listed under non-controlled drugs, the following apply:

A.) All non-unit dose controlled drugs shall be counted by two licensed personnel at <u>each shift change.</u> One licensed personnel from each shift will be responsible to count controlled drugs together.

B.) A record of this count is entered on the control order sheet. The sheet is retained for at least five years.

EXAMPLE:

Unit: 5 NE

REVISED 4/96

DATE	TIME	NAME	COMMENT/ DISCREPANCY	REPORTED TO	EMERGENCY BOX/CLOSET
4/12/96	7 AM	[illegible] RN	~~0~~	N/A	✓
	3 PM	[illegible] RN	~~0~~	N/A	✓
	11 PM				

C.) If a controlled substance is wasted, the signatures of two nurses are required (see section entitled, "Disposal of Drugs" Subsection E).

III C3-2

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

RESIDENT MEDICATION REFUSAL

POLICY:

When a resident refuses medication, the drug, dose, and time of refusal shall be documented on the medication kardex and the Twenty-Four Hour Report Sheet. The physician shall be notified.

PROCEDURE:

1. Explain to the resident in layman's terms the reason for the medication, the therapeutic advantages and the disadvantages of not taking their medications.

2. Offer the resident a beverage or snack of their liking to consume with their medications.

3. If family members / friends are visiting, please elicit their assistance in encouraging the resident to take their medications.

4. Try more than once to encourage the resident to take their medications. Document number of attempts made.

5. If the resident addresses concerns regarding the volume of drugs to be taken at one time or preference for liquid medication, please discuss the resident's drug regime with the attending physician and request a change.

6. If the resident comments on the unpleasant taste of the medication, with the residents agreement, mix the mediction in a beverage or soft food product (for example, juice or pudding).

7. If the resident continues to refuse to take the medication, document the drug, dose, time of refusal on the back of the medication kardex.

8. Notify the physician of the resident's refusal to take the medication.

Revised 12/97

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

NARCOTIC AND BARBITURATE COUNT PROCEDURE

POLICY:

Narcotic count is completed every eight (8) hours at the change of shift by the Nurse going off duty and the nurse coming on duty. Each nurse is responsible to sign the Narcotic and Barbiturate Check Sheet.

Emergency equipment is checked every shift and is present and available on each unit.

PURPOSE:

In order to comply with Federal Laws governing schedule II drugs and in order to ensure the maintenance of accurate narcotic and barbiturate counts and to maintain a record of those counts, the Narcotic and Barbiturate Check Sheet is completed.
In order to ensure the availability of emergency equipment at all times on each unit.

PROCEDURE:

1. Using a pen, document the units's name in the space provided.

2. Document the date.

3. At 7:00 a.m. change of shift, the 11:00 p.m. - 7:30 a.m. nurse and the 7:00 a.m. - 3:30 p.m. nurse will count the narcotics and barbiturates.

4. Each nurse will sign his/her name in the spaces provided.

5. At the 3:00 p.m. change of shift, the 7:00 a.m. -3:30 p.m. nurse and the 3:00 - 11:30 p.m. nurse will count the narcotics and barbiturates.

6. Each nurse will sign his/her name in the spaces provided.

7. At the 11:00 p.m. change of shift, the 3:00 p.m. - 11:30 p.m. nurse and the 11:00 p.m. - 7:30 a.m. nurse will count the narcotics and barbiturates.

8. Each nurse will sign his/her name in the space provided.

EXAMPLE:

Unit: 5N

DATE	TIME	NAME	COMMENT/ DISCREPANCY	REPORTED TO	EMERGENCY BOX/CLOSET
9/25/96	7 AM		✓	NA	✓
	3 PM		✓	NA	✓
	11 PM		✓	N/A	✓
9/26/96	7 AM		✓	NA	✓
	3 PM		✓	NA	✓
	11 PM				

9. When the nurse works a double shift on the ICF units and he/she is the only scheduled licensed person, the supervisor or another licensed person from another unit will count narcotics/barbiturates with the scheduled nurse.

10. When a discrepancy is found in the count, the discrepancy is documented in the space provided and the discrepancy is reported to the unit manager or supervisor immediately.

    a. The name of the person the discrepancy is reported to is written in the space provided.

EXAMPLE:

9/26/96	7 AM		✓	NA	✓
	3 PM		✓	NA	✓
	11 PM				✓
	7 AM				

    b. An incident report is initiated regarding the discrepancy.

    c. An investigation of the missing narcotic/barbiturate shall take place.

11. If no discrepancy is found, a zero mark (~~0~~) is placed in the space provided.

12. The presence of the emergency box in the medication room is checked and the expiration date is checked.

13. The emergency equipment in the emergency closet is checked against the equipment checklist.

14. When both the emergency box is present and current and the appropriate equipment is found to be present in the emergency closet, a check mark ( ) is placed in the space provided.

EXAMPLE:

DATE	TIME	NAME	COMMENT/ DISCREPANCY	REPORTED TO	EMERGENCY BOX/CLOSET
9/25/96	7 AM	[illegible]	⊖	NA	✓
	3 PM	[illegible]	⊖	NA	✓
	11 PM	[illegible]	⊖	NA	✓
9/26/96	7 AM	[illegible]	⊖	NA	✓
	3 PM	[illegible]	⊖	NA	✓
	11 PM				

a. If the emergency box is not present or has expired, a notation is placed in the space provided regarding the action taken.

b. If equipment in the emergency closet is missing or outdated, a notation is placed in the space provided regarding action taken.

EXAMPLE:

9/26/96	7 AM	[illegible]	⊖	NA	✓
	3 PM	[illegible]	⊖	NA	—
	11 PM	[illegible]	discrepancy missing	Alice Fisher, Supv	✓
9/27/96	7 AM	[illegible]	⊖	NA	✓
	3 PM	[illegible]	⊖	NA	outdated Replaced
	11 PM	[illegible]	⊖	NA	✓

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

Narcotic & Barbiturates Check Sheet

Unit: _____

DATE	TIME	NAME	COMMENT/ DISCREPANCY	REPORTED TO	EMERGENCY BOX/CLOSET
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11PM				

Revised 4/98

Philadelphia Nursing Home
Episcopal Long Term Care
Department of Nursing

Skin Assessment

Policy Statement:

All residents will have a complete body skin assessment on a monthly basis, using the accepted Skin Assessment tool.

Upon admission, or at any time thereafter, if a resident is found to have any alteration in skin integrity (such as skin tears, reddened areas, blisters, and pressure sores), or if the resident has a Braden score of 16 or less, a Weekly Skin Assessment will be completed.

Criteria For Weekly Skin Assessments Are:

Those with skin alterations as defined above.
Those with Braden Scores of 16 or less.

For residents on weekly sksin assesment the following procedure will be initiated:

– WEEKLY full body skin assessment will be performed and documented by the licensed nurse. This process will occur until the next regularly scheduled quarterly (or full) MDS Assessment.

– At the time of the MDS assessment, the team will determine if the resident should revert to the routine monthly skin assessment schedule. This decision will be documented in the resident's plan of care.

RESPONSIBILITIES:

- CNA

1. If the CNA observes skin changes (i.e. skin tears, reddened areas, blisters and pressure sores or any opening in the skin) AT ANY TIME, the CNA will report the changes to the charge nurse, immediately.

- RN/LPN

2. The licensed person will:
   - validate the CNA's findings.
   - intiate the weekly skin assessment.
   - complete a skin assesment when a significant change.
   - write a nurse's note in the resident's record.
   - complete the Braden Scale when a significant change has occurred.

Purpose:

To examine , identify and document any alterations in skin integrity in an effort to prevent breakdown.

Procedure:

1. Each resident will be examined by an RN/LPN on a monthly/ weekly basis as appropriate.

2. Alteration in skin integrity, (including skin tears, blisters, reddened or pressure sores), are to be indicated on the anatomical model.

3. Residents that have pressure sores, are to have areas of breakdown noted on the anatomical model.

4. For residents with NEWLY IDENTIFIED pressure sores, the following steps are necessary:

    a. Incident report generated and forwarded to the Unit Manager for initial notification

    b. Physician notification by Unit Manager or designee.

    c. Family notification by Unit Manager or designee.

    d. Photographic documentation on the Weekly Wound Assessment and Evaluation form will be initiated by the licensed staff.

    e. Nurses Note by licensed nursing staff in the resident's record.

5. Completed Skin Assessment tools are to be filed in the resident's record under the Skin Care tab. The three most recent monthly assessments should be present in this section. Previous records are to be forwarded to the Medical Records Department for inclusion in the resident's thinned chart.

6. Documentation

Skin Assessment Tool

    a. The form is stamped with the resident's addressograph.

    b. The resident's name, room number and date are entered in the appropriate spaces.

    c. When an abnormality is found upon assessment, the corresponding line is checked.

d. The condition of the fingernails and toenails are documented by checking: yes or no

e. The body diagram is marked to correspond to the assessment.
(SEE EXAMPLE ATTACHED)

Braden Scale

a. See Braden Scale policy and procedure.

Treatment Kardex

a. The appropriate interventions, according to the Skin Care Prevention Protocols, are entered on the Treatment Kardex. (Interventions will be included on recaps).

Included are:

Weekly Skin Assessment
Monthly Skin Assessment
Wound Care
Routine Skin Care
Incontinent Care
Risk Status (low /moderate risk, high risk)

b. Documentation will occur on the Treatment Kardex according to the Treatment Kardex Policy and Procedure.

c. A laminated copy of the protocols are present in the treatment Kardex.

CNA Log

a. The appropriate interventions, according to the Skin Care Prevention Protocols, are entered on the CNA Log by the licensed person taking the order off and by the licensed person reviewing and/or noting the recap.

Included are:

Incontinent care
Routine skin care
Risk Status

b. A laminated copy of the protocols are present in the CNA Log book.

c. The CNA will place his/her initials next to the care/risk level to indicate that all areas of protocol have been performed (See Skin Care Prevention Protocols) .

Philadelphia Nursing Home

Girard & Cointilion Avenues ◆ Philadelphia, PA 19130

Managed and Operated by Epicopalian Home Care • 1001 Lehigh Avenue • Philadelphia, PA 19115-1091

BRADEN SCALE
FOR PREDICTING PRESSURE SORE RISK

ADDRESSOGRAPH

Patient's Name _____ Evaluator's Name _____ Date / Initials

SENSORY PERCEPTION *ability to respond meaningfully to pressure-related discomfort*	1. Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface	2. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has sensory impairment which limits the ability to feel pain or discomfort over ½ of body	3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort
MOISTURE *degree to which skin is exposed to moisture*	1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned	2. Very Moist: Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist: Skin is usually dry; linen only requires changing at routine intervals
ACTIVITY *degree of physical activity*	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	3. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours
MOBILITY *ability to change and control body position*	1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance	2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slightly Limited: Makes frequent though slight changes in body or extremity position independently	4. No Limitations: Makes major and frequent changes in position without assistance
NUTRITION *usual food intake pattern*	1. Very Poor: Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	2. Probably Inadequate: Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding	3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation
FRICTION AND SHEAR	1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem: Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times	
				Total Score

Predictive Scoring: A total score of twenty-three (23) points is possible. A score of 16 or below indicates risk.

Score	Degree of Risk
17 or higher	Routine Care
16-15	Low Risk
14-13	Moderate Risk
12 or less	High Risk

Initials _____ Full Name _____ Initials _____ Full Name _____ Initials _____ Full Name _____

AEL 2000

Philadelphia Nursing Home
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Skin Assessment

ADDRESSOGRAPH

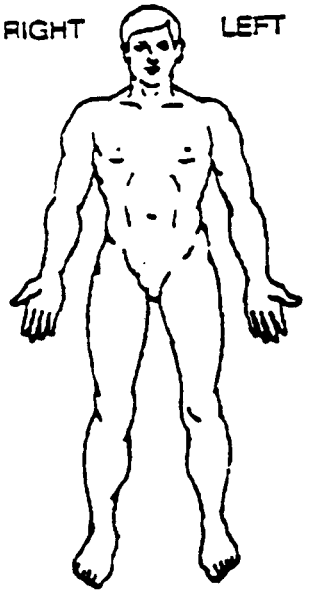
Resident Name/Room: _____ ***Date:*** _____

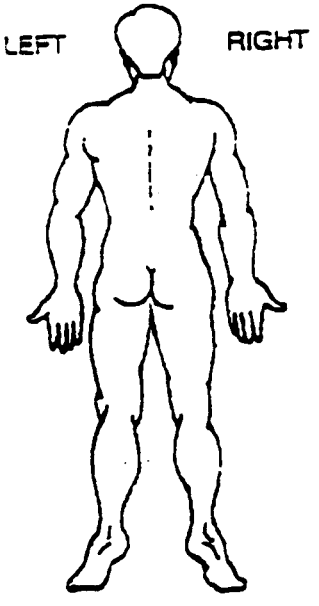
Please place a check mark (✓) in the appropriate space below upon completion of the resident full body assessment.

(Indicate any area marked **YES** on the anatomical model)

	Yes	No
1. Skin tears	_____	_____
2. Bruises/discolored areas	_____	_____
3. Rashes	_____	_____
4. Open areas (including wounds)	_____	_____
5. Dry skin	_____	_____
6. Other *(specify)*	_____	_____
7. Are fingernails short?	_____	_____
8. Are fingernails clean?	_____	_____
9. Are toenails short?	_____	_____

LPN or RN Signature: _____





SLTC-388

Skin Care Prevention Protocols

Routine Skin Care
(Braden Score 17 or higher)

Provide Skin Hygiene/ Protection

- Cleanse skin with soap, rinse & dry gently DAILY & prn
- Moisture with facility lotion BID (& prn) Residents requiring additional moisturizers, apply Atrac-tain Lotion (obtain from Central Supply)
- Inspect skin every day and during hygiene measures. Notify charge nurse of changes
- Pad bony prominences with pillows or other appropriate adaptive equipment (not blankets or folded sheets).
- Provide perineal care for residents who are immobile or incontinent (see Incontinence Policy)

LOW & MODERATE RISK
(Braden Score 16- 15) & (Braden Score 13-14)

PROVIDE SKIN HYGIENE/ PROTECTION

- Cleanse skin with soap, rinse and dry gently DAILY & prn
- Cleanse waste with Triple Care Cleanser immediately upon soiling
- Moisturize with facility lotion BID (& prn)
- Apply Peri-Care ointment under brief & to any areas
- of delicate skin
- Inspect skin daily for breakdown
- Avoid shearing force & friction. Lift, do not pull resident. Keep HOB @ 30 degrees or < **
- Release splints & other adaptive equipment q4h

HIGH RISK
(Braden Score 12 or <)

PROVIDE SKIN HYGIENE/ PROTECTION

- Cleanse skin with soap, rinse and dry gently DAILY & PRN
- Cleanse waste with Triple Care Cleanser immediately upon soiling
- Moisturize with facility approved lotion BID (& prn)
- Inspect skin q shift for breakdown & apply the following products in order
  1. Cleanse with Triple Care
  2. Apply 3 M No Sting Skin Barrier to gluteal region for incontinent residents (1 - 2 applications per 24 hour period).
  3. Moisture Skin with facility-approved Lotion
  4. Apply Peri-Care Barrier ointment
- Avoid shearing force & friction. Lift, do not pull resident. Keep HOB @ 30 degrees or < **
- Release splints & other adaptive equipment q4h

Pressure Reduction Relief/ Activity

- Encourage ambulation, as medically indicated.
- Perform ROM activity unless ordered otherwise.
- Assure that chair and/or wheelchair cushions or pads are properly positioned and inflated.
- Turn & reposition bedbound residents at least q2h and chairbound residents q1h
- Initiate turning schedule

PRESSURE REDUCTION/ RELIEF ACTIVITY

- Encourage ambulation, as medically indicated
- Position body with pillows & other support devices to prevent "skin on skin"
- Assure that bed linens are dry and wrinkle-free
- Static Air Mattress *requires ET Nurse Approval)
- Initiate turning schedule for bed-bound residents q 2 hours
- Assure that residents are weight-shifted at least q1hour while in the chair
- Foam overlay in place, if ordered *
- Elevate heels off bed using foam blocks OR pillow

PRESSURE REDUCTION/ RELIEF ACTIVITY

- Encourage ambulation, as medically indicated
- Position body with pillows & other support devices to prevent "skin on skin"
- Elevate heels off bed using foam blocks OR pillow
- Assure that bed linens are dry and wrinkle-free
- Static Air OR ↓ air loss Mattress in proper working order *
- Initiate turning schedule for bed-bound residents q 2 hours
- Assure that residents are weight-shifted at least q1 hour while in the chair

Nutrition

- Monitor eating and drinking pattern. Notify charge nurse for any changes

NUTRITION

- Monitor eating & drinking pattern - notify charge nurse of changes
- Monitor weight, I & O as ordered

NUTRITION

- Monitor eating and drinking pattern - notify charge nurse of chang
- Monitor weight, I & O as ordered

*requires ET Nurse Approval **unless ordered otherwise

Philadelphia Nursing Home
Episcopal Long Term Care
Department of Nursing

Routine Skin Care (Prevention) Protocol

Policy Statement:

All residents that are NOT identified as at risk for skin breakdown (Braden score 17 or higher) are to placed on the routine skin care prevention protocol.

Purposes:

-Prevent tissue breakdown
-Promote healing of compromised tissue
-Assure optimal tissue integrity

Procedure:

1. Turn & reposition bedbound resident at least every 2 hours following the turning schedule policy. Assure that documentation is complete. Assist the chair-bound resident to weight shift at least every 1 hour.

2. Pad bony prominences with pillows or other appropriate adaptive equipment Do not use folded sheets or blankets.

3. Apply facility-approved general usage lotion immediately after bathing daily. For residents requiring additional moisturizers, apply Atrac-tain Lotion (obtain fromCentral Supply).

4. Provide perineal care for residents who are immobile or incontinent. (Refer to Incontinence Care Policy).

5. Inspect skin every day and notify charge nurse for any changes.

6. Monitor eating and drinking pattern while feeding or observing residents during meals.

7. Notify charge nurse of changes in food or fluid intake.

8. Keep HOB at lowest degree of elevation (30 degrees is optimal) unless ordered otherwise. Limit the amount of time the HOB is elevated.

9. Documentation of all measures must be completed in the CNA Care Log:

    a. Skin care interventions will be added to the CNA log by the RN/LPN at the time of recap or at any time it becomes necessary.

10. Wound care interventions will be documented on the Treatment Kardex by the RN/LPN.

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Department of Nursing

INCONTINENCE PROTOCOL

Purpose:

Assure that skin remains in optimal condition and to prevent excoriation.

Policy:

All residents who require the use of incontinent briefs (or are otherwise found to be incontinent) will receive perineal care at least every 2 hours and after every incontinent episode. Provision of this care will be documented in the CNA Care Log under incontinence protocol.

Procedure:

1. Assure privacy is provided.
2. Explain procedure to resident.
3. Position resident comfortably on side, draping resident to minimize exposure and maintain dignity.
4. Spray Triple Care Cleanser over entire soiled area of skin.
5. Wipe skin clean and repeat procedure until entire skin area is clean.
6. Apply Peri-Care Petrolatum Ointment to all areas that may come in contact with urine and/or stool

Reminders.....

- Check the resident every two hours for incontinence
- Avoid use of briefs on residents unless absolutely necessary
- For residents on air beds, use special dry-flow incontinence pads (without application of briefs to residents - this allows optimal air flow and effects of bedrest to reduce pressure and maceration)
- Dispose of soiled linen in linen container following resident care
- Chart care in the CNA Care Log q shift.

NOTE: The CNA Care Log is individualized to include perineal care for the incontinent resident by the RN/LPN at the time of recap or at any time it become necessary.

INCONTINENCE PROTOCOL

- **Provide Privacy**
- **Explain procedure to resident**
- **Position resident comfortably on side, draping to ↓ exposure & maintain dignity**
- Spray Triple Care Cleanser over entire soiled area of skin.
- Wipe skin clean and repeat procedure until entire skin area is clean
- Apply Peri-Care Ointment to all areas that may come in contact with urine &/or stool.
- Check resident q2h for incontinent episodes
- Avoid use of briefs unless absolutely necessary
- If resident is on an air bed, use special dry-flow incontinence pads (without application of briefs - this allows air flow)
- Dispose of soiled linen in linen container following resident care.
- Chart care in the CNA Care Log q shift.

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Skin Care Prevention Protocols

Policy Statement:

All residents will be assessed by the licensed nurse for skin breakdown following facility guidelines using the Braden Scale (see policy). Dependent upon the residents' Braden score, the appropriate skin care protocol (ROUTINE, LOW & MODERATE OR HIGH Risk Incontinent) will be followed for care.

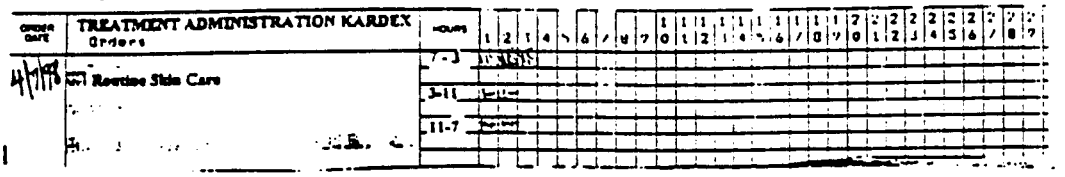
Procedure:

1. Braden score obtained and documented per policy

2. The licensed nurse will check the appropriate level of risk on the APS order sheet.

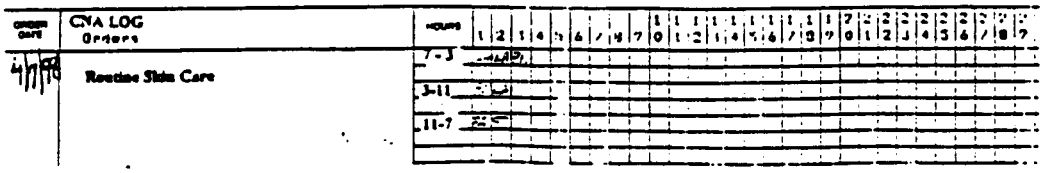
3. The order will be transcribed to the Treatment Kardex.

4. The RN/LPN will place his/her initials next to the prevention protocol as ordered to indicate that skin prevention protocols have been performed by the CNA as ordered.
Example:



5. The care/risk level will be entered into the CNA Care Log. The CNA will follow all aspects of that level of care as outlined in skin Care PREVENTION PROTOCOLS q shift.

6. The CNA will place his/her initials next to the care/risk level to indicate that all areas of protocol have been performed. (see below).
Example:



III C4-2
Revised 10/97

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Wound Assessment

Policy Statement:

All wounds (any alteration in skin integrity) will be assessed, measured, and documented on a weekly basis (every Wednesday).

Purposes:

1. To provide consistency and accuracy of wound assessment.
2. To promote the healing process using consistent treatment.
3. To assist in determining the outcome of treatment regimen.

Equipment:

- Assessment and Evaluation Form
- Skin Assessment Form
- Polaroid Camera/Briggs film (once monthly)
- Disposable measuring film
- Wound Care Binder

Procedure:

1. The nurse will initiate a Wound Assessment and Evaluation Form (attachment #1) on any new wound and at the beginning of each month. Procedure for any new wound is outlined in the SKIN ASSESSMENT POLICY.

2. Licensed personnel will obtain photographs of each wound the first week of the month, using the following technique:

    * Obtain camera from Education Department

    * Using Briggs film, hold camera exactly 10 inches from wound, using measurer provided with camera.

    * After photograph has fully developed, write resident's name, date, and ulcer location on bottom of print.

3. All assessment and documentation forms related to wound care for the current month are to be filed in the Wound Care Binder. Previous months are to be filed as outlined in the Skin Assessment Policy.

4. Physician rounds on residents with wound are to be accomplished by the Nurse Manager, Treatment Nurse, Wound Care Director and CNA assigned to the resident.

5. Treatment regimens are to be reviewed with the physician and updated as necessary.

6. All treatments that have been ordered by the physician are to be documented in the TAR and on the Weekly Wound Assessment and Evaluation.

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Wound Staging Process *

Initial Assessment

Assess pressure/venous ulcers using the Stage 1 - 4 scale following the definitions established by NPUAP and adopted by the AHCPR Pressure Ulcer Guideline Panels.

Follow-up Assessment - (think of the scale as an assessment of HEALING SCALE using the following definitions:

- *Stage IV* some necrotic tissue (eschar & slough) in wound base; fascia, muscle, tendon or bone exposed; minimal or no granulation tissue in wound base
- *Stage III* some granulation tissue in wound base; no necrotic tissue present
- *Stage II* granulation phase complete; reepithelialization beginning
- *Healed* Mark "1 - YES" in section M3 History of Resolved Ulcers on the MDS 2

* Krasner, Diane. (1997). *Recommendations for using reverse staging to complete the MDS 2,* Ostomy/Wound Management, 43: 3, p.13.

10/29/97 fs

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ADDRESSOGRAPH

WEEKLY WOUND ASSESMENT AND EVALUATION

RESIDENT_____- WOUND LOCATION_____

DATE OF ONSET_____ WHERE ACQUIRED_____

	WEEK 1	WEEK 2	WEEK 3	WEEK 4
DATE OF ASSESSMENT				
STAGE (I-IV, NON-STAGED)				
SIZE (length x width x deph) in cm.				
UNDERMINING/LOCATIONS				
TUNNELING/ LOCATIONS				
EXUDATE COLOR/ AMOUNT				
ODOR/ PAIN (+ OR -)				
WOUND BASE DESCRIPTION (pale, red, dry, moist)				
GRANULATION TISSUE (% PRESENT)				
EPITHIALIZATION (% PRESENT)				
WOUND EDGES (maccrated, irreg, approximated)				
PERIWOUND SKIN (maccrated, reddened)				
NECROTIC TISSUE TYPE/ AMOUNT (% PRESENT)				
CURRENT TREATMENT				
SUPPORT SERVICE (TYPE, SPECIALITY BED)				
NUTRITIONAL STATUS (TUBE FEED, GOOD,F,P)				
MOBILITY (OOB, BEDBOUND, PRONE CART, W/C)				
DEBRIDEMENT DATE/TYPE (SHARP, SURGICAL)				
PREVENTION STRATEGIES (TURN, OOB, ETC.)				
SIGNATURE: TREATMENT NURSE				

III C4-3

Philadelphia Nursing Home

Skin Care Guidelines

(Using Product Guidelines available at PNH)

Stage	Treatment	Rationale
Non-staged	* Debridement	* Promote granulation
I	* Relieve pressure * Tegaderm * Protective Barrier (3M, Pericare or Vaseline)	* Prevent tissue destruction
II	* Transparent Dsg * Tegasorb * Hydrasorb * Gauze/Ointment * Flexan	* Protect wound * Encourage epithelialization
III	* Gauze * Flexan * Sorbsan * Comfeel * Woun'dres * Fibracol * Mesalt * Santyl * Tegasorb * Whirlpool * VAC ? * Sharp debridement	* Must determine treatment goal before selecting wound management modality
IV	Same as above	

10/96 fs

Reviewed 4/98

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

BRADEN SCALE

POLICY STATEMENT:

All residents will be assessed and scored using the Braden Scale at the following intervals:

- Upon Admission
- Upon transfer
- With any significant change in status
- Concurrent with quarterly MDS

PROCEDURE:

1. Assessment is documented on Braden form by the licensed nurse.
2. Residents will be scored and categorized as follows
   - 17 or higher ROUTINE SKIN CARE
   - 16 - 15 LOW RISK for breakdown
   - 14 -13 MODERATE RISK for breakdown
   - 12 or less HIGH RISK for breakdown
3. Protocol interventions will be initiated and documented.
4. Completed Braden forms are to be filed in the MDS section of the resident's medical record.

NOTE: Interventions will be documented on the TAR and the CNA Log.

Philadelphia Nursing Home
Episcopal Long Term Care

Pressure Ulcer Treatment Guidelines

Stage	*Nutrition*	*Pressure Relief*	*Topical Therapy*	*Other Therapies*
I *Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration.*	• Ensure adequate intake to prevent malnutrition. • Consult Dietician, if necessary.	• Float heels & ankles off of sleep surface • Use pillows or foam wedges between bony prominences • Use pressure-reducing cushion, if appropriate • Develop written turning schedule (q2 turning in bed,q1 turning in chair) • Assure pressure relief from reddened area	• Keep area clean and dry • Use transparent dreg (Tegaderm) • Moisture Barrier (Clean N Moist, or Peri-Care, or 3M)	• Consider Wound Care Team Consult • Consider Rehab Consult
II Partial thickness skin loss involving epidermis, dermis, or both.	• Dietary Consult • If malnourished & able to eat, assist with oral feedings & oral supplements	• Same as above	• Cleanse wound with physiologic solution (Sea-Clens). • Hydrocolloid wafer (Tegasorb). Change q 3- 5 days and prn. • Hydrogel (Woun'dres) Change daily & prn • Transparent dressing (Tegaderm) for wounds with sm. amt drainage. Change q 5- 7 days & prn.	• Wound Care Team Consult • Consider Rehab Consult
III Full thickness skin loss involving damage to or necrosis of SQ tissue that may extend down to, but not through, underlying fascia. Ulcer presents clinically as a deep crater with or without undermining adjacent tissue.	• Same as Stage II	• Same as Stage I • Consider Specialty bed or overlay (requires Wound Team Approval)	• Cleanse wound with physiologic solution (Sea-Clens). • A.(FOR MOSTLY CLEAN, GRANULATING WOUNDS) • **Hydrogel with damp fluffed gauze (Woun'dres) Change daily & prn (# $ @ +) • NSS wet - damp Change daily or qshift & prn (# $ @ +) • Alginate packing (Seasorb) Change daily - for mod to heavy drainage ($ # @) B. WOUNDS WITH ESCHAR (<50% of wound) • **Enzymatic debriding agent (Santyl, Elase, Mesalf) Change daily & prn ($ # + @) C. Heel, ankle, & other foot wounds Same as Stage IV Dry, nontender heel eschar should remain open to air & floated to relieve pressure (per AHCPR guidelines)	• Wound Care Team Consult *(mandatory)* • Consider Rehab Consult • Consider short-term Hydrotherapy

Philadelphia Nursing Home
Episcopal Long Term Care

Pressure Ulcer Treatment Guidelines

Stage	*Nutrition*	*Pressure Relief*	*Topical Therapy*	*Other Therapies*
IV Full thickness skin loss with extensive destruction,tissue necrosis, or damage to muscle, bone or supporting structures (e.g., tendon or joint capsule).	* Same as Stage II	* Same as Stage I * Consider Specialty bed or overlay (requires Wound Team Approval)	A. Mostly clean, granulating wound * Same as stage III --- B. Wound with eschar (<50% of wound) * Same as Stage III --- C. Heel, ankle, & other foot wounds (< 50% eschar) * Hydrocolloid Wafer (Tegasorb) Change q 3 - 5 days & prn.	* Wound Care Team Consult * Rehab Consult * Consider short-term Hydrotherapy
Nonstaged	* Same as Stage II	* Same as above	* Requires debridement Use transparent film until evaluated by Wound Care Team	* Wound Care Team Consult * Rehab Consult

** Most preferred method/product for this indication
# Protect skin surrounding wound from excess moisture by applying a moisture barrier (PeriCare or 3M) at each dsg change
+ When preparing wet to damp gauze, unfold gauze to single-ply, moisten, squeeze out excess until just damp, and "fluff" gauze up prior to placing over or packing into wound
(t dressing materials loosely into all areas of undermining as well as to fill wound crater to skin surface level.
↓ ...r with nonwoven 4x4 gauze sponges, ABD-type pad, foam dressing (Hydrasorb), or nonadherent pad

IMPORTANT NOTES: Allow a minimum of 7 - 10 days of use prior to changing treatment
Report any dramatic deterioration in a pressure ulcer ASAP to Wound Care Team

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	Eff. Date 10/01/97 No. Pages 1 of 1
Title:	Medical Nutrition Therapy for Residents with Pressure Ulcers	

POLICY: Residents with pressure ulcers receive medical nutrition therapy to promote wound healing.

PURPOSE: To ensure residents with pressure ulcers receive the necessary nutritional therapy.

RESPONSIBILITIES:

1. The Registered Dietitian (RD) will review the Wound Care Book located on each Nursing Unit while making daily rounds.

2. The RD will evaluate and document the nutritional status of those residents with pressure ulcers at least monthly until it is healed. The RD will utilize information from the skin care assessment form, and relevant physical and social information when determining the nutritional plan of care.

3. The RD will increase the nutrients of affected residents by utilizing the following guidelines.

   A. Protein:

Stage I	1.2 - 1.4 gm/kg
Stage II	1.5 - 2.0 gm/kg
Stage III	1.5 - 2.0 gm/kg
Stage IV	2.0 - 2.5 gm/kg
Multiple:	2.0 - 2.5 gm/kg

   B. Fluid 35 - 40 cc/kg/day

   C. Recommending as appropriate: A multivitamin, Vitamin C, Vitamin A, or Zinc Sulfate (50 - 100mcg. Elemental zinc).

4. If the RD establishes that the resident is not positively responding to a given nutrient prescription, a revision to the prescription is recommended.

5. The medical nutrition therapy for each resident is individualized and assessed for acceptance by the resident to ensure effectiveness.

6. Information on pressure ulcers is communicated via the interdisciplinary resident Care Conferences.

7. The RD will request prealbumin testing, as indicated, to determine baseline nutritional status and as a monitor of nutritional improvement.

8. The RD will evaluate the need for continued medical nutritional therapy when the pressure ulcer/wound is healed.

Revised.
III C 1-1

DEPARTMENT OF NURSING

ASEPTIC TECHNIQUE

PURPOSE:

To provide aseptic, uniform dressing changes to long-term care residents.

REPONSIBILITY:

- LPN OR RN

PROCESS:

1. Check wound care cart for cleanliness and properly dated supplies.

2. Check treatment order in treatment book and check for any changes prior to performing treatment.

3. Assemble necessary materials from wound care to take to bedside:

    - dressings
    - scissors
    - gloves (at least two (2) pair)
    - cleansing solution
    - Rx medication
    - tape
    - reservoir for cleansing solution
    - plastic bags
    - chux

4. Assure that wound care treatment and any anticipated discomfort is explained to the resident.

5. Assure that resident is properly positioned, privacy curtains are drawn and resident is not overly exposed.

6. Wash hands and put on gloves before removing dressings.

7. During removal of dressings assure:

   a. Tape is removed by grasping edges, anchoring the skin and pulliing tape toward the wound.

   b. Transparent/Duoderm tape dressings are removed by loosening outer edges and gently pulling toward wound until dressing can be removed.

   c. Soiled dressings are discarded in plastic bag with gloved hand.

   d. Gloves are removed inside out and discarded into same plastic bag and top of bag is closed.

8. Wash hands and put on second pair of gloves before applying dressings.

9. Tape can be cut/torn in advance.

10. Place one chuck on overbed table or bedside table. (It is unacceptable to place dressings in the bed). Assure that a clean/sterile field is provided for dressings using inside of dressing package or disposable drape contained in dressing kit.

11. During cleansing of wound assure:

   a. NSS or prescribed cleansing solution is used.

   b. Cleanse wound from least contaminated area to most contaminated area.

   c. Gauze used for cleansing is discarded after each wipe.

   d. If Rx ointment is ordered, a small amount is discarded onto unused gauze prior to dispensing treatment amount.

12. During dressing application, only the outside of the dressing should be touched.

13. Transparent/Duoderm - like dressings are applied by gently laying dressing on skin to prevent shearing and nurse does not stretch dressing before applying.

14. Tape should be applied with half width on the skin and half width on the dressing: excessive use of tape <u>will</u> cause skin breakdown. Assure dressing is secured in place.

15. Remove gloves inside out and dispose in lidded trash can in resident's room or in trash outside of resident's room.

16. Wash hands.

17. Resposition resident as needed and make comfortable.

18. Dispose of infectious waste:

    a. Small tied off bags are placed in a larger plastic bag which is then carried to red infectious waste receptacle.

III C 6-1

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

RESIDENT CALL BELL

POLICY:

All residents will be provided with a call bell, or alternative means of alerting staff to their need for attention.

PROCEDURE:

1. The call bell will be placed within the reach of each resident when he is in bed.

2. The resident will be instructed in the use of the call bell.

3. Staff will be alert to signals that the call bell is on:
   A. Flashing light on intercom
   B. Beeping of intercom
   C. Lighted call signal over the resident's door

4. Staff will respond to the call bell on a timely basis by:
   A. Communicating through the intercom system
   B. Visiting the resident in his/her room

5. When a resident is unable to use the standard call bell (or while awaiting service) an alternative call device will be obtained from Central Supply, Extension 50914, 50916.

6. When a call bell is out-of-order it shall be reported to Plant Operations immediately at extension 50855.

7. If a call bell is noted to have frayed wiring, it shall be unplugged and taken out of service, marked as "Broken" and Plant Operations shall be notified.

12/95

III C 5-13

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

PROVISION OF FRESH WATER

POLICY STATEMENT:

The resident will be provided with fresh drinking water.

PROCEDURE:

1. During the 11p - 730a shift, the CNA will provide fresh water to each resident.

   A. If the resident is ordered a fluid restriction, the resident will not receive the 16 oz. container, but will receive the prescribed amount of fluid for each shift.

2. The CNA will mark a 16 oz. Styrofoam cup with resident's name, room number, and date.

3. The CNA will fill the cup with water and ice chips (if the resident prefers to have no ice the CNA will omit the ice chips).

4. The CNA will place a lid on the cup.

5. The CNA will provide a straw to the resident. If the resident is unable to place the straw in the lid, the CNA will do so.

6. The container will be placed on the resident's bedside table by the CNA.

7. The container will be refilled as needed.

8. If at any time, a new container is needed, it is to be replaced and the resident's name, room number and date is to be placed on the container.

MEAL DELIVERY SYSTEM

POLICY STATEMENT:

Meals arrive on the unit in meal tray carts and are delivered to each resident by the nursing staff. In order to maintain the safety of the resident, the meal tray is inspected by the licensed nurse and handed to the CNA for delivery to the individual resident.

PROCEDURE:

1. The resident is seated at the appropriate table in the dining room (see the seating arrangement board present in the dining room).

2. At the breakfast meal, the resident is prepared for the meal in his/her room.

3. In the event that the resident prefers to eat lunch or dinner in his/her room, the resident is prepared for the meal in that room.

4. Preparation for the meal shall include (as applicable):

   A. Seating the resident in a chair.
   B. Raising the head of the bed.
   C. Providing a moist washcloth so the resident can freshen his/her hands and face.
   D. Providing a bib.

5. The licensed nurse will remove the tray from the cart.

6. The licensed nurse will inspect the tray for accuracy of food provided against the diet order as given by the physician.

7. When the licensed nurse is satisfied with the accuracy of the food provided, he/she will hand the tray to the CNA who will deliver the tray to the specific individual for whom the tray is intended. (The resident's name and room number is present on the diet slip which is a part of the resident's tray.)

8. The resident shall be assisted, as needed, in preparation of the tray (i.e. opening of the juice container, cutting of the meat, etc.)

9. When the resident requires feeding or assistance with feeding , the CNA will provide that service.

10. When the meal is consumed, the CNA will document on the Meal Consumption Record the percentage of the meal that has been consumed. (See Meal Consumption Record Policy and Procedure.)

III C 5-9

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

MEAL CONSUMPTION RECORD

POLICY STATEMENT:

In order to maintain an accurate record of the residents food intake, the Meal Consumption Record is maintained.

PROCEDURE:

1. The Meal Consumption Record is completed at the end of each meal.

2. The Meal Consumption Record is placed in the Meal Consumption Log Book at the Beginning of each week and is made out to include:
   A. The week of _____
   B. The unit name
   C. Each resident's name and room number (if the resident is on tube feedings and is not taking nourishment by mouth, he/she does not become a part of the Meal Consumption Record).

3. The Meal Consumption Record is placed in the Meal Consumption Log Book and is maintained at the Nurses Station.

4. When the meal is finished, the CNA will enter the percentage of the meal consumed in the appropriate space. For instance, if the resident has consumed half of his breakfast on Monday morning, the CNA will enter "50%" in the block under the "B" for Monday. (See the pie chart Resident's Food Intake)

5. The pie chart, Resident's Food Intake is kept in the front of each Meal Consumption Log Book and is used to carefully determine the percentage of food ingested. (See attached).

6. Licensed nurses will review the Meal Consumption Record in order to:
   A. Identify and report problems
      1) Any identification of poor intake, for example 50% or less of meal

consumption in a 72 hour period, or very sporadic meal completions, are brought to the attention of the Dietician or designee.

B. Document in the resident's chart, in the Nurses Notes and/or the Monthly Summary, the amount of food consumed.

ELTC
Philadelphia Nursing Home

MEAL CONSUMPTION RECORD — Stable Residents

Week of: October 10 . Floor: _____ 2NE

10/95

		MON			TUES			WEDS			THRUS			FRI			SAT			SUN		
RESIDENT NAME	ROOM NO	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S	B	L	S
John Doe	250																					
Jane Doe	251A																					
Jean Doe	252C																					
Jim Doe	253B																					

Kenora
III C 5-1

EPISCOPAL LONG TERM CARE
PHILADELPHIA NURSING HOME

DEPARTMENT OF NURSING

RESIDENT'S WEIGHT

POLICY:

Resident weights are performed and recorded at least monthly. Resident weights are performed weekly when ordered by the physician or at the discretion of the dietician. Re-weights are performed when requested by the dietician.

PURPOSE:

In order to assess and track the physical and nutritional status of the resident.

PROCEDURE:

A. A weight is performed and recorded on each resident at least once per month.

B. All monthly weights are completed by the 10th of the month.

C. A weight is performed and recorded on a weekly basis when it is ordered by the physician or requested by the dietician.

   1. When a weekly weight is ordered by the physician or requested by the dietitian, the name of the resident is entered in the weight book under "weekly weights".

D. The CNA is assigned the task of weighing the resident by the Unit Manager or Charge Nurse.

E. Weights should be performed on the same scale each month/week.

F. Weekly weights should be performed on the same day of the week at approximately the same time of day.

G. Re-weights will be completed within 24 hours of the request for re-weight.

H. Resident weights are documented in the weight book.

I. Resident weights are transcribed from the weight book to the chart by the Unit Clerk.

J. When a resident has a weight gain or weight loss of 5 pounds or more, or a weight gain or loss of 5% of their previous body weight, the dietitian will notify the physician. The dietician will review the weight book weekly.

K. When a resident has a weight gain or loss of 5% of his/her body weight, a new MDS is initiated by the Interdisciplianry Team and the care plan is revised to address the problem.

III C 5-6

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	Eff. Date 5/95 Rev. Date 9/96 No. Pages 1 of 1
Title:	Nutritional Assessments	

POLICY: A comprehensive Nutritional Assessment will be completed for each resident within seven days of admission.

PROCEDURE:

1) The Clinical Dietitian or Dietetic Technician completes a nutritional assessment utilizing the Initial Nutritional History/Assessment Data Collection Form.

2) The assessment form is completed and placed in the residents medical record (Dietary section) within seven days of admission.

3) The completed assessment form remains is the resident's medical records until the records are closed.

4) The assessment includes, but is not limited to the following:
   a. Nutritional Intake - current food/fluid intake determined from observation of resident's intake and review of food intake records.
   b. Functional Capacity - review of feeding ability determined from observation of resident's intake and review of food intake records.
   c. Resident's Eating Habits and Preferences - determined from interviewing resident and/or family to determine need.
   d. Dietary Restrictions - obtained from written physician order.
   e. Physical Information - record height, weight, usual body weight, weight six months and one month prior to admission.
   f. Laboratory Studies - record all which are relevant to nutrition and hydration status.
   g. Clinical Observations - note any physician signs of malnutrition.
   h. Dental Status - ability to chew the ordered diet consistency.
   i. Medications - note all relevant routine medications and drug/nutrient interactions.
   j. Skin integrity - note condition of skin and specify stage and site of all open areas and presence of edema.
   k. Estimated Needs - calculate resident's estimated Calorie/Pro/Fluid needs, evaluate if diet and/or tube feedings meet estimated needs.
   l. Nutrition Problems/Goals/Approaches - identify nutrition problems and establish measurable foals and specific approaches to meet goals.

5) A brief note is written in the Dietary Progress Notes indicating the completing of the assessment and time frame for next nutrition note/follow-up (i.e., 30 days or 90 days).

III C5-15

Philadelphia Nursing Home
Episcopal Long Term Care

Restorative Dining Program

Purpose

To increase and promote independence in resident eating through observation, direct assistance, verbal cueing, and staff training.

Goals

- Identify residents with chewing and swallowing problems and functional disabilities that interfere with their ability to get food to their mouths.
- Assist residents to acheive their highest level of function related to independent feeding.
- Assure safety during the dining process by implementation of specific therapuetic interventions outlined by ST/OT.
- Maintain adequate nutrition and hydration.
- Maintain a calming atmosphere in order to support the residents' dining efforts.

Admission Criteria

* Residents must be able to assume a sitting position for AT LEAST 45 minutes and the ability to maintain attention with cueing.
* Residents identified as *high risk for aspiration* by ST, OT, or Nursing.
* Residents in need of instruction and/or monitoring on usage of adaptive equipment

- Residents discharged from therapy who need further instruction, reinforcement and continued training to improve their eating abilities.

- Residents with an unexplained weight loss or refusal to eat (for pre-determined observation period).

- Residents in need of instruction in self-feeding techniques.

Admissions Process

- ST will place an order for RESTORATIVE DINING PROGRAM on the resident's chart and complete the *Restorative Dining Notification Form* (attached).

Program Phase

- All resident on program will be brought to the 6th floor dining room by the Restorative Certified Nursing Aide (RCNA). If the RCNA is unavailable, the regular floor staff will see that the resident is brought to the dining room.

- Residents will be seated according to the seating plan devised by ST/OT which is present in the Restorative Dining Documentation binder. This seating plan is reviewed by ST/OT on a monthly and prn basis.

- Unless otherwise indicated, residents will be transferred from their wheelchairs and placed in dining room chairs to facilitate optimal seating for meal consumption.

- All meals will be supervised by a licensed employee (SST, OT, and/or Nursing).

- The RCNAs will assure that each resident has their specific cue card in place on the table during meals. Cue cards are reviewed and updated by ST/OT on a bi-weekly basis. RCNAs will be assigned to dining tables and will assure that cues an resident observation and assistance are provided as ordered.

- RCNAs will be present for all meals unless otherwise indicated by the Restorative Nursing Program Director.

* At the completion of the meal, the RCNA will complete the Restorative Dining Record and meal consumption record for each resident. These forms will be filed in the Restorative Dining binder for a 1 week period. Upon completion, each record is reviewed and signed by ST/OT and placed in the resident's chart.

Discharge Phase

Criteria

* Resident's ability to follow strategies independently are assessed as adequate by ST/OT.

* Resident has been determined by ST/OT to have reached optimal level of function

Philadelphia Nursing Home
Episcopal Long Term Care

Restorative Dining Notification

Resident: _____ Room:_____

Todays Date: _____

The following action for the above resident is requested:

(Place a CHECK mark in the appropriate box)

☐ Place on restorative dining program beginning _____ (date).

Diet ordered: _____

☐ Discharge resident from restorative dining program on _____(date).

Comments:

_____

_____

_____

_____

cc: ☐ Dietary Director ☐ Restorative Nursing Director

☐ Nursing Unit

9/97ls

Restorative Dining Evaluation Record

Resident_____ _____Room_____Diet_____

Date	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday		
	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D	B	L	D
Awake or Lethargic																					
Chewing	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Loosing food from mouth	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Drooling/increased secretions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Pocketing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Coughing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Choking	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Refusing food	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Avoiding certain foods	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
[illegible]t voice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Increased feeding time	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Selffeeding	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Using adaptive equipment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Unable to pick up food	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Able to sit upright	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Requires back/ head support	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Correct diet sent																					
Adapt.equip.as ord.																					
Initials																					

Initials	Full Name	Reviewed by ST/OT
_____	_____	_____
_____	_____	_____
_____	_____	
_____	_____	
_____	_____	

2/11/97

TIL C 5-17

Philadelphia Nursing Home
Episcopal Long Term Care

Dysphagia Team

Purpose

To identify those residents who demonstrate dysphagic symptomatology, physical limitations effecting independent feeding, and those at high risk for weight loss as related to tolerance of diet consistency.

Goals

- Continue to promote strategies addressed during skilled speech therapy and ooccupational therapy through restorative nursing

- Identify residents that may require skilled speech therapy or occupational therapy as it relates to PO intake.

Criteria

- Dysphagia rounds will occur in each dining room once a month throughout the facility. Participants of dysphagia team will include the following:

    * Speech Language Pathologist
    * Occupational Therapist
    * Charge Nurse
    * Licensed Dietician
    * Restorative CNA

- Schedule for rounds will be developed and distributed by SLP.

- Resident list for monitoring during rounds is to be generated 48 hours prior to rounds by the charge nurse on the unit, using the attached form.

PHILADELPHIA NURSING HOME
EPISCOPAL LONG TERM CARE

DEPARTMENT OF NURSING

POLICY: **Gastrostomy (Peg) Tube Feeding**

PURPOSE: To assure the accurate administration of enteral nutrition or medication as prescribed by the physician through an artificial opening in the abdominal wall.

PROCEDURE:

1. Explain procedure to the resident.

2. Wash hands prior to hanging the feeding bag to prevent the introduction of bacteria into feeding solution.

3. Position the resident in a semi-fowler's position (30-45° angle). Maintain the elevation of the head of the bed to prevent regurgitation and aspiration of the feeding solution.

4. Document on assignment sheet "*ELEVATE HEAD OF BED AT ALL TIMES*" to remind persons in contact with resident to keep HOB elevated.

5. Attach syringe to peg tube to check for residual. This monitors the degree of motility and prevents over feeding.

6. Adjust controller clamp for prescribed rate and verify the correct setting of the controls on the flexiflow pump. This will prevent a too rapid infusion of feeding solution which can lead to gastric distention.

7. Terminate the feeding if signs of obstruction (vomiting, marked distention) are present or if the resident feels nauseated. Report the condition to the physician.

8. After the feeding, instill 100cc of water to promote potency of the tubing, unless the resident is on fluid restriction.

9. Verify the integrity of the skin around the site and document accordingly.

10. In an emergency situation, aspirate tube and connect tube to low Gomco Suction to prevent aspiration.

11. Charting:

(A) In the Nurses Notes:

* Amount and content of feeding.
* Amount and content of residual.
* Amount of water used in flushing the tube.
* Any comment made by resident.
* General observation of the resident.
* Problems encountered.

(B) On the Intake and Output Sheet:

* Note time and amount of feeding.

III C5-11

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	Eff. Date 5/95 Rev. Date 2/96 No. Pages 1 of 1
Title:	Enteral Feedings	

POLICY: Enteral feedings via Naso-Gastric or PEG tubes are not used unless the resident's clinical condition that requires the use of the tube feedings as unavoidable. Clinical conditions which may indicate a need for enteral feedings include inability to swallow without chocking or aspiration, comatose or malnutrition resulting form inadequate oral intake.

PROCEDURE:

1) The physician orders all enteral feedings; orders for tube feedings must include the following:
   a. The brand name of the product
   b. The rate to be infused each hour
   c. The total number of hours and time to infuse the feeding
   d. Bolus or gravity feedings need to specify the volume and frequency of feedings need to specify the volume and frequency of feedings per 24 hours
   e. The volume of water flush per shift or after each feeding

2) Only commercially prepared formulas are utilized. The current formulary is provided by Sandoz Nutrition and supplemented by a limited number of specialized formulas from ROSS products.

3) The Nursing Staff is responsible for all feeding equipment, formulas and the administration of the tube feeding.

4) The volume of water flush for all tube feedings should be based on a resident's estimated water needs; standard water flushes are not recommended.

5) The Clinical Dietitian will complete an initial assessment and a monthly follow-up progress note to include the following:
   a. The nutritional composition of the tube feedings order and its nutritional adequacy in meeting the resident's estimated needs for calories, protein, water and all vitamins and minerals (RDAs).
   b. Any problems or limitations as a result of tube feeding; resident's tolerance to the tube feeding.

6) The Registered Dietitian will utilize the calendar or resident assessment form to keep an ongoing documentation schedule for all residents. See policy for periodic review of nutritional status.

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	Eff. Date 5/95 Rev. Date 2/96 No. Pages 1 of 1
Title:	**Weaning From Enteral Feedings**	

POLICY: Any resident on enteral feeding will be weaned from tube feedings unless it is nutritionally or medically contraindications.

PROCEDURE:

1) All residents receiving enteral feedings will be monitored for nutritional status.

2) If indicated, the resident will be slowly weaned from enteral feedings to improve oral nutrition intake.

3) The Clinical Dietitian will monitor oral intake and recommend adjustments to enteral feedings to improve oral nutritional intake

4) When the resident demonstrates the ability to consume enough food to meet their nutritional needs, the Clinical Dietitian will recommend discontinuing enteral feedings.

5) The Clinical Dietitian will document the resident's progression in the medical record.

6) The Clinical Dietitian will complete an initial assessment and a monthly follow-up progress note to include the following:
   a. The nutritional composition of the tube feedings order and its nutritional adequacy in meeting the resident's estimated needs for calories, protein, water and all vitamins and minerals (RDAs).
   b. Any problems or limitations as a result of tube feeding; resident's tolerance to the tube feeding.

7) The Registered Dietitian will utilize the calendar or resident assessment form to keep an ongoing documentation schedule for all residents. See policy for periodic review of nutritional status.

	PHILADELPHIA NURSING HOME **Administrative Policy and Procedure**	Eff. Date 7/95 Pages 1 of 1 Rev. 7/1/98
Title:	Tuberculosis Skin Testing Program	

Purpose:

To ensure administration of tuberculosis skin testing consistent with Center for Disease Control guidelines.

Policy:

Employee Skin Testing:

All employees will be skin tested at the time of initial employment and annually thereafter. Employees with positive skin testing results will be given chest x-rays and treatment as determined to be necessary by employee health and infectious disease.

Resident Skin Testing:

All residents will have a two step PPD administered on admission. Residents will subsequently have an annual PPD administered thereafter.

Procedure:

All residents of Philadelphia Nursing Home will have a repeat PPD completed by December 29, 1998.

The Mantoux test will be administered and read by the Infection Control Coordinator.

Test results will be documented on each residents' immunization record which remains in the medical record.

Effective January 1999 annual repeat PPD will be administered, interpreted and documented on each resident by specifically training Department of Nursing staff.

The Infection Control Coordinator will monitor the process, maintain a master log, administer and read PPDs on all new admissions.

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	No. Eff. Date 2/97 Pages 1 of 2
Title:	Rehabilitation Services	

PURPOSE:

To ensure the provision of comprehensive rehabilitation services by qualified physical, occupational and speech therapists in accordance with accepted professional standards to attain or maintain the highest practicable level of function.

POLICIES AND RESPONSIBILITIES:

1. Residents will be screened within forty eight (48) working hours of admission or readmission or through nursing referrals by therapy staff to determine if functional declines are present; skilled services are required; or for maintenance of optimal levels of function; or quarterly in conjunction with resident interdisciplinary care conferences.

2. Residents will be screened on a quarterly basis for changes in swallowing function and ability to maintain adequate nutrition and hydration on prescribed diet.

3. Initial resident evaluation will be completed within forty eight (48) working hours of a physician order and placed in the medical record.

4. Documentation of services
   a. Progress notes will be written for each resident receiving therapy services on a weekly basis.
   b. A monthly summary will be written at month's end for each resident receiving therapy services.

5. The interdisciplinary team will be informed of a resident's impending discharge from therapy services to ensure proper education has been provided and to allow for continuity of care by the team.

   a. A discharge summary will be completed for all residents discharged from skilled rehabilitation services within five (5) days of discharge.

6. Rehabilitation Staff will participate in the Department of Nursing Restorative Program to facilitate the residents return and/or maintenance of their highest practical level of function and well being.

   a. Assist facility staff in the development of general restorative programs related to the needs of facility residents

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	No. Eff. Date 8/95 Pages 2 of 2
Title:	Rehabilitation Services	

1. Restorative Dining
2. Positioning
3. Splinting
4. Range of Motion
5. Ambulation

b. Provide education/training and establishment of competence for all levels of Nursing.

7. Therapy staff will participate in M.D.S. completion for residents receiving therapy services.

8. Residents will receive therapy services at the bedside when they are unable to participate in services provided in the gym.

9. Therapy staff will present therapy-related information at interdisciplinary care conferences for residents receiving therapy services.

10. All therapy staff will adhere to all facility policies including but not limited to the following:

a. Universal Precautions/Infection Control
b. Equipment Maintenance
c. Resident rights
d. Reporting of Incidents/Accidents
e. Fire/Safety

	PHILADELPHIA NURSING HOME Administrative Policy and Procedure	No. _____ Effective: 6/95 Page 1 of 3
Title:	Medical Records	

POLICY: The Philadelphia Nursing Home shall ensure that a Medical Records Service is established which shall be responsible for filing, auditing, receiving, maintaining and appropriately disposing of all clinical resident records consistent with standards established by professional Medical Records Associations and by state and federal statute. A clinical/medical record shall be established for every resident upon admission to the Philadelphia Nursing Home. This record shall include clinical, medical and psychosocial information on every resident.

PROCEDURE:

1. A complete clinical record will be maintained for each resident in accordance with state and federal laws and regulations. All entries shall be made on a "current" basis, signed and dated. The resident record will serve as a basis for documenting, planning and recording all resident care and for providing a means of communication among all members of the resident care team.

2. All information contained in resident records shall be considered and treated as "confidential" information. Accordingly, information from the resident record shall be disclosed to authorized persons only and shall be released in a manner which is consistent with procedures and policies identified herein and in the policy which addresses "Confidentiality".

3. All resident/clinical records shall be maintained for a period of seven (7) years after the last date of service. In the event that the resident is a minor, records should be maintained for at least three (3) years after the minor comes of age under state law.

4. In the case of a disaster in Philadelphia Nursing Home, it will be the responsibility of the Medical Records Department to assure that a "master file" is stored in a secure location. In the event that evacuation of residents from Philadelphia Nursing Home to another location is required/initiated, it will be the responsibility of the Medical Records Department to assure that current records of current residents are retained and sent with the residents. If time permits, closed records should also be removed from Philadelphia Nursing Home or from danger in the event of disaster.

5. The Medical Records Department shall function under the direction of a full time records coordinator. In addition to the responsibilities already identified herein, it shall be the responsibility of the Medical Records Director and Department to:

   a. Ensure orderly control of all records, provide for the systematic filing of resident records.

   b. Compile records for authorized outside agencies who require medical/ statistical information:

      - Participate in gathering medical and statistical data.

- Provide medical record information requested by third-party payors and others upon appropriate written request.
- Prepare and oversee resident discharge records.

c. Safeguard proper use of and confidentiality of resident records, including guidelines for access and a release system.

- Make resident records available to professionals and other staff directly involved in care, as well as representatives of the Department of Aging - Ombudsmen.
- Provide residents with ready access to all their medical records within three (3) working days of an oral or written request (if not adjudicated incompetent by state laws). Reasonable fee may be charged for copies.
- Make available, after a death of a resident, the resident's medical record to the deceased resident's executor or administrator of decedent's estate or person responsible for disposition of the body (reasonable fee may be charged).

d. Ensure completion of discharge records within thirty (30) days of discharge.

- Clinical information pertaining to resident shall be centralized on resident's medical record.
- Records shall be easily retrieved within one (1) business day.

e. Maintain a master book with copies of forms used by each department. Records should include:

- Physicians orders and progress notes, nurses notes, medical history and physical examination reports and nursing and assessment.
- Identification information, admission data, documented evidence of informed Advance Directives, documented evidence of assessment of resident's (MDS), established treatment plan, and plans of care and services.
- Hospital diagnoses authentication, discharge summary, reports from attending physicians or transfer form, and therapeutic orders, reports of treatment, clinical findings, medication records, and discharge summaries including final diagnosis, progress or cause of death, autopsy reports and death certificates.
- Each professional discipline - history and progress notes completed in a timely fashion and addressing the individual needs of the residents.

- Symptoms and other indications of illness or injury; date, time and action taken must be included.

f. Conduct medical record and resident care audits.

- Review and analyze quarterly sample of records to determine accuracy, completeness, consistency and confidentiality.

- Reports monthly to the Associate Adminstrator, Patient Care Services regarding Medical Record services.

g. Maintain record for seven (7) years (long-term care) after the last date of service.