

FUNCTIONAL ASSESSMENT (page 2)

Resident Name:		Room #	DATE:	SCORE	SCORE	SCORE	SCORE
FUNCTION	LEVEL OF FUNCTIONING						
CONTINENCE	(1) Continent. (2) Occasionally incontinent but managed by resident. (3) Minor assistance needed such as reminders and/or assistance to and from bathroom during the day; incontinent at night. (4) Moderate assistance required – must have a schedule for toileting and be taken to and from the bathroom; needs assistance in cleaning. (5) Incontinent.			SCORE	SCORE	SCORE	SCORE
MENTAL STATUS	(1) Oriented in person, place and time but may have some occasional forgetfulness. (2) Changes of or cognitive impairment, dementia; requiring curing and reminders on occasion. (3) Mild impairment – some confusion, difficulty in remembering details in conversation, forgetfulness; may need guidance completing daily routine. (4) Moderate impairment – memory loss, especially of current events – may be anxious and/or agitated about memory loss; may appear to be functional on surface but detailed conversation reveals problems of withdrawal, depression, isolation, etc. (5) Heavy impairment in all areas thus requiring constant orientation program; prone to wandering, unable to remember personal information; confused as to time and place.			SCORE	SCORE	SCORE	SCORE
WANDERING	(1) Individual does not demonstrate wandering behavior. (2) Individual wanders throughout the facility unsupervised. Able to locate apartment with minimal direction. (3) Needs occasional direction/supervision due to inability to locate apartment. May occasionally wander into other resident apartments throughout the facility. Can be redirected. (4) Prone to wandering, unable to remember personal information, confused as to time and place. Unable to locate apartment at time without supervision. (5) Attempts or wanders inside and outside the building. May be unable to redirect due to resident mental status. Resident is appropriate for placement of Code Alert Device ☐ Yes ☐ No Code Alert Device placed on the resident ☐ Yes ☐ No Date: _____			SCORE	SCORE	SCORE	SCORE
Score of 3 or higher may indicate placement/use of the code alert system							
SHOPPING	(1) Individual takes care of own needs. (2) Minor assistance may be needed with transportation and/or carrying bundles. (3) Must be reminded to make deposits, write checks, pay bills, etc. (4) Needs assistance in every transaction. (5) Totally dependent – unable to shop for self.			SCORE	SCORE	SCORE	SCORE

FUNCTIONAL ASSESSMENT (page 3)

Resident Name:		Room #	DATE:	SCORE	SCORE	SCORE	SCORE
FUNCTION		LEVEL OF FUNCTIONING		SCORE	SCORE	SCORE	SCORE
FOOD PREPARATION		(1) Takes care of all areas of food preparation and clean up. (2) Heats and serves prepared meals/foods without prompting. (3) Can prepare and heat meals but needs prompting, needs assistance with use of kitchen equipment. (4) Will eat continental breakfast and go down for lunch and dinner. (5) Meals/snacks must be completely prepared and served to individual.					
HOUSEKEEPING		(1) Keeps apartment clean but needs help with heavy work (lifting or moving furniture or large items). (2) Can perform light housekeeping tasks such as dishwashing, bed making, dusting and vacuuming. (3) Staff will make bed daily. Housekeeping with clean weekly. (4) Cannot maintain orderliness of personal items, clothing or foodstuffs, which may cause a safety or health problem. (5) Staff must perform all tasks.					
LAUNDRY		(1) Sends out or does own. (2) Minimal assistance carrying clothes to laundry room; independent with washing, drying and folding (3) Family will do laundry (4) Housekeeping will do laundry (5) Other					
TRANSPORTATION		(1) Uses public transportation system or drives car. (2) Uses taxi or other means of transportation; makes own arrangements; does not drive. (3) Depends upon someone else for travel, unable to make arrangements. (4) Requires customized handicapped vehicle for transportation or requires supportive person to stay with him or her. (5) No travel at any time.					
TELEPHONE USE		(1) No assistance needed to make outgoing call or receive calls. (2) Assistance needed to initiate some calls, able to receive calls. (3) Only able to dial a few numbers committed to memory. (4) Only able to answer telephone. Does not initiate calls or remember number sequences. (5) Staff must make and receive calls or unable to use telephone.					

FUNCTIONAL ASSESSMENT (page 4)

Resident Name:		Room #	DATE:	SCORE	SCORE	SCORE	SCORE
FUNCTION		LEVEL OF FUNCTIONING		SCORE	SCORE	SCORE	SCORE
FINANCIAL MANAGEMENT		(1) Handles all finances and banking functions independently. (2) Is capable of conducting standard transaction (grocery shopping, pharmacy, dry cleaners, etc.) (3) Assistance is required in deciding and procuring. (4) Family handles financial affairs. (5) Requires a trustee or family-appointed guardian to handle all financial arrangements and is not responsible for financial obligations.		_____	_____	_____	_____
EATING		(1) Totally independent – uses assistive/adaptive devices. (2) Assistance needed occasionally in opening cartons, jelly packets, cracker wrappers, condiment jars, cutting meats. (3) Assistance – untidy, cannot hold cup or utensils; prompting required. (4) Regular prompting or cueing required; occasionally needs to be fed. (5) Dependent – physical assistance required for all facets of eating or has swallowing difficulties that require a mechanically altered diet.		_____	_____	_____	_____
WELL-BEING		(1) In good general overall health with no serious difficulties preventing independent living. (2) Stable chronic conditions – conditions not life threatening (chest pains, respiratory or arthritic problems, etc.) (3) Unstable chronic conditions where flare-ups may occur; including but not limited to diabetes, congestive heart disease, shortness of breath, edema of lower extremities, seizures or other diseases affecting mobility and independence. (4) Acute or life threatening conditions with some hope for recovery (including heart attack, some kinds of cancer, mild stroke, etc.) (5) Terminal illness – state of dying, comfort or pain reduction.		_____	_____	_____	_____
HEAVY MAINTENANCE & YARDWORK		(1) Totally independent – able to do maintenance and yardwork without assistance. (2) Requires assistance to do maintenance and yardwork. (3) Unable to do maintenance and yardwork.		_____	_____	_____	_____

Comments: _____

Signature/Title _____

Date _____

Signature/Title _____

Date _____

Signature/Title _____

Date _____

Signature/Title _____

Date _____

National Church Residences Healthcare

GLUCOMETER CONTROL RECORD

Meter Serial Number:

(7 digit number on back of meter, below the bar code)

★ Note any problems in section below.

[illegible]

★ Troubleshooting:

[illegible]

Resident/Family Grievance Protocol (Assisted Living)

POLICY

A resident and/or family member has the right to 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.

Traditions facilities will provide residents and their family members with prompt efforts to resolve grievances, including those with respect to the behavior of other residents and/or staff.

NOTE: Although this procedure refers to the rights of the resident in expressing his/her grievance(s), it should be understood that this process is also available to family members, guardians, health care surrogates, or any other representative of the resident in the event such resident is unable to express his/her concerns.

PROCEDURE

1. Encourage the resident to first call the Nurse Manager for the unit on which the resident lives if he/she feels a need to express, file, or otherwise communicate a grievance.
2. Encourage the resident and/or family member to contact the Director of Nursing, if in the opinion of the resident and/or their family member, their expression of concern and/or grievance goes unattended, unnoticed, or there is an obvious lack of timely response.
3. Encourage the resident and/or family member, if they feel the need to carry his/her grievance further, to contact the Administrator.
4. Address all issues and concerns either verbally or in writing (*Resident Concern Report*) depending on the party's request of the appropriateness of the response.
5. Provide direction and information on how to contact other outside sources for assistance in filing complaints and/or grievances. This information will be provided during Admission and will be posted within the facility regarding how and where to contact such sources.

Received by: _____

Concern filed on behalf of:

Concern filed regarding (dept. or person):

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears to be a standard notebook page.

Recorder, if other than filer

Date _____

National Church Residences Healthcare

Resident Concern Report *(side 2)*

Investigation Report:

Investigator's Signature

Date

Resolution and Disposition:

Administrator's Signature

Date

Signature of person filing concern

Date

Follow-up:

Signature

Title

Date

Facility Name:	Exam Location:
Scheduled Exam Date:	Examining Physician:
First Day of Work:	Employee Name:
Hire Date:	Employee Position:

Date _____

HIPAA

Use & Disclosure of Health Information

POLICY

Traditions facilities respect the importance of its residents' personal privacy, and understands the sensitive nature of its residents' health information. Facility also recognizes that Federal and State laws require that individually identifiable health information must be safeguarded against improper use or disclosure. It is Facility's policy not to use or disclose a resident's health information except as permitted by law, and to adopt safeguards to protect the confidentiality of its residents' health information.

PROCEDURE

General

(1) Verification

When implementing the procedures noted in this policy, Facility shall take reasonable steps to verify the identity and authority of the person or entity requesting access to a resident's health information. Reasonable verification procedures include, but are not limited to: reviewing an identification badge or license; a written statement on letterhead; personal knowledge of the requestor; or knowledge of the place of business, address, telephone number, etc. For purposes of notification of family or friends, Facility shall assume a person's involvement in the resident's care based on the circumstances, such as the fact that they visit the resident or sign necessary paperwork during the admission process.

(2) Minimum Necessary

When implementing the procedures noted in this policy, Facility shall make reasonable efforts to ensure that only the minimum amount of information necessary to satisfy the particular purpose of the use or disclosure is provided. Unless the circumstances indicate otherwise, Facility shall presume that requests from public officials, health care providers, plans and clearinghouses, professional members of Facility's workforce, business associates, requests for research, requests from the resident, and requests pursuant to a valid authorization are for the minimum amount of information necessary for the stated purpose.

(3) Release of Entire Medical Record

In general, Facility will not release a resident's entire medical record unless the release of the whole record is justified as reasonably necessary to accomplish the purpose of the requested use or disclosure. Unless the circumstances indicate otherwise, Facility shall presume that requests from public officials, health care providers, plans and clearinghouses, professional members of Facility's workforce, business associates, requests for research, requests from the resident, and requests pursuant to a valid authorization for the entire medical record are reasonable.

Use of Health Information for Treatment Payment or Health Care Operations

(1) Facility's Use and Disclosure

Facility may use or disclose a resident's health information for its own treatment, payment, or health care operations without consent or authorization from the resident. At all times, however, Facility will only use or disclose the minimum amount of health information necessary to accomplish the purpose of the use or disclosure.

(2) Disclosure to Outside Entities

- A. Treatment – Facility may disclose a resident's health information for the treatment activities of another health care provider.
- B. Payment – Facility may disclose a resident's health information for the payment activities of another health care provider.
- C. Health Care Operations – Facility may disclose a resident's health information for the health care operations of another health care provider only under the following conditions and restrictions:
 - Both the NF and the other entity must currently have, or in the past have had, a relationship with the resident;
 - The health information must pertain to the relationship between the entity and the resident; and
 - The disclosure must be for one of the following purposes:
 - ✧ Quality assessment and improvement activities;
 - ✧ Population-based activities relating to improving health or reducing health care costs;
 - ✧ Case management and care coordination;
 - ✧ Conducting training programs;
 - ✧ Accreditation, licensing, or credentialing activities; or
 - ✧ Health care fraud and abuse detection or compliance.

(3) Workforce access to medical record

The following classes of Facility's workforce shall have access to a resident's entire medical record, as needed, in order to accomplish their job duties: administration, nursing, dietary, social service, admission, therapy, and _____. In addition, the following classes of business associates and health care professionals, and their employees and agents, shall have access to the entire medical record, as needed, to accomplish their duties: ambulance providers, laboratories, pharmacies,

radiology providers, physicians, podiatrists, dentists, therapists, oxygen suppliers, audiologists, dialysis providers, hospice providers, optometrists, ophthalmologists, psychiatrists, psychologists, and _____. The Administrator, in conjunction with the Privacy Officer, may grant permission for other persons or classes of persons/entities to access a resident's medical record for the purposes of treatment. All persons, classes of persons, or entities that are not listed above in this policy and who do not have specific permission from the Administrator shall not access a resident's medical record.

(4) **Accounting of disclosures**

Facility does not need to keep an accounting of any disclosures made for treatment, payment or health care operations.

Notice with Opportunity to Agree/Object

(1) **General**

Facility may use or disclose health information without the written authorization of the resident for use in a facility directory or for notification purposes to family members or friends provided that the resident is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the disclosure or use.

(2) **Family and friends**

Subject to the conditions below, Facility may disclose to a family member, other relative, close personal friend, or any other person identified by the resident, health information (i) that is directly relevant to that person's involvement with the resident's care or payment for that care; and (ii) to notify such person of the resident's location, general condition, or death.

- A. Conditions if the resident is present – If the resident is present for, or otherwise available prior to, a permitted disclosure, then Facility may use or disclose the health information if it: (i) obtains the resident's agreement; (ii) provides the resident with an opportunity to object to the disclosure, and the resident does not express an objection; or (iii) reasonably infers from the circumstances, based on the exercise of professional judgment, that the resident does not object to the disclosure.
- B. Conditions if the resident is not present or is incapacitated – If the resident is not present, in an emergency, or the opportunity to agree/object to the use or disclosure cannot practicably be provided because of the resident's incapacity, Facility may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the resident, and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the resident's health care.

- C. Verification – Facility does not need to verify the identity of relatives or other individuals involved in the resident's care. Facility may rely on the circumstances as verification of involvement in care. For example, the fact that a person admits a resident to Facility and visits regularly is verification of involvement in the resident's care.

(3) Facility directory

- A. Permissible use – Except when an objection is expressed, Facility may use the following information to maintain a directory of residents in the facility:
- The resident's name.
 - The resident's location in the facility.
 - The resident's condition described in general terms that does not communicate specific medical information about the resident, e.g., fair, critical, stable, etc.
 - The resident's religious affiliation.
- B. Release upon request – Facility may disclose any of the previous four elements to clergy, and may release all of the information except for religious affiliation to anyone else who inquires about the resident by name. Note that the information in the facility directory may only be released upon request, thus the directory may not be posted in a publicly viewed area.
- C. Resident incapacity or emergency – If the opportunity to agree or object cannot practicably be provided because of the resident's incapacity or in an emergency, then Facility may use some or all of the information permitted above in a facility directory, if such disclosure is: (i) consistent with a prior expressed desire of the resident, if any, that is known to Facility; or (ii) in the resident's best interests as determined by Facility in the exercise of professional judgment. Facility must inform the resident and provide an opportunity to object to any uses or disclosures when it becomes practicable to do so.
- D. Notice – Facility shall notify residents that it will use a resident's health information for Facility's directory, and their right to object to such use, in the Notice of Privacy Practices.

(4) Accounting of disclosures

Facility does not need to keep an accounting of disclosures made to a facility directory or for notification purposes as noted above.

Authorization

All releases of a resident's health information not permitted when notice to agree or object is provided, or otherwise permitted/required by law, shall require the resident's authorization. The following protocol shall be followed with regard to resident authorizations:

(1) **Authority to release health information**

Only the Administrator or Privacy Officer may give permission for the release of a resident's health information pursuant to an authorization by the resident and/or his/her legal representative.

(2) **Authorization form must be used**

All requests for a resident's health information must be made in writing, and must be made using the facility's approved "Authorization for the Release of Health Information" (hereinafter, "Authorization").

(3) **Notify the Privacy Officer**

The Privacy Officer is to be notified of the receipt of any completed Authorization or other request for health information.

(4) **Review the Authorization for completeness**

Upon the receipt of an Authorization, Facility shall review it to ensure that all sections of the form have been filled out completely and accurately. Note that the spaces on the Authorization must be initialed by the requestor; check marks or other indicators are not acceptable. If the form is incomplete, then Facility shall return it to the requestor noting the areas that need to be completed in order to process the records request.

(5) **Verify the legal right of the requestor to the records**

Health information regarding a resident who is still living will only be released to the following persons:

A. The resident

B. The resident's attorney-in-fact under a Power of Attorney POA – Facility shall verify this assertion by reviewing a copy of the power of attorney. Facility will not assume that the mere existence of a power of attorney grants a person the right to obtain medical information from the resident's record. The power of attorney must grant the attorney-in-fact the power to obtain copies of the resident's health information.

C. The resident's attorney-in-fact under a Durable Power of Attorney for Health Care (DPAHC) – Facility shall verify this assertion by reviewing a copy of an

executed "State of Ohio Durable Power of Attorney for Health Care" form. Section 3(c) of that form states that the attorney-in-fact has the right to review facility medical records for the resident named on the form. Section 3(c) of that form states that the attorney-in-fact has the right to review facility medical records for the resident named on the form when the form is effective, i.e., when the resident has been determined by his/her attending physician to lack the capacity to make health care decisions for himself/herself and has documented that fact in the medical record.

- D. The resident's legal guardian – Facility shall verify this assertion by reviewing a copy of the designation of guardianship from the probate court of the county in which the facility is located.
- E. A person who has been specifically authorized by the resident or his/her Legally authorized representative, to obtain the health information – A resident may grant a person access to their health information by signing and dating a document that specifically grants a person the right to access his/her health information. When reviewing such a document, Facility will make sure that there is no time limit to the authorization and that it was dated prior to any incompetency of the resident. If a legal representative of the resident has executed this form, then in addition Facility shall review the underlying document providing the legal representative the legal right to the resident's health information.
- F. The ombudsman under certain circumstances. Under Ohio law, a representative of the state long-term care ombudsman program may have access to a resident's records that is reasonably necessary for the investigation of a complaint if consent has been given. Consent may be given in the following ways:
 - In writing by the resident;
 - Orally by the resident, witnessed in writing at the time consent is given by one other person plus an employee of the facility;
 - In writing by the guardian,
 - In writing by the attorney-in-fact (if the resident has authorized the attorney-in-fact to give such consent), and
 - In writing by the executor or administrator of the estate of a deceased resident.

If the representative from the ombudsman's office insists on reviewing records in the absence of an open investigation or without consent, then he/she is to be referred to the Administrator.

(6) Release of a deceased resident's health information

All of the legal rights to the resident's health information noted above cease on the resident's death, and the facility may only release such information to the resident's estate. Thus, Facility shall only release the health information of a deceased resident to the executor or administrator of the resident's estate after receiving a copy of a valid probate court appointment.

(7) Timeliness of access

- A. Records are on-site – If the requested information is maintained or accessible onsite at the facility, then Facility will provide access to the requested information within thirty (30) days of receiving the request.
- B. Records are off-site – If the requested information is not maintained or accessible on-site at the facility, then Facility will provide access to the requested information within sixty (60) days of receiving the request.
- C. Extension of deadline. If Facility is unable to act on a request within the applicable deadline noted above, then it may extend the deadline by no more than 30 days by providing the person making the request with a written statement of the reasons for the delay and the date by which it will complete action on the request. This written statement describing the extension must be provided within the standard deadline. Facility may only extend the deadline once per request for access.

(8) Access & making copies of health information

- A. Format of information requested – Facility will provide the requestor with access to the requested health information in the form or format requested, if it is readily producible in such form or format; or if not, then in a readable hard copy form, or such other form or format agreed to by Facility and the requester.
- B. Inspection and copying – Facility will arrange for a convenient time and place to inspect or obtain a copy of the protected health information, or mail a copy of the protected health information requested. Facility may discuss the scope, format, and other aspects of the request for access with the requester as necessary to facilitate the timely provision of access.

C. Payment of copying costs – (See Medical Records Manual)

- Copies are picked up. If a person picks up the copies of the health information that have been made at the facility, then he/she shall pay the copying costs at that time. Facility shall obtain a signed receipt from the person as evidence that the records were delivered.
- Copies are sent. If a person requests copies of the health information be made and sent to him/her, then Facility shall determine the number of pages of medical records requested, and the shipping costs associated with sending the records to the requestor. Facility shall notify the requestor of the cost for such records. Upon receipt of payment in full of the costs of copying and shipping the requested records, Facility shall send the records to the requestor by certified mail, return receipt requested.

(9) **Maintenance of a copy of all records that leave facility**

Facility shall keep an exact copy of all records provided to the requester along with the Authorization requesting the records. The copies of the records shall be filed in a secure location accessible only to the Administrator and Privacy Officer.

(10) **Summary of information rather than access**

Facility may provide the requester with a summary of the health information requested, in lieu of providing access to the protected health information or may provide an explanation of the health information to which access has been granted if: (a) the requestor agrees in advance to such a summary or explanation; and (b) the requester agrees in advance to the fees imposed, if any, by Facility for such summary or explanation.

(11) **Accounting of Disclosures**

Facility does not need to keep an accounting of disclosures made pursuant to an Authorization.

Business Associates

Facility shall enter into a written agreement with a business associate prior to releasing any resident's health information to the business associate. At a minimum, the agreement must provide that that business associate will:

- (1) Not use or further disclose the information other than as permitted or required by the agreement or as required by law.
- (2) Use appropriate safeguards to prevent the use or disclosure of information other than as provided for by the agreement.

- (3) Report to Facility any use or disclosure of the information of which it becomes aware that is not covered by the agreement.
- (4) Ensure that any agents of the business associate agree to the same restrictions and conditions that apply to the business associate.
- (5) Make protected health information available for access and amendment as required by Facility.
- (6) Make protected health information available as required to provide an accounting of disclosures.
- (7) Make its internal practices, books and records related to the use and disclosure of protected health information received from or created by or received by the business associate on behalf of Facility available to the Secretary of the Department of Health and Human Services for purposes of determining Facility's compliance with the business associate agreement requirement of HIPAA.
- (8) At termination of the agreement, if feasible, return or destroy all protected health information received from or created by or received by the business associate on behalf of Facility that the business associate maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, then extend the protections of the contract to the information and limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible.
- (9) The agreement must authorize Facility to terminate the agreement if Facility determines that the business associate has violated a material term of the agreement.

Facility shall use a standard business associate agreement that has been approved by _____. Any revisions to the standard business agreement must be approved by _____ prior to execution of the agreement.

Other Uses or Disclosures

Any uses or disclosures of a resident's health information that are not addressed in section (1) through (4) of this policy shall only occur with the approval of the Privacy Officer. Such other uses and disclosures may include, but are not limited to, uses and disclosures for the following purposes:

- (1) As required by law

- (2) For public health activities
- (3) About victims of abuse, neglect or domestic violence, such as reports to ODH
- (4) For health oversight activities, such as complaint surveys
- (5) For judicial and administrative proceedings, such as in response to subpoenas
- (6) For law enforcement purposes
- (7) Notification of coroners
- (8) Notification of funeral directors
- (9) For cadaveric organ, eye or tissue donation purposes
- (10) For research purposes
- (11) To avert a serious threat to health or safety
- (12) For specialized government functions, such as releases for military or veteran's activities, national security or intelligence activities, or use by a prison
- (13) For workers' compensation
- (14) Disclosures of de-identified information

Denial of Access to Health Information

Facility may restrict a resident's right to inspect and obtain a copy of his/her health information in the instances noted below. The Privacy Officer must authorize any denials of access to health information.

- (1) **Denials without a right of review**
Facility may deny a resident access to records that contain his/her health information without providing the resident an opportunity for review, i.e., without an appeal, when:
 - A. The resident requests copies of psychotherapy notes.
(Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. The following are excluded from the definition of psychotherapy notes: medication

prescription and monitoring, counseling start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.)

- B. The resident requests information compiled in anticipation of use in a civil, criminal or administrative action or proceeding.
- C. The health information is subject to the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- D. The resident agreed to a temporary denial of access when consenting to participate in research that includes treatment, and the research is not complete.
- E. The health information was obtained from someone other than a health care provider under the promise of confidentiality and access would likely reveal the source of the information.

(2) **Denials with a right of review**

Facility may deny a resident access to records that contain his/her health information, but must provide the resident the right to have such denials reviewed, in the following circumstances:

- A. Facility has determined that the access is likely to endanger the life or physical safety of the resident or another person.
- B. The health information makes reference to another person who is not a health care provider, such as another resident, and a licensed health care professional has determined that the access requested is likely to cause substantial harm to such other person.
- C. The request for access is made by a resident's personal representative, and a licensed health care professional has determined that access is likely to cause substantial harm to the resident or another person.

(3) **Requirements if access is denied**

If access is denied, in whole or in part, for one of the reasons noted in section (2) above, then Facility shall do the following:

- A. To the extent possible, give the resident access to any other health information requested, after excluding the health information as to which Facility has a ground to deny access.
- B. Provide a timely, written denial to the resident. The denial will be in plain language and contain: (i) the basis for the denial; (ii) if applicable, a statement of

the resident's review rights, including a description of how the resident may exercise those rights; and (iii) a description of how the resident may complain to Facility or to DHHS. The description will contain the name, or title, telephone number or office of the designated privacy contact person for Facility.

- C. If Facility does not maintain the health information requested, and Facility knows where the information is maintained, then inform the resident where to direct his/her request.
- D. If the resident has requested a review of the denial, Facility will designate a licensed health care professional, who did not participate in the original decision to deny, to act as a reviewing official. Facility will promptly refer a request for review to the reviewing official. The designated reviewing official will determine, in a reasonable amount of time, whether or not to deny the access based on the standards noted in this section (G). Facility will promptly provide written notice to the resident of the determination of the designated reviewing official, and take other action as is necessary to implement the designated reviewing official's determination.

Privacy Officer Responsibility

The Privacy Officer shall be responsible for overseeing the implementation of the steps in this policy and procedure, including the following:

- (1) Ensuring that the Notice of Privacy Practices adequately discusses Facility's use and disclosure policies.
- (2) Designing and updating, as appropriate, the Authorization form, as well as any standard forms developed to be used for the use and disclosure of health information.
- (3) Reviewing any requests for a resident's health information pursuant to an Authorization, determining whether to deny a resident access to health information, and responding in the required time frames.
- (4) Notifying the Administrator of any requests that he/she receives for a copy of the resident's health information, and informing the Administrator of decisions to grant or deny access to health information.

Hospice

POLICY

Traditions participates in hospice care as an approach to caring for terminally ill residents that requires *palliative* care such as relief of pain and uncomfortable symptoms, as opposed to providing *curative* care. All covered hospice services will be available as necessary to meet the needs of the resident *prior* to the resident's admission.

PROCEDURE

1. The Hospice will assess the unique needs of the resident and develop a plan of care.
2. The Hospice and facility will agree upon a coordinated Plan of Care.
3. Identify the care and services which the facility and hospice will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care.
4. Assure a registered nurse from hospice is designated to coordinate the implementation of the Plan of Care.
5. Assure the Plan of Care includes directives for managing pain and other uncomfortable symptoms.
6. The hospice will revise and update the Plan of Care as necessary to reflect the resident's current status and communicate to the facility team.
7. The facility will contact the Hospice for any orders/treatment needed for the resident. The Hospice is responsible to contact the physician for sure orders/treatments.
8. The facility and hospice are responsible for performing their respective functions that have been agreed upon and included in the Plan of Care and for which they are responsible.
 - Hospice retains the overall professional management responsibility for directing the implementation of the Plan of Care.

Resident iButtons

POLICY

It is the policy of Traditions to maintain an information button or iButton on every resident in our health care facilities who use the Optimus electronic medical record system. The iButton is an electronic form of resident identification and all care that can be documented electronically will be entered into that resident's e-chart only.

PROCEDURE

1. When a resident is admitted to the facility, admission staff or admitting nurse (for after business hours admissions) will explain to the resident/responsible party that the facility uses the Optimus EMR system and that an iButton will be created for the resident and placed on their person or on a personal item that belongs to that resident. The admitting nurse will have the resident/responsible party complete the *iButton Acknowledgement Form*.
2. Staff will ask the resident's permission to scan the iButton and inform the resident as necessary as to the purpose of scanning the iButton to maintain dignity of the resident and allow the resident the right to refuse this action.
3. The iButton, when scanned by the caregiver, brings up the resident name on the PDA device. The Resident name is also written on the wrist band. The caregiver is responsible to check the name on the PDA and wrist band to ensure they match prior to recording information.
4. All pertinent staff will be instructed on usage of the iButton during the orientation process. Instruction will include informing the resident of the need to be excused from conversation with the resident while completing clinical documentation and that the assessment process may also include asking the resident specific questions that are then entered into the electronic record.
5. The *iButton Acknowledgement Form* will be placed in the miscellaneous section of the resident's medical record.

iButton Bracelet ACKNOWLEDGEMENT FORM

The iButton is part of this facilities electronic documentation process that allows access to enter data into the electronic clinical record. It is a device worn on the wrist, much like an identification band/bracelet used in a hospital.

I _____ have been informed of the use and reason
(Resident Name)
for the iButton bracelet. I am also aware of my rights in regards to placement of the bracelet.

- ☐ I have agreed to have the iButton placed on my person.
- ☐ I decline to have the iButton placed on my person but am agreeable to have the
iButton placed _____.

I also understand that I have the ability to change my decision at any given time regarding the use of the iButton bracelet.

Resident Signature

Date

Responsible Party Signature

Date

Staff Signature

Date

GUIDELINE

Interdisciplinary Team (IDT) Referral Form

PURPOSE

The *IDT Referral Form* is used to notify interdisciplinary team members and other health care professionals of those residents with actual or potential health problems that require additional assessment or further evaluation.

RESPONSIBLE PARTY

Any clinician who believes a resident requires additional assessment or further evaluation of actual or potential health problems.

PROCEDURE

1. Enter the resident's name, room number, physician's name and date of referral.
2. Select the IDT member or other consult that the resident is being referred to.
3. Enter the reason for the referral.
4. Sign and date the form.
5. Document the referral on the *24 Hour Report*.
6. Residents with referrals on the *24 Hour Report* will be discussed in morning meetings with the Interdisciplinary Team.

Interdisciplinary Referral Form

Resident Name: _____

Date: _____

Physician: _____

Room #: _____

Discipline Referring To:

- | | | | |
|--|--|--|--|
| ☐ Infection Control | ☐ Dietary | ☐ Resource Coordinator | ☐ Social Services |
| ☐ Activities | ☐ Restorative Nursing | ☐ Business Office Manager | ☐ Dietician/Diet Tech |
| ☐ Nursing | ☐ Medical Records | ☐ Admissions/Marketing | ☐ Housekeeping |
| ☐ MDS Coordinator | ☐ Maintenance | ☐ DON | ☐ Therapy |
| ☐ Laundry | ☐ Memory Care
Program Director | ☐ Other _____ | |

Reason for Referral:

Signature

Date

Follow Up to Referral

Findings:

Recommendations:

Signature

Date

Incidents and Accidents: Report and Investigation, Interdisciplinary Team Review and Final Disposition

Assisted Living

POLICY

Incidents and accidents are to be promptly and thoroughly reviewed and investigated. Significant incidents and accidents are to be immediately reported to facility and corporate administration. National Church Residences (NCR) defines an incident as an event, occurrence, or happening that may result in actual or potential harm of a resident. Incidents and accidents may include, but are not necessarily limited to the following:

- Fall/suspected falls
- Fractures
- Head injuries
- Unexplainable/unusual bruises/skin tears
- Medication errors
- Missing residents
- Confirmed resident to resident altercations
- Confirmed resident to staff altercations
- Suspected abuse or neglect or misappropriation of property
- Self inflicted injuries

A report is completed upon the occurrence of an incident and accident as a part of the Continuous Quality Improvement (CQI) process to identify opportunities to enhance and improve the quality of care and services provided to our residents. The Incident and Accident Report, Investigation, and follow up are **NOT** a part of the resident's medical record. These documents are confidential and exclusively for CQI purposes.

Incident and accidents in which there is a suspicion of mistreatment, neglect, abuse, misappropriation of resident property will be reported immediately to the Administrator and the Director of Nursing and shall be investigated according to the *NCR Abuse Policy/Procedure*.

Incident and accidents related to a possible missing resident will be reported to the Administrator/ Director of Nursing and will be investigated according to the *NCR Missing Resident Policy/Procedure*.

If a medical device has been suspected to contribute to the incident and accident, the facility will refer the event to the Administrator for compliance with the Safe Medical Device Act.

PROCEDURE In the event of an incident or accident at the facility, the following procedure shall be implemented.

The licensed nurse will be responsible to:

1. Provide emergency medical treatment as indicated and protect the resident/visitor/volunteer from further immediate harm or potential harm.
2. Report the incident and accident to the physician, family, and immediate supervisor and document the notification in the medical record.
3. Report the incident and accident to the Administrator and Director of Nursing per the 24 Hour Report. The Administrator and Director of Nursing will be immediately notified of all significant incidents and accidents.
4. Complete an *Incident/Accident Report* if the incident and accident occurred to any of the following individuals:
 - Resident
 - Visitor
 - Volunteer

NOTE: If the incident and accident involved an employee, refer to the *Employee Report of Incident/Injury Form*.

5. Obtain and record vital signs. Complete neurological checks (if applicable due to the person striking their head, per the *NCR Neurological Assessment Policy and Procedure*).
6. Document the occurrence in the nursing notes of the resident's medical record. Document only objective facts such as:
 - Date
 - Time
 - Person involved
 - Location of the incident and accident
 - Where the involved person was found (i.e. sitting on floor, lying on right side, etc.)
 - Assistance given by staff
 - Objective findings of physical examination
 - Names of persons notified (i.e. family, physician)

7. Initiate the investigation as to how the incident and accident occurred and immediate actions taken.

The Interdisciplinary team will be responsible to:

8. Discuss incidents and accidents after morning operations meetings with a subgroup of the facility CQI Committee.
9. Record new interventions resulting from the review of the incident and accident on the *Interdisciplinary Team Review Form*.

The Director of Nursing/designee will be responsible to:

10. Ensure complete investigation of the incident and accident. Steps for a thorough investigation may include but are not limited to:
 - Interview affected person, if possible
 - Interview all witnesses and others who may have knowledge of the incident. Obtain written statements (per *Employee Statement Form*).
 - Observe immediate surrounding environment
 - Review medication regimen
 - Review current interventions to determine if they were in place and functioning at the time of the incident and accident
11. Provide follow up and resolution to the investigation and attach all supporting documentation to the *Incident/Accident Report and Investigation Form*.
12. Inform the person responsible for education of staff members, if additional staff education is required, and attach a copy of education provided using the *Employee Education Form*.
13. Ensure completion of required documentation and submitting the *Incident/Accident Report and Investigation Form* for review at least weekly to the Administrator and Medical Director. Following the review, the Administrator and Medical Director shall sign and date the report.
14. Maintain a facility copy of the *Interdisciplinary Team Review Form* for CQI purposes.
15. Enter pertinent information into the *Incident/Accident Tracking Log* and the *Quality of Care Summary Report*, which are components of the CQI Process.
16. Review and analyze incident and accident data/trends and develop implement action plans to resolve issues on an ongoing basis at Quality of Care meetings and at Quality Improvement Committee meetings.

The Administrator/designee will be responsible to:

17. Notify the NCR Risk Manager promptly of all significant incidents and accidents and events that include but are not limited to:

- Fall with a serious injury
- Any fracture
- Significant medication error
- Missing resident
- Suspected or confirmed staff to resident abuse
- Resident to resident abuse
- Any facility visit by law enforcement, FBI, AG, or the OIG
- Require a resident/visitor/volunteer to be hospitalized.
- Contact from a resident's attorney, service of a lawsuit, request for medical records (after an event in which a resident experienced a negative outcome), or other legal issues.

18. Ensure that the facility does not maintain any copies of the *Incident/Accident Report and Investigation Form* or attachments (i.e. *Employee Education Forms*) in the facility.

19. Forward all *Incident/Accident Report and Investigation Forms* and supporting documentation at least monthly to the NCR Corporate Office for storage and compliance with NCR policies.

GUIDELINE

Incident/Accident Report and Investigation, and Interdisciplinary Team Review Forms

PURPOSE The *Incident/Accident Report and Investigation Form* is used to document and report incident and accidents. This form also assists in tracking incident and accidents, investigation, identification of a particular resident who is having repeated incident and accidents, and the identification of trends. The *Incident/Accident Report and Investigation Form* is a 2 sided legal document that is initiated as soon as the discovery takes place and is completed by the end of that shift.

The *Interdisciplinary Team Review Form* is completed once the investigation is completed at the next morning operations meeting held.

RESPONSIBLE PARTY The *Incident/Accident Report* is completed by the nurse who discovers the incident and accident. The *Incident/Accident Investigation Form* is initiated by the nurse and completion ensured by the Director of Nursing/designee. The *Interdisciplinary Team Review Form* is completed by members of the facility Interdisciplinary Team at the morning operations meeting.

PLACEMENT The *Incident/Accident Report and Investigation Form* and all supporting documentation (including witness statements) will be sent to the home office at National Church Residences promptly by the Administrator/facility designated staff person.

The facility will maintain a copy of the *Interdisciplinary Team Review Form* per medical record retention guidelines in a designated facility file as directed by the Administrator.

INSTRUCTIONS

1. Complete all sections of the *Incident/Accident Report* and the *Incident/Accident Investigation Form*. Obtain additional supportive documentation and information as the investigation warrants to ensure that a thorough investigation has been completed.
2. The Interdisciplinary Team will complete the *Interdisciplinary Team Review Form* at the conclusion of the investigation at the next morning operations meeting.
3. Forward the completed report to the Director of Nursing for review and signature.
4. The Director of Nursing/designee will forward all information to the Administrator/Medical Director for review and signature.

Employee's Report of Injury or Illness

POLICY

National Church Residences strives to ensure that each employee remains free of injuries and illnesses that may occur during employment. In the event of an employee injury/illness, National Church Residences will make every effort to ensure that the employee receives the appropriate follow up care and treatment of the injury/illness.

PROCEDURE

1. In the event of an employee injury or illness that occurs during the course of employment, instruct the employee to complete a packet of the approved NCR forms or refer the employee to the National Church Residences Intranet Site - Cornerstone. If the employee is using the Intranet site:
2. Locate Human Resources information and open the folder identified as Workers Compensation.
3. Open the Workers Compensation Policies and Procedures folder.
4. Open the folder for Workers Compensation Procedures for Ohio
5. Follow instructions and forms provided for providing medical assistance, treatment, and reporting the employee injury/illness.

INCIDENT/ACCIDENT REPORT

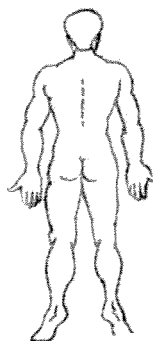
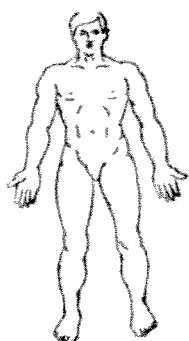
The Incident/Accident Report is initiated at the time of incident. This report is **CONFIDENTIAL AND PRIVILEGED**. It is not to be part of the medical record, but a tool used as a part of the facility's quality improvement program and revision of a resident's Plan of Care.

Facility Name: _____

Date of This Incident: _____

Name of Person Involved in Event: _____ Last First	Sex: ☐ Male ☐ Female	Age: ☐ Adult ☐ Child	☐ Resident ☐ Visitor ☐ Volunteer	Time of Incident: _____ AM PM	Location of Incident: ☐ Resident Room # _____ ☐ Bathroom ☐ Lounge ☐ Hallway ☐ Other: _____
Change in Person's Mental Status: ☐ N/A ☐ Yes ☐ No	Side Rails: ☐ N/A ☐ Yes ☐ No ☐ Assist bar	Bed Ht: ☐ Up ☐ Down	Restraint in Use: ☐ N/A ☐ Yes ☐ No ☐ Side Rail ☐ Seat belt ☐ W/C tray ☐ Other _____		Medications: ☐ Antipsychotic ☐ Antidepressant ☐ Diuretic ☐ Cardiac ☐ Anti-anxiety ☐ Other: _____
Were personal alarms turned on? ☐ N/A ☐ Yes ☐ No	Environmental Factors: ☐ N/A ☐ Clutter ☐ Noise ☐ Handrail ☐ Floor Problem ☐ Broken/sharp equipment ☐ Lighting ☐ Other _____			Footwear: ☐ Bare feet ☐ Slippers ☐ Grippy socks ☐ Socks ☐ Shoes Shoelaces tied? ☐ Yes ☐ No	
Alarm malfunction? ☐ Yes ☐ No					
Did this Accident/Incident Involve a Resident's Medication? ☐ Yes ☐ No If Yes: _____ Signature of Nurse Responsible					
If yes: ☐ Incident was related to the administration of a medication ☐ Incident involved a pharmacy error					
If pharmacy error, Date and Time Pharmacy Notified: Date: _____ Time: _____ AM PM					
Name of Pharmacist Spoken to Regarding Incident: _____					
Describe exactly what happened: (Use objective facts only) _____ _____ _____ _____ _____					
Notification of Physician: Date: _____ Time: _____			Responsible Party Notification: Date: _____ Time: _____		
Physician Name: _____			Person's Name: _____		
Was Person Seen by a Physician? ☐ Yes ☐ No	Was First Aid Given? ☐ N/A ☐ Yes ☐ No	Was Person Sent to Hospital? ☐ Yes ☐ No Hospital Sent To: _____			
Vital Signs: Temp: _____ Pulse: _____ Resp: _____ BP: _____/_____ SaPO2: _____ Blood Sugar (if IDDM): _____					

Indicate with (X) the location of an injury AND by the corresponding number for the type of injury:



Type of Injury

- | | |
|-----------------|----------------|
| 1. Non-Apparent | 5. Laceration |
| 2. Hematoma | 6. Skin Tear |
| 3. Abrasion | 7. Swelling |
| 4. Burn | 8. Other _____ |

Reviewed by Administrator

Date

Reviewed by Director of Nursing

Date

Reviewed by Medical Director

Date

Name of Person Completing Report

Date

Pharmacist Signature (Pharmacy Error)

Date

INCIDENT/ACCIDENT INVESTIGATION

This report is **CONFIDENTIAL AND PRIVILEGED**. It is not to be part of the medical record, but a tool used as a part of the facility's quality improvement program and revision of a resident's Plan of Care.

Resident Name: _____ Date of Event: _____ Time of Incident: _____ am/pm

DESCRIPTION OF THE INCIDENT: _____

IMMEDIATE ACTIONS TAKEN (and intervention put in place to prevent a re-occurrence): _____

Staff Assigned to Resident (See *Employee Statement Form*): _____

INVESTIGATION OF THE INCIDENT:

What did the resident state he/she was trying to do at the time the incident occurred? _____

Environmental factors: Floors Dry ☐ Yes ☐ No Unobstructed Path ☐ Yes ☐ No Clothing Appropriate ☐ Yes ☐ No
Appropriate Footwear ☐ Yes ☐ No Lighting Appropriate ☐ Yes ☐ No Problem w/ Medical Equipment ☐ Yes ☐ No

Behavioral change: ☐ Yes ☐ No **If yes:** ☐ Agitation ☐ Increased Confusion ☐ Increased Anxiety
☐ Poor Impulse Control ☐ Other _____

Current medical condition may have contributed to the incident: ☐ Yes ☐ No **If yes:** ☐ Acute infection
☐ Arthritis ☐ Drop in systolic blood pressure ☐ Diabetes with neuropathy ☐ Gait, balance problems
☐ Syncope, dizziness ☐ Other _____

Was resident attempting to toilet when incident occurred? ☐ Yes ☐ No Resident has signs of urgency ☐ Yes ☐ No

Were assistive devices in use at time of incident? ☐ N/A ☐ Yes ☐ No

Was resident wearing glasses and/or hearing aide at the time of incident? ☐ N/A ☐ Yes ☐ No

Does the resident take medications that could have contributed to the incident? ☐ N/A ☐ Yes ☐ No
If Yes: ☐ antihistamine ☐ anti-hypertensive ☐ diuretic ☐ hypoglycemic ☐ psychotropic ☐ hypnotic ☐ other _____

Was resident non-compliant with planned interventions? ☐ Yes ☐ No

Was Fall Risk Assessment completed? ☐ Yes ☐ No

Was Case Manager notified? (Medicaid Waiver only) ☐ Yes ☐ No

Signature/Title of Person Completing Investigation

Date

INTERDISCIPLINARY TEAM REVIEW FORM – Assisted Living

Resident Name: _____

Room Number: _____

Date of Incident: _____

Time of Incident: _____

Did this incident involve a resident fall? ☐ Yes ☐ No

Review of previous incidents completed to identify possible trends? ☐ N/A ☐ Yes

SUMMARY OF FINDINGS: _____

☐ Responsible party notified of incident ☐ Case Manager Notified (*Medicaid Waiver only*)

☐ Physician notified of event

☐ Resident's plan of care appropriately revised and meets resident's current needs. (*Medicaid Waiver only*)

☐ In house investigation completed by _____

☐ No allegation, suspicion, or confirmation of abuse, neglect, or misappropriation of property.

INTERDISCIPLINARY TEAM DISCUSSION: _____

INTERVENTION(S) RECOMMENDED BY IDT:

☐ Therapy screen

☐ Defined perimeter mattress

☐ Mats on floor

☐ Proper footwear

☐ Orthostatic blood pressure

☐ Low bed

☐ Move room closer to nurses station

☐ Devices _____

☐ Other _____

☐ Medication Review

☐ Lab Review

☐ Other _____

INTERDISCIPLINARY TEAM SIGNATURES:

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Signature/Title *Date*

Director of Nursing *Date*

Administrator *Date*

INCIDENT/ACCIDENT REPORT

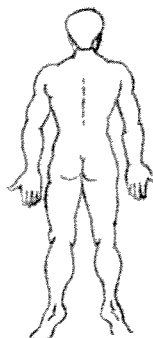
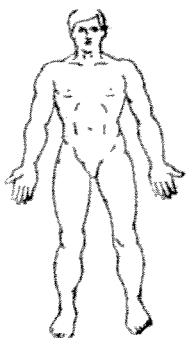
The Incident/Accident Report is initiated at the time of incident. This report is **CONFIDENTIAL AND PRIVILEGED**. It is not to be part of the medical record, but a tool used as a part of the facility's quality improvement program and revision of a resident's Plan of Care.

Facility Name: _____

Date of This Incident: _____

Name of Person Involved in Event: _____ Last First	Sex: ☐ Male ☐ Female	Age: ☐ Adult ☐ Child	☐ Resident ☐ Visitor ☐ Volunteer	Time of Incident: _____ AM PM	Location of Incident: ☐ Resident Room # _____ ☐ Bathroom ☐ Lounge ☐ Hallway ☐ Other: _____
Change in Person's Mental Status: ☐ N/A ☐ Yes ☐ No	Side Rails: ☐ N/A ☐ Yes ☐ No ☐ Assist bar	Bed Ht: ☐ Up ☐ Down	Restraint in Use: ☐ N/A ☐ Yes ☐ No ☐ Side Rail ☐ Seat belt ☐ W/C tray ☐ Other _____		Medications: ☐ Antipsychotic ☐ Antidepressant ☐ Diuretic ☐ Cardiac ☐ Anti-anxiety ☐ Other: _____
Were personal alarms turned on? ☐ N/A ☐ Yes ☐ No	Environmental Factors: ☐ N/A ☐ Clutter ☐ Noise ☐ Handrail ☐ Floor Problem ☐ Broken/sharp equipment ☐ Lighting ☐ Other _____			Footwear: ☐ Bare feet ☐ Slippers ☐ Grippy socks ☐ Socks ☐ Shoes Shoelaces tied? ☐ Yes ☐ No	
Alarm malfunction? ☐ Yes ☐ No					
Did this Accident/Incident Involve a Resident's Medication? ☐ Yes ☐ No If Yes: _____ Signature of Nurse Responsible					
If yes: ☐ Incident was related to the administration of a medication ☐ Incident involved a pharmacy error					
If pharmacy error, Date and Time Pharmacy Notified: Date: _____ Time: _____ AM PM					
Name of Pharmacist Spoken to Regarding Incident: _____					
Describe exactly what happened: (Use objective facts only) _____ _____ _____ _____ _____					
Notification of Physician: Date: _____ Time: _____			Responsible Party Notification: Date: _____ Time: _____		
Physician Name: _____			Person's Name: _____		
Was Person Seen by a Physician? ☐ Yes ☐ No	Was First Aid Given? ☐ N/A ☐ Yes ☐ No	Was Person Sent to Hospital? ☐ Yes ☐ No Hospital Sent To: _____			
Vital Signs: Temp: _____ Pulse: _____ Resp: _____ BP: _____/_____ SaPO2: _____ Blood Sugar (if IDDM): _____					

Indicate with (X) the location of an injury AND by the corresponding number for the type of injury:



Type of Injury

- | | |
|-----------------|----------------|
| 1. Non-Apparent | 5. Laceration |
| 2. Hematoma | 6. Skin Tear |
| 3. Abrasion | 7. Swelling |
| 4. Burn | 8. Other _____ |

Reviewed by Administrator

Date

Reviewed by Director of Nursing

Date

Reviewed by Medical Director

Date

Name of Person Completing Report

Date

Pharmacist Signature (Pharmacy Error)

Date

INCIDENT/ACCIDENT INVESTIGATION

(Complete for Incidents Related to Medication Administration)

This report is **CONFIDENTIAL AND PRIVILEGED**. It is not to be part of the medical record, but a tool used as a part of the facility's quality improvement program and revision of a resident's Plan of Care.

Resident Name: _____ Room Number: _____
Date Reported: _____ By: _____
Date Discovered: _____ By: _____
Date of Event: _____ Time of Event: _____ AM PM
Family/Resident Informed: _____ Date & time: _____ Physician Notified: _____ Date & time: _____
Treatment Orders Received: _____

Medication/Dosage/Route of Administration Involved: _____

Source of Information: ☐ Medical Record ☐ Verbal ☐ Other (Specify): _____

DESCRIPTION OF EVENT: _____

MEDICATION ERROR TYPE:

1. Administration Error

- ☐ Wrong drug
- ☐ Wrong strength or quantity
- ☐ Wrong route
- ☐ Wrong dosage form
- ☐ Missed dose
- ☐ Stop order exceeded
- ☐ Wrong resident
- ☐ Wrong day/time
- ☐ Resident allergic to medication

2. Dispensing Error

- ☐ Drugs not available
- ☐ Wrong drug
- ☐ Wrong strength
- ☐ Other (Explain) _____
- ☐ Wrong dosage form
- ☐ Incorrect resident

3. Failure to Follow Procedure (Explain)

4. Documentation Error

- ☐ Transcription error
- ☐ Charting error
- ☐ Legibility

MEDICATION ERROR CLASSIFICATION

- ☐ Error occurred, medication did not reach resident
- ☐ Error occurred, reached resident, no harm
- ☐ Error occurred, resulted in need for increased monitoring, no harm
- ☐ Error occurred, resulted in need for treatment or intervention

CORRECTIVE ACTION

- ☐ Verbal Counseling
- ☐ Policy & Procedure Review
- ☐ Additional training
- ☐ Written counseling
- ☐ Other _____

SIGNATURES:

Nurse Involved in Incident Date

Director of Nursing Date

Medical Director Date

Administrator Date

Pharmacist Date

Employee Statement Form

Resident Name: _____

Date & Time of Incident: _____

Please describe the incident: _____

Was the incident witnessed? ☐ Yes ☐ No

If yes, who witnessed the incident: _____
please list all staff and/or others (visitors/family)

When was the resident last observed by you? _____

What was the resident's activity at that time? _____

Please describe the resident's behavior: _____

When was the last time the resident was toileted? _____

If applicable, were the devices/interventions ordered in place and working? ☐ Yes ☐ No

If no, please explain: _____

Are there any other staff members that had contact with the resident? ☐ Yes ☐ No

If yes, please list: _____

Employee Signature

Date

Employee Education Form

This report is **CONFIDENTIAL AND PRIVILEGED**. It is not to be part of the medical record, but a tool used as a part of the facility's quality improvement program and revision of a resident's Plan of Care.

Directions: This form is to be completed by a designated facility staff member assigned to complete employee education. The form is used when a staff person requires education/re-education regarding an incident/accident occurrence. Write a brief summary of the event, what the staff person was educated on, and have both the staff person and the facility staff member assigned to complete the education sign and date the form.

Incident/Accident necessitation education/re-education:

Education Provided:

Employee Name

Title

Date

Staff Member Name

Title

Date

LPN Role in Infusion Therapy

POLICY Traditions facilities will follow Chapter 4723-17 Ohio Board of Nursing Laws and Rules regarding the role of the LPN in infusion therapy.

PROCEDURE **The LPN without an IV Therapy Card May Perform the Following:**

1. Verify the type of peripheral IV solution
2. Examination and documentation of the peripheral infusion site
3. Discontinue a peripheral IV device
4. Perform routine dressing changes at the insertion site of peripheral venous or arterial infusion, peripherally inserted central venous catheter, or central venous pressure subclavian infusion

The LPN with an IV Therapy Card May Perform the Following:

1. Venipuncture with a needle/catheter into a peripheral vein of the hand, forearm, and/or antecubital fossa area on a person 18 years of age or older.
2. Assemble and maintain equipment for gravity drip infusion or electronic controlling devices, excluding resident controlled devices.
3. Initiate the infusions of select intravenous solutions as ordered by a licensed physician, dentist, or podiatrist, and calculate infusion rate using standard formulas. (Selected solutions are limited to the following: Dextrose 5% (D5W), Dextrose 5% in 0.9% sodium chloride (D5.9NS), Dextrose 5% in 0.45% sodium chloride (D5.45NS), Dextrose 5% in 0.2% sodium chloride (D5.2NS); Normal Saline (0.9%NS); Sodium Chloride (0.45%NS), Sodium Chloride 0.2% (0.2NS) and/or Lactated Ringers (LR).
4. Maintain the intravenous solutions listed above to pre-existing peripheral or central intravenous lines or PICC lines. (NOTE: 'Maintain' is defined as to administer or regulate an intravenous infusion according to the prescribed flow rate)
5. Regulate and monitor the prescribed flow rate of intravenous solutions.

6. Hang subsequent container of intravenous solutions listed that contain vitamins or electrolytes, after the RN initiates the infusion of the same solution.
7. Compound/reconstitute/administer an antibiotic by direct or piggyback infusion.
8. Initiate, convert and flush peripheral intermittent infusion device (heparin/saline locks). The peripheral intermittent infusion devices may be flushed with normal saline alone or followed with Heparin to maintain peripheral venous patency of an intermittent infusion device when the Heparin does not alter an individual's clotting time and is a non-therapeutic strength.
9. Perform routine intravenous administration set changes only on a peripheral intravenous line.
10. Observe, report, and record the individual's response to the intravenous therapy including the condition of the intravenous infusion site.

Prohibitions

1. Initiate or maintain blood or blood components, solutions for total parenteral nutrition, cancer therapeutic drugs, solutions administered through an arterial line or any line that is not in the peripheral or central venous system, or any investigational drug.
2. Initiate intravenous therapy in a peripheral vein other than a vein of the hand, forearm, or antecubital fossa.
3. Discontinue central venous, arterial, or other line that is not in a peripheral vein.
4. Discontinue peripherally inserted central catheters (PICC)
5. Mix, prepare or reconstitute any medication (other than IV antibiotic) for intravenous therapy.
6. Inject medication, except for heparin or saline, to flush an intermittent peripheral infusion device by bolus or push.
7. Aspirate any intravenous line to maintain patency.
8. Change tubing on any line other than a peripheral line, including, but not limited to arterial line or central venous line.

Injuries of Unknown Source

POLICY

Traditions will investigate all injuries sustained by its residents. Facility staff shall report all "injuries of unknown source" to the Administrator and the Ohio Department of Health ("ODH") in accordance with this policy.

Residents, interested family members, or other persons may contact any member of the Administration or the facility's nursing staff at any time with questions or concerns about a resident's injury.

DEFINITIONS

Injury of Unknown Source. An injury is classified as an "injury of unknown source" when **both** the following conditions are met:

1. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident;

AND

2. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.

PROCEDURE

Initial Inquiry

Upon the discovery of an injury to a resident, an inquiry to determine whether the injury qualifies as an "injury of unknown source" will be completed, and a conclusion reached within twenty four (24) hours of discovery of the injury.

1. **Determination of whether the injury was witnessed or can be explained by the resident.** A determination will be made whether the injury was observed by any person or can be explained by the resident. If the injury was witnessed or can be explained, then no further investigation or reporting is necessary under this policy.

If the source of the injury was not observed by any person and the source of the injury can not be explained by the resident, then a determination will be made whether the injury is suspicious.

2. **Determination of whether the injury is suspicious.** In making a determination of whether an injury is suspicious, the facility will consider the following:

- ♦ the extent of the injury;

- ♦ the location of the injury (*e.g.*, the injury is located in an area not generally vulnerable to trauma);
- ♦ the number of injuries observed at one particular point in time; and
- ♦ the incidence of injuries over time.

If a determination is made that the injury is not suspicious, then it does not qualify as an "Injury of Unknown Source" and, thus, no further investigation or reporting is necessary. (Traditions will still investigate to determine the likely cause of the injury so that appropriate care planning may take place).

If a determination is made that the injury is suspicious, then it shall be considered an "Injury of Unknown Source".

3. Documentation of analysis. If a determination is made that an injury does not qualify as an "Injury of Unknown Source", then the reasons for that determination will be documented through the facility's CQI process.

Notify

1. Administrator & Director of Nursing. Once a determination is made that the injury qualifies as an "Injury of Unknown Source", the Administrator/Director of Nursing will be notified immediately.
2. Refer to *Abuse, Neglect, Mistreatment and/or Misappropriation of Resident Property* in Section A of the Clinical Administrative Manual for further procedures.

Follow-up

1. The facility will evaluate and make necessary changes in resident's care plan to protect against the occurrence of another similar injury.
2. The facility will determine if modifications to existing policies and procedures (or new policies and procedures) are needed to prevent similar injuries from occurring in the future.
3. The facility will conduct in-service training for its staff, as appropriate.

Insects/Pests: Resident Safety

POLICY

Traditions strives to protect the residents, staff, and visitors from insects and other pests by controlling infestation through contracts with outside pest control agencies. It is the responsibility of all staff members to detect and report immediately the presence or potential presence of pests to the Administrator and DON/Nurse Manager.

In the event that insects and/or pests are noted in a resident's room or on the resident, immediate steps will be taken to prevent or decrease the risk for actual or potential harm.

PROCEDURE

Potential Presence

1. Observe the resident room when entering for potential signs of insects and other pests.
2. Observe area surrounding the resident (i.e., bed, linens) to strive to assure no insects or pests are present.
3. Report presence or potential presence of pests immediately to the Administrator and DON/Nurse Manager.

Actual Presence

4. Remove resident(s) immediately from the vicinity.
 - If there is not potential for harm (i.e., fly, small spider), eliminate and dispose of insect/pest. Resident removal is unnecessary.
5. Place resident(s) in an area free of insects/pests (i.e., Activity Room, Living Room, empty resident room/bed) until insects/pests are removed.
6. Report presence or potential presence of pests immediately to the Administrator and DON/Nurse Manager.
7. Return resident to their room when it is free of insects/pests.

Presence on Resident

8. Remove immediately, and as many as possible, the insects/pests from the resident.

9. Transport the resident immediately to the shower room and attempt to remove the insects/pests, as appropriate.
10. The licensed nurse will notify the physician immediately if the resident has been bitten or is suspected to have been bitten by the insects/pests.
11. Monitor for signs and symptoms of an actual or potential harmful response to insect/pest bites, including vital signs.
 - Transport resident immediately, while waiting on physician response, if an allergic response is suspected.
12. Notify Emergency Medical Squad immediately for transport to ER, if resident suffered numerous bites.
13. Notify Emergency Medical Squad immediately for transport to ER, if resident has a potential or actual allergic response to bite(s).
14. Notify family and/or legal representative of incident.
15. Document incident in the Nurse's Notes.
16. Initiate an *Incident/Accident Report*.

Inservice Hours

Nurse 

Name: _____

Date of hire: _____

[illegible]

I.V. Medication Flowsheet

GUIDELINE

- PURPOSE** To document infusion therapy maintenance
- POPULATION** Complete this form for any resident receiving Infusion Therapy with a Vascular Access Device (VAD).
- RESPONSIBLE PERSON** All areas of the *I.V. Medication Flowsheet* are completed by and RN/LPN.
- INSTRUCTIONS**
1. Enter the resident's name and room number.
 2. Enter a checkmark (✓) to indicate the type of VAD.
 3. Enter continuous I.V. fluid and/or intermittent fluid.
 4. Enter the location of the VAD.
 5. Check the number of lumens.
 6. Complete each section of the flowsheet based on frequency described. Enter initials in corresponding day/shift boxes.
 7. Complete signature area and initials.
 8. Maintain with the Treatment Record and/or MAR while in use.
 9. Upon completion, file in the resident's medical record.

I.V. Medication Flowsheet

Resident Name:	Room #	Type of IV:	Peripheral	Groshong	Central	PICC	Implanted ports	Midline
Scheduled Times	Start Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Primary IV fluid (include solution & additives, volume and rate)								
IV start (Document on pg. 2)								
Tubing Δ q 48 hrs - TPN & filter q 24 hrs								
IV Medication (include drug and dose, diluent and volume, rate and frequency)								
NS Flush _____ mL Δ & p meds								
Tubing Change q _____ hrs								
IV Medication (include drug and dose, diluent and volume, rate and frequency)								
NS Flush _____ mL Δ & p meds								
Tubing Change q _____ hrs								
Heparin Flush: _____ Units/mL								
_____ mL q _____ hrs								
Site location _____								
Site check q shift								
Document any findings & interventions in Nurses Notes.								
Peripheral line site Δ q _____ days unless otherwise prescribed								
Injection Cap Change q _____ Each lumen ☐								
Dressing Change q _____								
IV Discontinued Date:								
Diagnosis for IV:								
Allergies:								
Site Check (code):								
1. No problems								
2. Redness at site								
3. Swelling at site								
4. Complaints of pain								
Site Location (code):								
1. Right hand								
2. Right forearm								
3. Right antecubital								
4. Right upper arm								
5. Left hand								
6. Left forearm								
7. Left antecubital								
8. Left upper arm								
9. Right chest wall								
10. Left chest wall								
11. Other - see comments								

IV Medication Flowsheet (page 2)

Resident Name:

INITIALS

SIGNATURE

INITIALS

SIGNATURE

INITIALS

Room #:

SIGNATURE

DATE	TIME
11/11/2011	11:11

COMMENTS: Use space below to explain procedures from other side, if needed – i.e., reason for site change

NURSE'S INITIALS

Licensure Verification – Nursing Assisted Living

- POLICY** A facility designated RN will be appointed and responsible for verification of licensure for all nurses, newly hired and renewals.
- PURPOSE** To meet any compliance regulations set forth by the state and to ensure that employees have the appropriate credentials to perform the job.
- PROCEDURE**
1. Upon offering a position with NCR, the applicant will be advised of the requirement to provide necessary information for credentialing.
 2. The facility designated RN will obtain licensure information on nurses by utilizing the internet website of the Ohio Board of Nursing.
 - The Ohio Board of Nursing website provides sufficient information for licensure verification. The print out from this website is sufficient for new hire processing and for state regulations.
 - It is no longer required or considered to be appropriate protocol to copy the nursing license and keep for the file. This practice should cease.
 3. The RN designee will sign and date all RN and LPN licensure verifications on the web print out.

GUIDELINE

Master Signature Log

PURPOSE	To eliminate the need for nurses to sign individual resident MARs and TARs each month.
RESPONSIBLE PERSON(S)	Director of Nursing or designee – Assures signatures of all new and current nurses
PLACEMENT	The <i>Master Signature Log</i> will be kept in a binder located at the nurse's station.
PROCEDURE	1. Enter the current date in the "Date" column. 2. Print first and last name in the "Print Name" column. 3. Enter the accepted initials for your title in the "Title" column (i.e., RN, LPN, STNA) 4. Sign your name in the "Signature" column, starting with first name. 5. Enter your initials in the "Initials" column <i>exactly</i> as you will be entering your initials on the medical record(s). 6. Place the <i>Master Signature Log</i> in a designated binder.

[illegible]

Medicaid Waiver – Assisted Living Assisted Living Service

POLICY

Traditions facilities that accept Medicaid Waiver residents will provide services that promote aging in place, individual independence, choice, and privacy through the provision of services, as authorized by the resident's assisted living care plan as identified in 173-39-02.16 of the Ohio Administrative Code.

PROCEDURE

1. Prior to service delivery, each facility staff member will receive inservice education in the following subject areas:
 - Principles and philosophy of aging
 - The aging process
 - Intermittent curing, redirecting, and environmental cues for cognitively impaired residents and/or behaviorally impaired residents
 - Confidentiality
 - The resident's care plan process
 - The resident's right to assume responsibility for decisions related to his/her care
2. Facility staff under the age of 18 years of age shall not perform the following:
 - Assist with medication supervision, medication administration, or delegated nursing tasks
 - Transportation
 - Hands on assistance with bathing, toileting, or transferring a resident without one site supervision
3. The Director of Nursing/Designee will provide and document at least eight hours of continuing education annually for facility staff who provide personal care (with the exception of licensed professional staff whose scope of practice include the provision of personal care service).
4. The Director of Nursing/Designee will ensure the implementation of the Medicaid Waiver resident's care plan.
 - The care plan will be completed by the resident's case manager
 - The care plan will be maintained on the resident's chart
 - Facility staff will document all services provided to the resident as identified in the care plan on the *Resident Care Log*.

5. Care Conferences will be held quarterly for each Medicaid Waiver resident. Documentation will include the following:

- Date and time of the care conference and who attended
- The resident's satisfaction and appropriateness of the assisted living care plan
- Review of the *Resident Care Log* to assure implementation of the care plan and that staff are providing personal care appropriately.

Medicaid Waiver – Assisted Living Community Transition Services

POLICY

Traditions assisted living facilities who accept Medicaid Waiver residents will assist each resident with community transition services as required under rule 173-39-02.17 of the Ohio Administrative Code.

PROCEDURE

1. The Administrator/Designee will communicate with the resident's case manager to determine what /items have been approved and authorized (up to \$1500) by the case manager.
2. Upon admission to the facility, facility designated staff will take the resident and/or responsible party shopping so the resident/responsible party can choose all approved items.
3. The facility will purchase the selected items for the resident and will obtain an itemized receipt for all purchased items. The itemized receipt will include the following:
 - Name of vendor from which the item was purchased
 - Accurate description of the item purchased
4. All purchased items will be delivered to the facility not later than 90 days after the resident's admission date.
5. Upon delivery of the approved purchased items the resident/responsibility will sign an inventory sheet that identifies all purchased items have been received.
6. The Business Office Manager will maintain a file of all purchased items and a copy will be maintained in the resident's medical record.
7. The Business Office Manager will submit a copy of the resident's expenses to the NCR corporate office and NCR corporate office will then bill Medicaid for the purchased items.
8. Upon the death or discharge of a Medicaid Waiver resident all purchased items become the property of the resident/estate.

Medicaid Waiver – Assisted Living Employment of Family as Caregiver

POLICY

Traditions facilities who accept Medicaid waiver residents will adhere to OAC 173-39-02 (B) (5) regarding relatives not caring for Medicaid waiver residents.

PROCEDURE

1. Traditions employees who provides direct care duties will inform the Director of Nursing/Designee during new employee orientation of any relative who is a Medicaid waiver resident at the facility.
2. Staff who are a parent, step parent, or spouse to a Medicaid waiver resident will not be assigned to care for the resident.

Medical Equipment

POLICY

Traditions utilizes medical equipment based on manufacturer's instructions for use and maintenance. Staff members are trained on the safe and effective use of medical equipment. Equipment for resident use is selected based on the individual identified needs. The facility maintains copies of manufacturer materials on the use and care of the medical equipment. Equipment owned by the facility is tested for operational safety prior to resident use and maintained by the designated facility staff. Rental and/or leased equipment is checked for operational safety prior to resident use. Rental and leased equipment is tracked to maintain the proper identity, ownership, and dates for required testing and maintenance.

RESPONSIBLE PERSON

Administrator and DON

PURPOSE

- Provide information on the safe and proper use of medical equipment.
- Maintain medical equipment according to manufacturer recommendations.
- Select medical equipment for resident specific use based on identified needs.

PROCEDURE

1. Determine designated staff member(s) to be responsible for the review, care, maintenance, and tracking of all owned, rental & leased medical equipment.
2. Provide training and credential staff on the proper use of medical equipment. Document upon completion.
3. Select equipment for resident use based on identified individual needs. The selection process includes an evaluation of, but is not limited to:
 - Cognitive status
 - Clinical conditions
 - Functional status
 - Size of resident (i.e., height and weight)

4. Follow manufacturer's instructions for the assembly, care, and maintenance of medical equipment.
5. Maintain cleaning and maintenance schedules, and quality assurance checks on owned, rental or leased medical equipment.
6. If there is a failure of the medical equipment, refer to the *Safe Medical Device Act* procedure (located in the Clinical Administrative Manual).

Medicare Documentation Requests/Denials Additional Documentation Request (ADR) (Skilled Nursing and Assisted Living)

POLICY

Traditions Medical Records staff will coordinate with the clinical and therapy team and Corporate Biller to obtain facility medical records documentation requested as a result of an additional documentation request (ADR). All documents will be reviewed by the appropriate discipline for accuracy and completeness prior to submission to Corporate Biller.

PROCEDURE

1. The Corporate Biller is notified of the Medicare Documentation Request (Additional Documentation/Denial) who will log each claim on spreadsheet to ensure compliance with deadlines.
2. The Corporate Biller will request the applicable documents from facility Medical Records staff.
3. Medical Records staff will obtain the documents and provides them for review by the Facility Rehabilitation Manager, Director of Nursing and MDS Coordinator as applicable.
4. A copy of the documents will be sent by the Facility Rehabilitation Manager to the Director of Rehabilitation Services for review. The following *therapy* documents must be included at minimum for the dates requested:
 5. Plan of Treatment for Rehabilitation (Eval/700)
Signed by therapist and MD, dated by the MD, original in hard chart (usually only "page 1 of 2").
 6. Completion of Plan of Treatment for Rehabilitation
Completion of evaluation/700, will either be completed at discharge summary or at end of certification with reason for continuation of services into another certification period, signed by therapist (not MD) and original in hard chart (page 2 of above).
 7. Updated Plan of Treatment for Rehabilitation
Re-certification/701, if treatment continues beyond initial certification period. Signed by therapist and MD, dated by the MD, original in hard chart (usually only "page 1 of 2").
 8. Completion of Plan of Treatment for Rehab
Same as number 2 with either continuation or discharge.

9. Progress Note
Completed every seven (7) days from evaluation, including weeks of recertification and discharge, signed by therapist and co-signed by PT/OT if written by PTA or COTA, original in hard chart.
10. Daily Notes
"Incidental" daily clinical notes; if present must be signed/co-signed by therapist, original in hard chart.
11. Service Log Matrix
Daily log/Billing Grid.
12. Signed Physician Orders
For Initial "EVALUATION and TX" and covering treatment for duration of care; treatment order must include Discipline, Frequency, Duration and Modalities (must match Plan of Care and billing). Signed and Dated by therapist, nurse and MD.
13. If the dates requested do not include the initial evaluation, include this and any subsequent re-certification documents and physician's orders up to and including the month requested. Weekly progress notes and Service Logs do not need to be included for months not requested unless there is a reason to believe they would better support services provided during the month of request.
14. The documents need to be reviewed and returned to the Corporate Biller by Medical Records within 5 days or less of request.
15. The Corporate Biller will review for completeness and logic.
16. If all reviews are met positively, then the Corporate Biller will submit to CMS.
17. If reviews have concerns then the Corporate Biller and/or the Director of Rehabilitation Services will notify the specific disciplines to resolve within 5 days of notification. (Therapy, DON). The Administrator will be copied at this time.
18. Any remaining concerns will be resolved by involvement of the Administrator, Vice President of Clinical Services and Director of Rehabilitation Services. The Vice President of Clinical Services will inform the Corporate Biller if/when it is approved to send to CMS.
19. **OUTPATIENT THERAPY:**
 - (A) Follow steps one and two of the procedure above.
 - (B) Medical Records will obtain the documents and the Facility

Rehabilitation Manager will review for completeness and accuracy.

- (C) The documents need to be reviewed and returned to the Corporate Biller by Medical Records within 5 days or less of request.
- (D) The Corporate Biller will review for completeness and logic.
- (E) If all reviews are met positively, then the Corporate Biller will submit to CMS.
- (F) If reviews have concerns then the Corporate Biller will notify the Director of Rehabilitation Services and Medical Records staff who will notify the specific disciplines to resolve the issues within 5 days of notification. (Therapy). The Administrator will be copied at this time.
- (G) Any remaining concerns will be resolved by involvement of the Administrator and Director of Rehabilitation Services. The Director of Rehabilitation will inform the Corporate Biller if/when it is approved to send to CMS.

Medication Administration Times for Person Centered Care

POLICY

Traditions facilities operate under a person centered model of care. In this model, the resident choices are honored in the areas of hour of sleep, rising, meals, activities, etc. Medication administration also follows the resident's preferences unless the physician orders a medication to be given at specific set times.

Medication administration times are as follows: Upon rising, before/after lunch, before/after dinner, and hour of sleep. Medications are given per individual resident preference and physician orders.

If the facility is using an electronic medical record system, the current system is not capable of utilizing open time frames for medication administration. Due to this limitation, the electronic medical record will use a specific time as a "time marker" for medication administration unless the physician order specifies differently.

PROCEDURE

1. Identify the resident's preferences for when they would like to receive their medications.
2. Determine if there are any specific physician orders for medications that must be given at set time frames.
3. If a medication is to be given per a specific physician timeframe, the nurse will add this information to the resident's medication administration record or electronic medication record entry under physician's instructions.
4. Medications should not be given during a resident's sleeping hours.
5. Resident's on round the clock pain control should continue to be awakened to receive their pain medication.

Medication Error(s)

POLICY

Traditions strives to ensure that residents will not experience undue discomfort and/or have their health and safety placed in jeopardy due to a medication error. Traditions also strives to ensure that residents will be free of all non-significant and significant medication errors during their stay.

PROCEDURE

1. Administer medications safely and accurately using a licensed nurse.
2. Check the medication against the prescription or order before they are administered.
3. Prepare and administer medication using the same person.
4. Administer medication within prescribed time frames.
5. Identify resident before medication is administered.
6. Administer medications according to the frequency, route and dose prescribed.
7. Administer medications only to the residents for whom they are ordered.
8. Assess vital signs prior to medication administration when indicated.
9. Evaluate the continuing need for and use of PRN medications by the resident.
10. Report immediately, significant and non-significant medication errors. (Refer to the "Incidents/Accidents: Report, Investigation, Follow-Up and Disposition" Policy.)
11. Develop and maintain processes for defining, identifying, and reviewing significant medication errors collaboratively with Nursing, Pharmacy, and other appropriate staff through the CQI Committee.

Non-Discrimination of Residents

POLICY

Traditions has designed and implemented processes which strive to ensure equal treatment of all residents without regard to race, color, national origin, sex, handicap, or religion. The same requirements are applied to all individuals, and residents are assigned rooms without regard to race, color, national origin, handicap, or religion. There is no distinction in eligibility for or in the manner of providing resident services. All services are available without distinction to all residents and visitors regardless of race, color, national origin, sex, handicap, or religion. All persons and organizations having occasion either to refer persons for services or to recommend a Traditions facility are advised to do so without regard to race, color, national origin, sex, handicap, or religion.

PROCEDURE

1. Assign a room according to resident gender excluding married couples wishing to reside in the same room together.
2. Provide all services as ordered by the physician and per the resident's plan of care.

Notification of Resident Change in Condition

POLICY

Traditions clinicians will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur. If known, the facility shall also notify the resident's legal representative or an interested family member.

PROCEDURE

Notification of changes shall include:

Immediate Notification –

1. An accident involving the resident ***which results in injury and has the potential for requiring physician intervention***
2. A ***significant*** change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental or psychosocial status in either ***life-threatening conditions or clinical complications***
3. A need to alter treatment ***significantly*** (i.e., a need to discontinue an existing form or treatment due to adverse consequences, or to start a new form of treatment)
4. A decision to transfer or discharge the resident from the facility

Prompt Notification –

1. A change in room or roommate assignment'
2. A change in resident rights under Federal or State law or regulations pertaining to care of the resident

MEDICAID WAIVER RESIDENTS:

1. The facility will also notify the case manager within one (1) day for each Medicaid waiver resident when:
 - a. The resident refuses services repeatedly
 - b. The resident moves to another address
 - c. There are changes in the physical, mental, and/or emotional status of the resident, changes in environmental and/or other health and safety issues
 - d. The resident is hospitalized or has died
 - e. There is a suspicion of abuse, neglect, and/or exploitation of a resident
 - f. The resident's level of care changes and the facility must transfer the resident to a skilled nursing facility.

Nurse Practitioner Acute Visit Form

Name: _____		DOS: _____		☐ Skilled ☐ Nonskilled	
DOB: _____		Physician/Facility: _____		☐ Hospice ☐ Home Visit	
Chief Complaint: _____			HPI: (symptoms, duration, context, severity, timing, location, modifying factors)		
Allergies: _____					
Code Status: _____					
Past Medical/Surgical/Social/Family History:			Vital Signs:		
			Temp _____ Pulse _____ Resp _____ B/P _____ WT _____ Pain (1-10) _____		

DIAGNOSIS	ROS	PHYSICAL EXAM	DIAGNOSIS	ROS	PHYSICAL EXAM
HEENT	Tenderness ☐ Y ☐ N	Tenderness ☐ Y ☐ N	CARDIAC	Chest Pain ☐ Y ☐ N	S3 S4 Murmur ☐ Y ☐ N
	Tinnitus ☐ Y ☐ N	Cerumen imp. ☐ Y ☐ N		Palpitations ☐ Y ☐ N	Pedal Pulses + _____ ☐ Y ☐ N
	Gum Tender ☐ Y ☐ N	Discharge ☐ Y ☐ N		Radiating Pain ☐ Y ☐ N	Arrhythmia ☐ Y ☐ N
	Hearing Changes ☐ Y ☐ N	PERRL ☐ Y ☐ N		Edema ☐ Y ☐ N	Pedal Edema + _____ ☐ Y ☐ N
	Discharge ☐ Y ☐ N	Oral, Pharynx ☐ Y ☐ N	NEURO	Dizziness ☐ Y ☐ N	CN II - CNXII Intact ☐ Y ☐ N
	Sinus Pain ☐ Y ☐ N	Lesion ☐ Y ☐ N		Paralysis ☐ Y ☐ N	Tremors ☐ Y ☐ N
	Dry Mouth ☐ Y ☐ N	Nasal Mucosa ☐ Y ☐ N		Tremors ☐ Y ☐ N	Arm Drift ☐ Y ☐ N
	Vision Changes ☐ Y ☐ N	TM ☐ Y ☐ N		Tingling ☐ Y ☐ N	Gait ☐ Y ☐ N
Chewing Problems ☐ Y ☐ N		Numbness ☐ Y ☐ N	DTR's ☐ Y ☐ N		
ENDOCRINE	Goiter ☐ Y ☐ N	Lymphadenopathy ☐ Y ☐ N	PSYCH	Confusion ☐ Y ☐ N	Judgment ☐ Y ☐ N
	Polyuria ☐ Y ☐ N	Thyroid Enlargement ☐ Y ☐ N		Delusions ☐ Y ☐ N	Orient P & T ☐ Y ☐ N
	Polyphagia ☐ Y ☐ N	Blood Sugars ☐ Y ☐ N		Apathy ☐ Y ☐ N	Agitation ☐ Y ☐ N
	Fatigue ☐ Y ☐ N		Insomnia ☐ Y ☐ N	Obtunded ☐ Y ☐ N	
	Heat and Cold ☐ Y ☐ N		MUSC/SKEL	Pain ☐ Y ☐ N	Tenderness ☐ Y ☐ N
	Intolerance ☐ Y ☐ N			Swelling ☐ Y ☐ N	Muscle Weakness ☐ Y ☐ N
Polydypsia ☐ Y ☐ N		Cramping ☐ Y ☐ N		Swelling ☐ Y ☐ N	
GASTRO	NV ☐ Y ☐ N	Tenderness ☐ Y ☐ N	SKIN	Ecchymosis ☐ Y ☐ N	Crepitus ☐ Y ☐ N
	Diarrhea ☐ Y ☐ N	Organomegaly ☐ Y ☐ N			ROM ☐ Y ☐ N
	Constipation ☐ Y ☐ N	Masses ☐ Y ☐ N		Itch ☐ Y ☐ N	Skin Ulcer ☐ Y ☐ N
	Pain ☐ Y ☐ N	Hemorrhoids ☐ Y ☐ N	Discharge ☐ Y ☐ N	Lymphedema ☐ Y ☐ N	
	Bloating ☐ Y ☐ N	Stool OB ☐ Y ☐ N	Pain ☐ Y ☐ N	Breast Masses ☐ Y ☐ N	
	Heartburn ☐ Y ☐ N	Bowel Sounds ☐ Y ☐ N	Moles ☐ Y ☐ N	Nipple Discharge ☐ Y ☐ N	
RESP	Appetite ☐ Y ☐ N			Rash ☐ Y ☐ N	
	Inc. Secretions ☐ Y ☐ N	Rales ☐ Y ☐ N	GU	Hematuria ☐ Y ☐ N	Discharge ☐ Y ☐ N
	Dyspnea ☐ Y ☐ N	Wheeze ☐ Y ☐ N		Dysuria ☐ Y ☐ N	Lesion ☐ Y ☐ N
	Wheeze ☐ Y ☐ N	Rib Tenderness ☐ Y ☐ N		Polyuria ☐ Y ☐ N	Supra pubic tender ☐ Y ☐ N
	Orthopnea ☐ Y ☐ N	Percussion ☐ Y ☐ N	Incontinent ☐ Y ☐ N	Masses ☐ Y ☐ N	
	Cough ☐ Y ☐ N	Rhonci ☐ Y ☐ N		Prostate ☐ Y ☐ N	
	Barrel Chest ☐ Y ☐ N	OTHER		☐ Y ☐ N	
	Egophony ☐ Y ☐ N			☐ Y ☐ N	
	O2 Sat ☐ Y ☐ N			☐ Y ☐ N	

MEDS:	LABS:
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PRACTITIONER SIGNATURE	Patient: ☐ New ☐ Est.	E/M CODE:
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This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears to be a standard notebook page.

1)

2)

3)

4)

5)

1)

2)

3)

4)

5)

Ombudsman

POLICY

An Ombudsman is available to all residents to represent them to ensure quality care, resolution of complaints, and education on issues of residents.

PROCEDURE

1. Obtain the name and phone number of the Ombudsman for your facility.
2. Post the information on how to access the Ombudsman in an area easily and readily accessible to residents and/or families.
3. Assure the role and advocacy of the Ombudsman is supported by all facility staff.

GUIDELINE

Oral Nutrition/Hydration Waiver

PURPOSE To document the resident/responsible party's decision to ignore recommended care and treatment regarding the resident's diet consistency, and/or consuming oral intake.

RESPONSIBLE PERSON(S) Licensed Speech Language Pathologist, Licensed Nurse

INSTRUCTIONS

1. Notify the attending physician and Director of Nursing of the resident's refusal to follow recommended care and treatment regarding the resident's diet consistency, and/or consuming oral intake.
2. Explain risks to resident choosing to ignore recommended care and medical treatment.
3. Read and carefully explain the *Oral Nutrition/Hydration Waiver* to the resident/responsible party.
4. Obtain the signature of any resident ignoring the recommended care and treatment and witness signature.
5. If the resident/responsible party refuses to sign the waiver, notify the Administrator.
6. File the waiver in the resident's medical record.

DETERMINATION TO IGNORE MEDICAL ADVICE & RELEASE OF LIABILITY REGARDING ORAL NUTRITION/HYDRATION

Name of Resident

The resident noted above has had an evaluation completed by a speech language pathologist who has recommended the following: _____

The resident and, as applicable, the undersigned attorney-in-fact, guardian, or other interested person who may direct the care received by the resident (the undersigned are collectively referred to as the "Interested Parties"), however, wish to exercise the resident's right to refuse recommended care and treatment. Specifically, the Interested Parties wish for the resident to consume the following or to have the following diet consistency: _____

The Interested Parties understand the following with regard to this decision:

- 1) The resident's physician, speech language pathologist, and the facility in which the resident lives all **DO NOT RECOMMEND THIS COURSE OF ACTION**. Indeed, the resident's current care plan specifically states that the resident is NOT to consume the items or consistency listed above.
- 2) If the resident consumes nutrition and hydration as noted above, then there is a **HIGH RISK** that he/she will suffer a **SERIOUS NEGATIVE HEALTH OUTCOME** including, but not limited to the following: **MALNUTRITION AND WEIGHT LOSS, PRESSURE SORES, DEHYDRATION, MENTAL STATUS CHANGES, RENAL FAILURE, COMA and DEATH.**
- 3) Another **HIGH RISK** is that the resident will aspirate the food or liquid that he/she consumes, which means there is a high likelihood that he/she will inhale material from his/her stomach, oral/pharyngeal tract or both into his/her lungs. Aspiration can result in **SERIOUS PULMONARY COMPLICATIONS** and possible death. The pulmonary complications include, but are not limited to, the following:
 - a) **Pneumonia**: An inflammation of the lungs associated with the entrance of foreign matter such as food particles into the respiratory passages.
 - b) **Abscess**: A localized cavity with pus resulting from the death of lung tissue with surrounding pneumonia.
 - c) **Airway obstruction**: A blockage of the airway resulting in difficulty breathing or complete loss of airway and suffocation.

- d) **Adult respiratory distress syndrome:** Respiratory failure with life-threatening respiratory distress and lack of oxygen associated with various acute pulmonary injuries including bacterial or viral pneumonia or aspiration of gastric contents.

The Interested Parties have had the opportunity to meet with the resident's physician, a speech language pathologist, and the director of nursing (or his/her designee) of the facility in which the resident lives. They have explained the reasons why they do not recommend the care decision that the Interested Parties have made, and the Interested Parties have had the opportunity to ask them questions about the consequences of the decision that they are making. The Interested Parties have had all of their questions answered to their satisfaction.

Fully understanding the risks of their decision, the Interested Parties willingly accept and assume such risks because they believe that the benefits of their decision outweigh those risks. The Interested Parties understand that this decision is contrary to the recommendations of the resident's care givers, and, thus, would like to release those care givers from any liability for their decision to ignore medical advice. The Interested Parties therefore agree voluntarily to the following release:

RELEASE OF LIABILITY: I hereby agree on behalf of myself, and on behalf of my heirs, executors, administrators, successors, assigns, and any other person or entity claiming by or on my behalf to discharge the resident's current attending physician and any other physician who may care for the resident in the future, and Traditions, and its past, present and future officers, directors, shareholders, members, agents, servants, representatives, partners, affiliates, attorneys, subsidiaries, predecessors, successors and assigns from any and all claims, demands, causes of action, damages and actions of whatsoever kind or nature, legal or equitable, whether arising out of contract, tort, or otherwise, known or unknown, foreseen or unforeseen, which I once had, now have, or may in the future have (or that I may bring on behalf of the resident) against the persons and entities noted above, including but not limited to any and all claims related to, arising out of, or in connection with, directly or indirectly, any mental or physical injuries that the resident or I may suffer as a result of the determination to ignore medical advice as noted above. I further covenant and agree not to bring or cause to be brought or prosecuted any suit, action or administrative proceeding in any federal or state court or administrative body with respect to any matter covered by this release of liability.

By signing this Determination to Ignore Medical Advice & Release of Liability ("Release"), and in connection with the release of claims and covenant not to sue set forth above, I acknowledge that: (a) I am knowingly and voluntarily entering into this Release; (b) this Release has been written in understandable language and all of its provisions are understood by me; (c) this Release is being signed by me without relying upon any statements by Traditions or its representatives concerning the nature or extent of any claims or damages or legal liability; and (d) I have been advised in writing to consult with an attorney before signing this Release and been given fair opportunity to do so.

IN CONSIDERATION OF TRADITIONS CONTINUING TO RENDER SERVICES TO THE RESIDENT, I DO FOR MYSELF (AND ON BEHALF OF THE RESIDENT, IF APPROPRIATE) AGREE TO THE TERMS OF THIS DETERMINATION TO IGNORE MEDICAL ADVISE & RELEASE OF LIABILITY.

SIGNATURE OF RESIDENT

Signature

Date

Witness

Date

SIGNATURE OF INTERESTED PARTIES

Durable Power of Attorney for Health Care. I am the resident's attorney-in-fact as designated through a valid durable power of attorney for health care (DPAHC). I have provided a copy of DPAHC to the facility.

Signature

Date

Print Name

Guardian. I have been appointed the resident's guardian. I have provided the facility with a copy of a valid letter of appointment of guardianship from probate court, which indicates that I am the resident's guardian of person.

Signature

Date

Print Name

Other. I am the resident's family member, friend or advocate who has the responsibility of making care decisions for the resident.

1)

Signature

Date

Print Name & Relationship

2)

Signature

Date

Print Name & Relationship

3)

Signature

Date

Print Name & Relationship

Overtime – Extended Work Due to Weather and Other Emergencies

POLICY

In order to protect our residents in time of emergency, it is the policy of Traditions facilities that, during weather and other emergencies, staff may be required to remain working past their normal shift hours.

PROCEDURE

1. Inform staff this excess period will extend until replacement staff have been located and have arrived at the facility.
2. Inform all employees they must be released by their line manager prior to leaving the facility.
3. Make every attempt to obtain and transport replacement staff.

Care of Resident Personal Items

POLICY

Traditions has designed and implemented processes which strive to ensure safekeeping of resident personal items. Residents and their families are informed during admission of the facility's efforts to protect property and personal belongings. The staff is oriented to the facility's efforts to protect the property, practice infection control, and implement safety measures upon hire.

PROCEDURE

1. Facility designated staff will attempt to identify each personally owned item by placing the resident's name on the item (if possible). This would include, but not be limited to:
 - All articles of clothing and shoes/slippers
 - Personal hygiene articles (toothbrush, comb, denture cup, etc.)
 - Appliances (TV, radio, fan, etc.)
 - Wheelchair, walker, cane, etc.
 - Furniture (chair, dresser, TV stand, etc.)
2. Document the personal items on the *Inventory of Personal Effects* (see Medical Records Program).
3. Store personal hygiene items utilizing infection prevention practice.
4. Determine at admission if the family or facility is to do the laundry of personal items of clothing.
5. Maintenance staff will assure each personal electrical item brought into the facility has been inspected for safety.
6. Initiate an investigation using the *Personal Items – Theft and Loss Investigation* if a personal articles is missing.

Personal Items – Theft and Loss Investigation

POLICY

Traditions has designed and implemented processes to strive to prevent the theft/loss of resident's clothing and other belongings. While maintaining the resident's right to refuse in accordance with State requirements, clothing and other personal belongings will be marked in a manner that properly identifies the resident without defacing the property. Marking personal belongings permits identification and validation of ownership if an article is lost, stolen, or misplaced. (Refer to the *Abuse, Neglect, Mistreatment and/or Misappropriation of Resident Property* policy for further prevention measures if theft/misappropriation of property is suspected.)

Even with prevention measures in place, Traditions realizes not all thefts/misappropriation of property and losses can be prevented. Traditions facilities will investigate all presumed thefts, misappropriation of property, and losses and take action as needed. The facility will assist the resident in the recovery of lost or stolen items.

The facility shall not be responsible for the loss of money and loss or damage to jewelry, documents, or other personal property retained in resident's possession unless otherwise required under State law.

PROCEDURE

1. Conduct an initial search by contacting all departments that had contact with the resident to see if the item(s) could be located.
2. Notify the Administrator, DON, and immediate supervisor.
3. Meet with the resident or their responsible party to discuss what is missing and how the disappearance may have occurred.
4. Initiate the *Personal Item Loss Report* form if item is not located.
 - Document the **description** of the article using **objective** terms (i.e., "yellowish colored ring with a clear setting," not a "gold ring with a diamond setting").
5. Request staff conduct an exhaustive search of the facility such as:
 - Focus on areas that are frequented by the resident.
 - Thoroughly look through the resident's bedside stand, closet, etc. (Obtain resident's permission prior to search.)

- Focus on rooms of residents that wander and are known to pick up unattended articles.
 - Request laundry personnel check through laundry in the laundry area.
 - Check washers and dryers.
 - Closely monitor food trays as they are picked up and returned to dietary.
6. Assist the resident in replacement of the missing items (according to facility practice), if the item cannot be located.
7. Notify the Administrator, Director of Nursing, and employee's immediate supervisor if there is an allegation of theft/misappropriation of property.
- Refer to the *Abuse, Neglect, Mistreatment and/or Misappropriation of Resident Property* policy and complete an investigation regarding the allegation.
 - The administrator/designee will notify authorities per state requirements.

GUIDELINE

Resident's Personal Item Loss Report

- PURPOSE** To document and facilitate the search for the presumed loss of a resident's personal items.
- POPULATION** To be completed for all residents when a personal article is not located on the initial search.
- RESPONSIBLE PERSON(S)** Shift Supervisor, Charge Nurse, or designee
- PROCEDURE**
1. Enter the following information:
 - Person completing report
 - Date
 - Resident's name
 - Resident's room number
 2. Document the date the resident and/or family first noticed articles was missing.
 3. Document a description of the missing item in objective terms, e.g.
 - Yellow – not gold
 - Silver color – not silver, white gold, or platinum
 - Clear stone – not a diamond
 - Red stone – not a ruby
 4. Enter the estimated value of the item.
 5. Enter a description of:
 - Resident's account of how the article may have disappeared
 - What the resident was doing when they noticed it was missing
 - Where they were when they last noticed the item

6. Describe what the staff has done to search for the missing item and place a checkmark (✓) in the appropriate box as the facility and grounds are searched. Enter areas searched in "Other" if not listed.
7. Document other actions taken by the facility, i.e.:
 - Requested assistance from immediate caregivers and other staff to assist in identifying where and when the item was last seen.
 - Assisted resident in replacement of the missing item.
8. Place a checkmark (✓) in the appropriate box as the Administrator, DON, and Social Services Department are notified. Enter the date on the appropriate line.
9. Document all other comments in the appropriate section.
10. The original copy should be given to the Administrator and the duplicate to the appropriate discipline.

Resident Personal Item Loss Report

Person Completing Report: _____

Date: _____

Name of Resident: _____

Room # _____

Date First Noticed Item(s) Missing _____

Description of Item(s) _____

Resident/Family's Description of how disappearance may have occurred (i.e., left on food tray; in Activities room, etc.)

What has staff already done to search for this item? _____

Area Searched by Staff:

- | | |
|--|--------------------------------------|
| ☐ Bedside Stand | ☐ Activities |
| ☐ Dresser | ☐ Kitchen |
| ☐ Closet | ☐ Other Rooms |
| ☐ Laundry Area | ☐ Patio |
| ☐ Dining Room | ☐ Bathroom(s) |
| ☐ Other _____ | |

Other Action Taken by Facility: _____

Notified:

- ☐ Administrator ☐ DON ☐ Social Service

Comments: _____

Original – Administrator

Duplicate – Applicable Discipline (Director of Housekeeping/Laundry, Social Services Director, Director of Nursing)

Pets Visitation/Therapy

POLICY Traditions recognizes that pets offer companionship and emotional support and may be psychologically beneficial. Traditions allows both therapeutic pet visits and pets residing at the facility.

It is the policy of Traditions that pets will be allowed to reside in resident rooms. In the care of a resident's leave of absence, for whatever reason, the pet cannot remain in the facility.

All pets visiting/residing in the facility must wear a current animal license tag, valid rabies tag and tag bearing owners name, address and phone number.

Infection prevention and control involves cooperation of facility staff, veterinarians, residents, and families. The following procedures will be followed.

PROCEDURE

Pet Therapy

1. Require animals participating in pet therapy sessions to be:
 - Tame and docile
 - Current and complete with regard to recommended immunizations
 - In good health
 - Routinely screened for enteric parasites and/or have evidence of a recently completed anthelmintic regimen
 - Free of ectoparasites (e.g., fleas, ticks)
 - Free from obvious dermatologic lesions that could be associated with bacterial, fungal, or viral infections or parasitic infestations
 - Clean and well-groomed
 - Supervised by persons who know the animals and their behavior

2. Assure handwashing or hand hygiene measures (using alcohol-based hand degerming agents when a sink is not available) for all residents and staff after handling of animals.
3. Avoid direct contact with animal urine or feces.
4. Clean urine or feces from environmental surfaces utilizing gloves and leak-resistant (i.e., "zip-lockable") plastic bags to discard absorbent material used in the process.
5. Discourage animal visitation for residents with:
 - Underlying asthma
 - Recognized allergies to cat or dog hair
 - Respiratory allergies of unknown etiology
 - Immunosuppressive disorders
6. Restrict animals from the following areas of the facility:
 - Food preparation kitchens
 - Laundry
 - Storage area for clean supplies
 - Medication rooms
 - Isolation and protective environments
 - Resident dining area

Pet Visitation

1. Require animals participating in pet visitation or sessions to be:
 - Tame and docile
 - In good health
 - Free of ectoparasites (e.g., fleas, ticks)
 - Free from obvious dermatologic lesions that could be associated with bacterial, fungal or viral infections, or parasitic infestations
 - Clean and well-groomed
 - Supervised by persons who know the animals and their behavior

2. Assure handwashing or hand hygiene measures (using alcohol-based hand degerming agents when a sink is not available) for all residents and staff after handling of animals.
3. Avoid direct contact with animal urine or feces.
4. Clean urine or feces from environmental surfaces utilizing gloves and leak-resistant (i.e., "zip-lockable") plastic bags to discard absorbent materials used in the process.
5. Discourage animal visitation for residents with:
 - Underlying asthma
 - Recognized allergies to cat or dog hair
 - Respiratory allergies of unknown etiology
 - Immunosuppressive disorders
6. Restrict animals from the following areas of the facility:
 - Food preparation kitchens
 - Laundry
 - Storage area for clean supplies
 - Medication rooms
 - Isolation and protective environments
 - Resident dining area
7. Prohibit the following pets which pose an unacceptable risk of disease. The pets include, but are not limited to:
 - Skunks
 - Raccoons
 - Bats
 - Turtles

Pets Residing in Facility

Refer to facility specific policy and procedure.

Photographs – Resident Identification

POLICY

Photographs will be taken of all residents on admission and annually thereafter. Photographs will be used primarily for the purpose of identification, which may include, but is not limited to:

- Assist staff with the identification of residents
- Assist search team with identification in the event of a possible elopement
- Memory Care Units for room recognition

PROCEDURE

1. Explain to the resident and family or legal representative that the photograph is used primarily for *identification purposes*.
2. Prepare the resident for the photograph. Assure the following:
 - Hair is combed neatly
 - Clothes are straightened and neat looking
 - Women have make-up on *if* used
 - Placed in a location/position suitable for taking a picture if possible (e.g., sitting in chair, HOB elevated, etc.)
3. Focus the camera so only the upper torso is in the view finder, making the picture so the face is easily identifiable.
4. Enter the following on the developed picture. Resident's:
 - Name (first, last, and nickname, if applicable)
 - Date photo was taken
5. Place the picture in a protective cover or in a photo type album/binder
6. Place the album/binder in an area not easily accessible to other residents or the general public
7. Retake picture annually and follow step #4.
8. Remove previous photo from album/binder and destroy. Replace with current photo.

Physician Choice

POLICY

Traditions offers each resident the freedom of choice of physicians to the greatest extent possible. When a referring physician doesn't follow their residents in long term care, the resident and/or family is notified and given an opportunity to contact another physician of their choice, or they may elect to use a Traditions covering physician.

Each resident will also be informed that in the event their physician is unavailable, that the center will arrange for another attending physician to direct and meet their medical needs until their physician can be reached.

Should a resident or responsible party choose to change their attending physician while in the center, the resident or responsible party has the right to do so and must inform the current attending physician of their wishes.

PROCEDURE

1. Offer each resident or responsible party a choice of either their own primary physician or a physician arranged by the facility at the time of admission.
2. Ask each new resident or responsible party, should they not be able to make a sound choice at the actual time of admission, the name of the physician who he/she prefer to be their attending physician.
 - If that physician does not practice at the facility, inform the resident or responsible party of the names of the physicians who do practice at the facility.

Physician's Orders

POLICY

At the time each resident is admitted, the facility will have physician's orders for their immediate care. The physician's orders will be verified by the ***attending*** physician at the facility. All physician's orders will be dated and signed according to State and Federal regulations.

Clinicians may take verbal and/or telephone orders as permitted by their state licensure board.

PROCEDURE

1. Obtain one of the following types of physician's orders:
 - Verbal
 - Telephone order
 - Transmitted by facsimile machine (according to State/Federal regulations)
 - Written by the physician
2. Assure orders contain specific information including, but not limited to, the following (as applicable):
 - Date
 - Time
 - Resident name
 - Dosages
 - Routes
 - Frequency
 - Sites
 - Stop dates
 - Location (i.e., hospital, home, facility, etc.)
3. Clarify unclear written orders by reviewing with the physician requesting clarification and documenting clarification on the *Physician's Telephone Order* as an "Order Clarification."
4. Confirm verbal and telephone orders by repeating back to the physician.
5. Obtain physician signature on verbal telephone orders according to State/Federal regulations.

6. Obtain a diagnosis for each medication ordered.
7. The licensed nurse will assure the interdisciplinary team is aware of applicable orders.
8. Fax all orders immediately to the pharmacy.
9. Confirm accuracy of orders when the new monthly orders arrive from pharmacy.

Physician Standing Orders

MEDICATIONS

1. Acetaminophen 650 mg PO or 500 mg rectal, give every 4 hours PRN for elevated temperature > 100° or general discomfort. Notify physician of elevated temperature.
2. Imodium (one capsule or liquid equivalent) PO, give every 4 hours PRN for diarrhea. Notify physician if diarrhea persists for 24 hours.
3. Antacid/Simethicone susp. 30 ccs PO, give every 4 hours PRN for nausea/upset stomach. Do not give to renal residents. Notify physician if condition persists for 24 hours.
4. Guaifenesin 2 tsp. PO tid x 3 days for cold symptoms (i.e. cough, congestion, nasal drainage). Notify physician when started and if symptoms persist past 3 days.
5. Milk of Magnesia 30 ccs PO every day, PRN, for constipation.
6. Colace 100 mg 1 PO every day, PRN for constipation.

Bowel Protocol – if no BM in 3 days

- Give Milk of Magnesia 30 cc PO daily PRN for constipation
 - If no result give 1 Dulcolax Suppository rectally
 - If no results, give Fleets enema rectally. Call physician if problem persists.
7. May switch to liquid or crushable equivalent medication when needed.

TREATMENTS

1. Initiate oxygen at 2 liters per minute per nasal cannula or mask PRN for signs of cyanosis or shortness of breath. Physician must be notified immediately of patient's condition and reason for initiating oxygen therapy. Obtain O₂ SATS PRN per physician order.
2. Debrox ear gtts. PRN for earwax. Instill 5 – 10 gtts. Both ears bid up to 3 days. Place cotton ball in ear. (Do not use if ear pain is present.) Irrigate ear with warm water on day 4.
3. Skin Tear Treatment – follow *Wound & Skin Treatment Guidelines*.
4. Stage I, II, III, IV – follow *Wound & Skin Treatment Guidelines*.
5. May apply protective barrier cream as needed.

ADDITIONAL ORDERS

1. All intermediate care patients under my care go out on pass with medication per judgment of nurse. Special arrangements must be made with physician for overnight passes. Medicare and insurance patients' LOA's must be reviewed with Supervisor prior to obtaining order.
2. All residents under my care may receive a liberalized diet.
3. Diet consistency may be downgraded per nurse and diet technician judgment.

4. Diet consistency may be upgraded per judgment of speech therapist. The dietician can upgrade diet for non-swallowing issues only. *Example: dentures fixed, teeth pulled.*
5. Supplements may be added or discontinued per judgment of nurse/dietician/diet tech.
6. All patients under my care may have Fluogen 0.5 ml IM x 1 yearly (when available) unless allergic or refused by family.
7. Two-step Mantoux (PPD) test on all new residents who have not had previous known significant Mantoux tests and who do not have a record of two-step or single step Mantoux testing within the past twelve months preceding admission. If resident is positive reactor, obtain chest x-ray and obtain questionnaire annually.
8. Administer pneumonia vaccine per facility protocol.
9. May perform accucheck at discretion of nurse with physician notification if ≥ 400 or ≤ 60 .
10. May use "Insta Glucose" oral product as needed for hypoglycemic reaction. If not effective, may use Glucogen IM with physician notification.
11. Oral suction PRN, for inability to maintain airway due to excessive secretions.
12. Residents that are receiving anti-hypertensives will have blood pressure monitoring daily upon admission for seven (7) days and weekly thereafter. Physician to be notified if the resident's blood pressure reading is not within the following parameters:
 - Systolic between 90 and 140
 - Diastolic between 50 and 100

LAB ORDERS

Medication	Lab	Frequency
Digoxin	Dig Level	Every 6 months
Anticonvulsants Dilantin, Depakote, Phenobarb Tegretol (Not Neurontin)	CBC Anticonvulsant drug level	Every 6 months
Theophylline	Theophylline	Every 6 months
Lithium level	Lithium level	Every 6 months
Diuretics	BMP/MAG level	Every 6 months
Maintenance Anticoagulants	PT/INR	At least monthly
Urinary Anti-infectives	C/S Urine	F/U UA C/S within 2 weeks after ATB therapy, if symptomatic
Thyroid	Thyroid T3, T4, TSH	Yearly
Diabetics	Hgb A1C	Every 6 months with BMP
Procrit/Aranesp	Hgb/Hct	Weekly or monthly prior to Procrit/Aranesp

ADDITIONAL FACILITY SPECIFIC STANDING ORDERS

- 1.
- 2.
- 3.

Physician's Signature

Date

Press/Media Request for Information

POLICY

Traditions designs and implements processes to strive to assure accurate and effective communication with the press and/or media. Traditions has designated the Director of Communications to act as spokesperson in the event the press or media request a statement regarding confidential information or information that may potentially be viewed as having a negative affect on the facility.

RESPONSIBLE PERSON

Administrator

PROCEDURE

1. Notify the Chief Operating Office or Director of Communications if there is a press/media request for a statement.
2. Instruct staff not to discuss any circumstances or events with the press/media.

Private Duty Sitters

POLICY

Traditions recognizes the resident's and/or family's right to hire a private sitter.

Traditions employees are prohibited from providing "private care" for residents of the facility.

PROCEDURE

1. Inform the resident and/or family of the following:
 - They are responsible for obtaining and hiring the private sitter.
 - The private sitter must follow all standards of practice and care as set forth by Traditions.
 - The sitter is prohibited from performing functions they are not licensed or certified to perform.
 - The sitter must communicate with the nurse on duty of care they have provided for the resident.
 - The sitter must communicate with the nurse on duty if they observe a change or potential change in condition.
2. Instruct the private duty sitter they are required to report to the nurse on duty when they arrive and again prior to their leaving.

Product Standardization

POLICY

Traditions has designed and implemented processes which strive to ensure continuity of product, equipment, and resource utilization throughout the organization through product standardization. Product standardization promotes consistency when monitoring, analyzing, and tracking resident outcomes and provides cost-effective best practice.

PROCEDURE

1. Obtain current standardized product formulary and order guide.
2. Order standardized products from the corporate approved business partner only.
3. Request product substitution from the Administrator only when unavoidable.
4. Attempt to inform and educate physicians regarding the standardized order guide and the rationale for standardization.
 - If a physician orders a product not on the formulary, request the order be changed to an alternative product from the formulary.
5. If the product or equipment is not on the current approved formulary, contact the Product Selection Committee chairperson to have the product considered.

QUALITY CARE SUMMARY DEFINITIONS

Assisted Living

**The Assisted Living Quality Care Summary" reporting period covers from the 1st day of the previous month to the last day of the previous month. The completed form is to be submitted to the home office no later than the end of the day on the 5th day of the current month. Use the "Comments" section to identify specific resident names who are included in the report.

1. **Total Residents Served** – This is the total number of residents served as of midnight of the day prior to completion of the form.
2. **Total Units Occupied** – The total number of units occupied as of the midnight of the day prior to completion of the form.
3. **# residents at Level 0 care** – Resident scores no greater than Level 0 on the LOC Tool
4. **# residents at Level 1 care** – Number of residents who require a higher level of care than what is included in level 0
5. **# residents at Level 2 care** – Number of residents who require a higher level of care than what is included in Level 1
6. **# residents at Level 3 care** – Number of residents who require a higher level of care than what is included in Level 2
7. **# residents at Level 4 care** – Number of residents who require a higher level of care than what is included in Level 3
8. **# residents at Level 5 care** – Number of residents who require a higher level of care than what is included in Level 4
9. **Respite** – Number of residents who are in the facility for a respite care stay.
10. **Admission for the month** – Total number of admissions for the previous month
 - a. **New admissions** – The total number of residents admitted to the facility without a prior admission.
 - b. **Readmissions** – The total number of residents readmitted after a hospital stay, skilled nursing home stay, or a stay at an other level of care and the bed is being held pending re-admission.
11. **Discharges for the month** – Total number of discharges for the month
12. **Deaths** – Total number of resident deaths for month
13. **Unexpected Deaths** – Total number of residents who experienced an unusual event that resulted in death.
14. **Transfers to ER** – Total number of residents who were sent out to the ER during the previous month

15. **Admissions to hospital** – Total number of residents who were admitted to a hospital during the previous month
16. **Admissions to SNF** – Total number of residents who were admitted to a skilled nursing facility during the previous month
17. **# of skilled residents** – Total number of residents receiving skilled services (such as, but not limited to: IVs, catheter changes, visits by hospice nurse, tube feeding, etc) for the previous month
18. **# of hospice residents** – Total number of residents who have elected or are currently receiving hospice benefits for the previous month
19. **# residents who fell** – Total number of residents sustaining a fall during the previous month
20. **Total # of falls** – Total number of falls in the facility during the previous month.
21. **# residents with >1 fall** – Total number of residents who fell 2 or more times within the previous month
22. **Incidents/Accidents with Injuries** – The number of residents who experienced a significant incident/accident that resulted in an injury that required medical attention/evaluation (fractures, large lacerations/hematomas, or head injuries) and any event reported to the Ohio Department of Health. (list resident name and type of injury in comments section)
23. **Residents Totally Dependent w/eating** – Total number of residents who require staff to feed them at mealtime.
24. **Residents on Coumadin** – Total number of residents receiving Coumadin
25. **# residents giving self meds** – Total number of residents who self-administer their own medication for the previous month
26. **# residents with pressure ulcers** – Total number of residents who had a pressure ulcer – stage I, stage II, stage III, or stage IV during the previous month
27. **# residents with wanderguards** – Total number of residents who had on a Wanderguard device during the previous month
28. **Undesirable Weight Loss** – The total number of residents who have experienced an undesired weight loss of 5% in the past month or 3% weight loss for residents on weekly weights. The resident only remains on the report if they continue to lose weight the following week. If the resident stabilizes and loses no further weight, they fall off of the report.
29. **Terminally Ill Residents with Weight Loss** – the number of residents who are terminally ill who have experienced weight loss in the past month/week.
30. **Undesirable Weight Gain** – The total number of residents whose weight gain is 5% in one (1) month and 7.5% in three (3) months.
31. **Missing Resident** – All residents with an episode of leaving the facility without staff knowledge.

32. **Risk Agreement** – All resident with legal contract to share in negative outcome that may occur in facility.
33. **Home Health Visits** – The total number of Home Health visits provided by a Home Health Agency during the past month.

Refusal of Medication & Treatment

POLICY

Traditions has designed and implemented processes which strive to ensure residents are informed of the benefits and consequences of treatment being ordered by the physician or proposed by the interdisciplinary team. Traditions considers resident speech, hearing, and comprehension deficits to ensure that they fully understand the information. In honoring the resident's right to participate in their decisions, Traditions generally supports residents when they decide to refuse care or treatment to the extent permitted by law. Exceptions to this policy would be where the decision made by the resident appears to endanger the life of the resident or the health and safety of other residents.

PROCEDURE

1. The DON will interview the resident to determine what the resident is refusing and why, in order to address the resident's concerns.
2. The DON will assess the reasons for the resident's refusal of treatment and attempt to clarify and educate the resident/family as to the consequences of such refusal, and will discuss alternate methods of treatment.
3. Notify physician and family of resident's wishes. Document each refusal in the medical record.
4. The care plan team will assess the resident's needs and offer the resident alternative treatments will continuing to provide all other services outlined in the care plan.
5. The Interdisciplinary Team will revisit such refusal on a quarterly basis or sooner if there is a significant change in condition.
6. Notify the Administrator if the resident's refusal for care or treatment would endanger the life of the resident or the health and safety of other residents.

Resident Care Log (Assisted Living Only)

Month/Year:	Facility Name:							Apt #:							Resident Name:																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
BATH																																
Tub/shower/WP																																
Partial/complete																																
Assist																																
Set up Only																																
PERSONAL HYGIENE																																
Assist w/dressing																																
Assist w/undressing																																
Hair Care/Brush/																																
Shampoo																																
Skin/Foot Care																																
Shave/Groom																																
Nail Care Clean/File																																
Oral Care - Brush/																																
Swab Denture																																
Toileting q2 hours																																
Incontinence Care q2hours																																
BM (S/M/L)																																
ACTIVITY																																
Meal Assistance																																
Assist to/from dining room																																
Assist to/from activities																																
HOUSEKEEPING																																
Tidying Daily																																
Bed making																																
Linen change																																
Laundry																																
Trash																																
OTHER																																
Monitor q _____ hour																																
INITIALS																																
(D) Day																																
(E) Evenings																																
(N) Nights																																

Complete in pencil within 48 hours of admission

Section R

RESIDENT CARE SHEET

TOILETING:

- ☐ bedside commode
- ☐ incontinent bowel
- ☐ incontinent bladder
- ☐ catheter
- ☐ toileting schedule

LOCOMOTION:

- ☐ ambulatory
- ☐ cane
- ☐ walker
- ☐ wheelchair
- ☐ needs staff assistance

HEARING:

- ☐ no difficulty
- ☐ partially deaf
- ☐ totally deaf
- ☐ uses hearing aids

BATHING:

- ☐ no help needed
- ☐ prep help only
- ☐ back/lower legs
- ☐ total help

MENTAL STATUS:

- ☐ oriented x3
- ☐ mild impairment
- ☐ moderate impairment
- ☐ severe impairment

SUPPORT:

- ☐ none
- ☐ 1 person assist
- ☐ 2 person assist
- ☐ total

EYESIGHT:

- ☐ good
- ☐ wears glasses
- ☐ blind

PARALYSIS:

- ☐ none
- ☐ right arm/leg
- ☐ left arm/leg

DRESSING:

- ☐ no assist
- ☐ partial assist
- ☐ total assist

HYGIENE:

- ☐ no help
- ☐ reminders needed
- ☐ partial assist
- ☐ total assist

HOUSEKEEPING:

- ☐ make bed
- ☐ wash dishes
- ☐ other _____

Fill in all the pertinent areas. Lines have been left for a staff member to put in information, tips, etc that will help all staff members render the best care possible.

- ☐ Prefers to be called _____
- ☐ Loves to _____
- ☐ Hates to _____
- ☐ Formerly did (occupation) _____
- ☐ Food preferences _____
- ☐ Food dislikes _____
- ☐ Falls: ☐ no risk ☐ at risk intervention(s): _____
- ☐ Skin: ☐ no risk ☐ at risk intervention(s): _____
- ☐ Pain: ☐ none ☐ intermittent ☐ constant intervention(s): _____
- ☐ Hydration: ☐ no risk ☐ at risk intervention(s): _____
- ☐ Wanderer: ☐ no risk ☐ at risk intervention(s): _____
- ☐ _____
- ☐ _____

NAME: _____

DOCTOR: _____

APT #: _____

Resident Orientation to the Facility

POLICY

Traditions has designed and implemented processes which strive to ensure a smooth transition in the placement of the resident. Traditions will provide a facility orientation to the new resident and/or family which will include, but is not limited to, the following procedure.

PROCEDURE

1. Orient the resident/family to their new room:
 - Roommate
 - Call light (bed and bathroom)
 - Bed controls
 - Television
 - Over-the-bed light(s)
 - Window shade(s)
 - Nightstand
 - Closet
2. Provide the resident/family with a tour of the facility, placing emphasis on the following:
 - Dining Room
 - Activities
 - Activities Calendar
 - Administrator's Office
 - DON's Office
 - Therapy (as applicable)
 - Business Office
 - Social Services
 - Living Room/Lounge
 - Outdoor area
 - Posted regulatory information (e.g., State survey, ombudsman, etc.)
3. Inform the resident/family of the *routinely* scheduled times for:
 - Med pass
 - Meals
 - Laundry
 - Bath/shower days
 - Visiting Hours

4. Introduce them to their primary caregivers.
 - Discuss routine of care provided, including Plan of Care process and resident/family involvement.
5. Reinforce orientation on a daily basis until resident/family become familiar with their surroundings.

Resident Rights

POLICY

Traditions will address ethical issues and respect residents' rights in providing care. Traditions recognizes the residents' right to a quality of life that supports privacy, confidentiality, independent expression, choice and decision making, consistent with State and Federal law and regulations.

PROCEDURE

1. Explain resident rights to resident at or before admission. Give resident a copy of the Resident Rights in writing.
2. Involve resident in all aspects of care.
3. Involve resident in resolving conflicts about care decisions.
4. Involve resident in decisions to provide or withhold resuscitative services.
5. Involve resident in decisions to provide, forgo, or withdraw life-sustaining treatment.
6. Involve resident in decisions related to care at the end of their lives.
7. Involve the resident's guardian or other person appointed under State law to act on the resident's behalf if that resident has been adjudged incompetent.

Risk Agreement

Reference 3701-17-57

Policy:

A residential care facility may, in its management's sole discretion, choose to enter into a risk agreement with a resident or the resident's sponsor with the consent of the resident. Under a risk agreement, the resident or sponsor/responsible party agrees to assume responsibility for making decisions affecting the scope and quantity of services provided by the facility to the resident, and the facility agrees to assume responsibility for implementing the resident/sponsor's decision. The facility shall identify the risks inherent in a decision made by a resident or sponsor not to receive a service provided by the facility. A risk agreement is valid only if it is made in writing. The residential care facility shall maintain a copy of any risk agreement in the resident's record.

Each residential care facility that has a policy of entering into risk agreements shall provide each prospective resident, or the prospective resident's sponsor with the consent of the resident, a written explanation of the policy and the provisions that may be contained in a risk agreement. At the time the information is provided, the facility shall obtain a statement signed by the individual receiving the information acknowledging that the individual received the information. The facility shall maintain the signed statement on file.

Procedure:

1. Upon choosing to enter into a risk agreement, the facility shall contact the resident/responsible party to discuss the specific issue causing the risk and explain all components of a risk agreement, including but not limited to the following:
 - a. Responsibility for making and implementing decisions affecting the scope and quantity of services provided by the facility to the resident
 - b. Risks inherent in a decision made by a resident/responsible party to not receive a service provided by the facility.
2. Prior to entering into any risk agreement, the Administrator/designee shall notify the corporate risk manager and legal counsel of the facts and circumstances giving rise to the risk agreement.
3. Upon receipt of the risk agreement from legal counsel, the resident/responsible party shall review the content of the agreement and both the facility and resident/responsible parties will sign the agreement.
4. The Administrator/designee will communicate the details of the risk agreement to appropriate facility staff.
5. A copy of the risk agreement shall be maintained in the resident's file in the business office.

Room Changes, Transfers and Discharges

POLICY

Traditions will inform residents of the facility's policy regarding room changes, transfers and/or discharges and to provide sufficient preparation and orientation to residents to ensure safe and orderly room changes, transfers and/or discharges.

It is the policy of Traditions to admit, transfer, discharge, or implement room changes according to the resident's acuity and level of care. Transfers and discharges will be conducted according to State and Federal regulations.

PROCEDURE

Room Changes

Residents may request a room change. The facility will attempt to accommodate the resident's request.

The facility may change the assignment of a resident's room or roommate. Once a decision to change a resident's room has been made, Social Services/designee will promptly notify the resident and the resident's legal representative or interested family member of the room change. Reasonable notice of the room or roommate change, including oral or written explanation of the reason for the change, will be given to the resident prior to the room or roommate change.

Discharges

Resident will be discharged from the facility as soon as medically possible with a written physician's order or upon signing a *Release Against Medical Advice* form. If the resident, family, and/or responsible party requests a discharge that is against medical advice, the *Release Against Medical Advice* form, the reason for the discharge and evidence that the issue was discussed with the resident, family, and/or responsible party will be recorded in the resident's medical record.

1. Reasons for which a resident may be discharged from the facility.
 - a. The facility determines that the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
 - The resident's physician must document evidence in the resident's clinical record that a discharge is necessary.

- b. Such action is appropriate because of the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.
 - The resident's physician must document evidence in the resident's clinical record that a discharge is necessary.
- c. The safety of individuals in the facility is endangered.
 - The resident's physician must document evidence in the resident's clinical record that a discharge is necessary.
- d. The health of individuals in the facility would otherwise be endangered.
 - The resident's physician must document evidence in the resident's clinical record that a discharge is necessary.
- e. The resident has failed, after reasonable and appropriate notice to the resident and/or the resident's responsible party, 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, the facility will charge a resident only allowable charges under Medicaid.
- f. The facility loses its license, certification, or otherwise ceases to operate.

Preparation for Discharge

Residents being discharged from the facility will be provided with adequate preparation to ensure a safe and orderly transfer from the facility, and the home or setting to which the resident is discharged will have accepted the resident.

Notification

It is the policy of Traditions to provide resident with a 30-day written notice of an impending discharge from the facility, except in an emergency or where otherwise exempted by statute, rule or regulation wherein written notice will be given as soon as practicable. The Notice of Discharge will be given to the resident/responsible party by the Administrator. The notice will include:

- The reason for the discharge.
- The effective date of the discharge
- The location to which the resident will be discharged

- A statement that the resident has the right to appeal the action to the state within 10 days after receipt of the notice of the proposed action to the State's legal services office to which the appeal should be sent.
- The name, address, and telephone number, of the state's Long-Term Care Ombudsman.
- The address and the telephone number of the state Legal Rights Services for resident who are developmentally disabled and/or mentally ill.

Social Services will promptly notify resident and resident's legal representative or interested family member, of a change in room or roommate. The facility reserves the right to make room changes as necessary to meet all of its residents' care needs.

Safe Medical Device Act

POLICY

Traditions will comply with the Safe Medical Device Act (SMDA) reporting and tracking requirements of the Food and Drug Administration (FDA). (Revised November 2000.) This act requires reporting of an undesirable experience, actual or suspected, associated with the use of a medical product in the care/treatment of a resident or staff member. The event is *serious* and will be reported when the resident outcome is:

- Death
- Life-threatening
- Hospitalization (initial or prolonged)
- Disability
- Requires intervention to prevent permanent impairment or damage

The facility will report suspected medical device related deaths to both FDA *and* the manufacturer if known. Serious injuries will be reported to the manufacturer *or* to FDA, if the manufacturer is unknown. (Refer to the "Medical Device Reporting" Procedure in this section of the manual for instructions on reporting.)

Product problems will be reported when there is a concern about the quality, performance, of safety of any medication or device. Problems may include:

- Product contamination
- Defective components
- Poor packaging or product mix-up
- Questionable stability
- Device malfunction
- Labeling concerns

Examples of medical devices include, but are not limited to, the following:

- Apnea monitors
- Blood glucose
- Catheters
- Contact lenses
- Defibrillators
- Hearing aids
- Infusion pumps
- Lift devices
- Pacemakers
- Restraints
- Shower chairs
- Side rails
- Syringes/needles
- Thermometers
- Ventilators
- Wheelchairs

1. Complete *MedWatch FDA 3500A* form when made aware of potential or actual undesirable experience.
2. The Administrator/designee reports the event to the manufacturer and/or FDA, as applicable, no later than 10 days after becoming aware (acquiring information about a reportable event) of the actual event using a *MedWatch* form. Refer to the *Guidelines and Forms* section of this manual.

If, after investigation, it is determined the event did not cause a reportable undesirable outcome, file the completed form in the Medical Device Reporting (MDR) file.

Medical Device Reporting

If a medical device, as defined in the Policy, causes potential or actual harm as defined by the FDA, the facility will complete the *MedWatch* (FDA – 3500A) form.

If a medical device causes actual harm, as defined by the FDA, the facility designee will assure the following forms are completed:

- *MedWatch (FDA 3500 A)*
- *Incident/Accident Report*

The facility will notify the VP of Clinical Services of any safe medical devices issue per the Incidents & Accidents Policy.

Medical Device Reporting (MDR) Files

The facility Administrator will maintain a Medical Device Reporting (MDR) event file in a designated area of the facility for two years. The event file includes documents relating to deliberations and decision making processes used to determine if an event is an MDR reportable event (*even if the facility decides not to submit an MDR*).

The facility will permit official, credentialed FDA employees, at reasonable times, to access the MDR files in order to verify the records and to copy them if requested.

PROCEDURE

Medical Device Reporting

1. Notify the Administrator, Director of Nursing, and/or immediate supervisor immediately if you suspect a death or serious injury/illness may have been caused by a medical device.
2. Investigate the incident immediately and determine if a device has or may have caused or contributed to the death or serious injury/illness of a resident or employee.
 - Document actions taken during evaluation of incident, including any statements made.
3. Request the appropriate person (the person who notified the Administrator/DON in Step #1) complete the *Incident/Accident Report* as applicable. Refer to the Incidents & Accidents Policy.
4. The Administrator/designee communicates the results of your evaluation/investigation to the VP of Clinical Services or designee if it is suspected that the medical device may have contributed to the death or serious injury/illness of a resident or employee.
5. Complete the *MedWatch* form immediately if death or serious injury/illness is suspected as it relates to a medical device:
6. Fax the completed *MedWatch* form to David Kayuha, CAO for National Church Residences, immediately after completion.
7. Send the completed *MedWatch* form to the *device manufacturer* after discussion with David Kayuha and insurance company confirms an actual or suspected death or injury/illness due to a medical device.

8. Send the completed *MedWatch* form to the **FDA** after discussion with David Kayuha and insurance company confirms an actual or suspected **death** due to a medical device.

Food and Drug Administration
Center of Devices and Radiological Health
"FDA User Report"
P.O. Box 3002
Rockville, MD 20847-3002

9. Assure the report is received by the FDA within 10 days of the Administration/DON becoming aware of the suspected death or injury/illness due to the medical device.
10. Mail copies of **all** reports completed at the facility to:

National Church Residences Healthcare
2335 North Bank Drive
Columbus, Ohio 43220

Medical Device Reporting (MDR) Files

1. Identify the file(s) as MDR event file(s).
2. Assure MDRs are filed to facilitate timely access.
3. Place the following in the MDR event file:
 - a. Documentation of the reporting decisions
 - b. Decision making process
 - c. Copies of all completed MDR forms
 - d. Other information submitted to the FDA, distributors, and manufactures
4. Incorporate certain information by reference (such as medical records, resident files, and engineering reports) rather than include them in the MDR event file.
5. Maintain the MDR event file in a readily accessible, designated area of the facility for two years.

Salon Equipment and Area: Cleaning of

POLICY Traditions facilities with salons will follow the appropriate infection prevention and control procedures to prevent and reduce the potential for nosocomial infections.

**RESPONSIBLE
PERSON(S)** Beautician/designee

PROCEDURE

1. Salons will follow the regulations of the Ohio Board of Cosmetology regarding cleaning procedures.
2. Assure a Material Safety Data Sheet (MSDS) is easily accessible.
3. Lock equipment and chemicals in a protected area.
4. Lock door of salon when no one is present.

GUIDELINE

Secured Unit Assessment Assisted Living

PURPOSE

Traditions utilizes a secured unit for residents with Alzheimer's Disease and other related dementias who are at high risk for leaving a facility without staff awareness. Placement on the secured unit is to provide for safety and quality of life benefits for each resident assessed as needed.

Residents with cognitive impairment and wandering behaviors will be assessed on admission and at least quarterly to ensure that placement on the secured unit is appropriate.

INSTRUCTIONS

1. On admission to the facility, each resident with cognitive impairment and wandering behaviors will be assessed using the *Prevention and Management of Missing Residents Assessment* form.
2. If the assessment indicates a resident requires placement on the secured unit, placement will be made.
3. The physician will document reasons/justification for placement on *Secured Unit Assessment*.
4. If a resident residing on the secured unit no longer requires placement on a secured unit, but does benefit from the Memory Care Program, the risks and benefits of continued placement will be discussed with the resident's responsible party.
5. If it is determined that the benefit outweighs the risk of being on a secured unit, Memory Care Program Director/designee will document responsible party approval and that placement is still necessary using the *Secured Unit Assessment* form.
6. Residents on a secured unit will be reviewed at least annually or with a significant change in condition.
7. Cognitively alert residents who are placed on a secured unit will be educated that they are residing on a secured unit and will be given the access code information so that they can freely leave the unit as desired.

Secured Unit Assessment Assisted Living

Resident Name: _____

Room Number: _____

Reason for Assessment:

☐ Admission ☐ Annual ☐ Change of Condition ☐ Other _____

Assessment Criteria	Date		Date		Date		Date		Date	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Resident at risk for leaving facility without staff awareness. If yes, see <i>Assessment for Exit Seeking Behaviors/Wandering Behaviors</i>										
2. Resident has a history of attempts to leave the facility.										
3. Resident benefits from Memory Care Program.										
4. Resident does not require secured unit but chooses to remain on secured unit.										
5. Placement on secured unit is appropriate for resident due to wandering behavior/benefit from Memory Care Program.										
6. Resident does not benefit from placement on secured unit and will be moved from unit as soon as a bed is available off unit.										
7. Resident is alert and oriented and able to leave unit at will.										

Physician Rationale/Justification – Secured Unit Placement: _____

Signature of Staff Person Completing Assessment

Date

Physician Signature

Date

The risks and benefits of the secured unit have been explained to: _____

Name of Responsible Party

By: ☐ Phone conference ☐ In-person meeting

Responsible Party Signature

Date

Staff Signature (Provided education)

Date

Witness Signature (Phone Conference)

Date