

Contents

- Philosophy3
- Advance Directives.....4
- Advance Directives.....7
- Advance Directive Information8
- Assessments.....9
 - Coordination with PASARR Program9
 - Psychosocial11
 - ISVH – Psychosocial History13
 - Brief Interview for Mental Status (BIMS).....15
 - PHQ-9.....17
 - Abnormal Movement Scale19
- Suicide Threats21
- Care Plan Participation, Resident/Family23
- Discharge Summary and Plan.....25
- Trauma Informed Care27
- Dementia Care – Grief.....28
- Bed Hold Policy30
- Community Services File31
- Council Meetings.....32
 - Resident Council Meetings.....32
 - Family Council Meetings33
- Department Services -Social Services34
- Pastoral Services.....37
- Spiritual and Religious Activities38
- Grievances: Filing grievances/Complaints39
 - Grievances: Grievance Form41
- Freedom from Abuse, Neglect & Exploitation.....42
- Abuse Prevention Program – Abuse Prevention Components.....50
 - Abuse Prevention Program Components 1 & 2.....51
 - Screening & Training51
 - Abuse Prevention Program Components 352
 - Prevention.....52
 - Abuse Prevention Program Components 4 & 554
 - Identification/Investigation.....54
 - Abuse Prevention Program Components 656
 - Protection.....56
 - Abuse Prevention Program Components 757

Reporting/Response, Agencies	57
Abuse Prevention Program Components 7	59
Reporting/Response, Facility Management	59
Reasonable Suspicion of a Crime - Against a Resident Reporting From	63
Resident-to-Resident Altercations	64
Mood/Behavior Medication Review Committee	65
1. Frequency, Location, Time and Place.....	65
Behavioral Health Services.....	66
Use of Psychotropic Drugs	69
Individualized Care and Services for Residents with Dementia and the Use of Antipsychotic Medication in Residents with Dementia	71
Psychotropic Medication Justification Tracking & Charting.....	74
Informed Consent for Psychotropic Medication Non-Antipsychotic	76
Informed consent for Antipsychotic drug use in Dementia Residents and Antipsychotic Use for Approved Diagnoses	77
Quarterly Psychotropic Medication Review	79
Risk versus Benefit of the use of Certain Medications for Dementia Residents and their Agents	83
Quality of Life: Accommodation of Needs	84
Quality of Life: Dignity	86
Quality of Life: Self Determination and Participation.....	88
Quality of Life: Communication Services, Title VI	90
Quality of Life: Experimental Research	91
Quality of Life: Mail.....	92
Quality of Life: Personal Property.....	93
Quality of Life: Resident Right to Share a Room.....	94
Quality of Life: Change of Room or Roommate	95
Quality of Life: Telephones, Resident Use of	97
Quality of Life: Telephone Accessibility.....	98
Quality of Life: Pets, Animals, and Plants.....	99
Pet Therapy/Visitation Policy.....	100
Quality of Life: Smoking.....	102
Smoking Classification Assessment	104
Smoking Assessment Worksheet – Quarterly and PRN	105
Agreement for Safe Smoking	106
Resident Rights.....	107
A Resident’s Bill of Rights.....	109
Sexual Expression of Residents.....	117

Philosophy

Social Work Practices is a theory-based client centered discipline providing services to individuals, families, groups and society as a whole. As a professional practice, a code and ethics govern individuals working within the field. Central to the purpose of the code of ethics is its function as a formalized expression of accountability, provides explicit criteria regulating the behavioral of social workers, promotes competence and responsibility practice by social workers, and protects the public from exploitation by incompetent practitioners.

One of the core elements of social work practice is its under girding knowledge base subsumed under five categories: human behavior and the social environment, social welfare policy and service, social work practice methods and theory, research, and field practicum.

The Social Services Department of Idaho State Veterans Home-Boise employs the services of licensed Social Workers. These staff members are dedicated to providing quality services to the Veteran, his/her family system, the facility as a whole and society. The department employees those individuals that have solid clinical knowledge and skills, adhere to moral and ethical integrity, are strong advocates, demonstrate competence within the field of social work, are accountable and responsible.

The Social Services Department is dedicated to the dignity and self-worth of the veteran and his receiving care in the least restrictive environment, ensuring his rights as an individual are respected and upheld.

Oni Kinberg LCSW
Social Services Director

Rick Holloway
Home Administrator

Advance Directives

Highlights	Policy Statement
	<p>Advance directives will be respected in accordance with state law and Idaho State Veterans Home facility policy.</p> <p>Policy Interpretation and Implementation</p>
Provision of Written Information Relative to Advance Directives	1. Prior to or upon admission of a resident to the Idaho State Veterans Home, the Admissions Coordinator or designee will provide written information to the resident or his/her designee concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.
Discrimination	2. Each resident and/or his/her designee will also be informed that our facility’s policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive.
Inquiry of Advance Directives	3. Prior to or upon admission of a resident, the Admissions Coordinator or designee will inquire of the resident, and/or his/her family member/designee, about the existence of any written advance directives.
Documentation in Medical Record	4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.
OBRA Definitions Relative to Advance Directives	5. In accordance with current definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to:
Living Will	a. Living Will — A document that specifies a resident’s preferences about measures that are used to prolong life when there is a terminal prognosis.
POST	b. POST — Physician Orders for Scope of Treatment
Do Not Resuscitate	c. Do Not Resuscitate — Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used.
Do Not Hospitalize	d. Do Not Hospitalize — Indicates that the resident is not to be hospitalized, even if he or she has a medical condition that would usually require hospitalization.
Organ Donation	e. Organ Donation — Indicates that the resident wishes his or her organs to be available for transplantation upon his or her death.
Autopsy Request	f. Autopsy Request — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) has requested an

Feeding Restrictions	autopsy be performed upon the death of the resident. (Note: The person making the request must still be contacted for permission prior to performance of the procedure.)
Medication Restrictions	g. Feeding Restrictions — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) does not wish for the resident to be fed by artificial means (e.g., tube; intravenous nutrition, etc.) if he or she is not able to be nourished by oral means.
Other Treatment Restrictions	h. Medication Restrictions — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) does not wish for the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy, etc.).
Out-of-State Documents	i. Other Treatment Restrictions — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) does not wish for the resident to receive certain medical treatments. Examples include, but are not restricted to, blood transfusions, tracheotomy, respiratory intubation, etc.
Annual Review of Resident’s Advance Directives	6. If advance directive documents were developed in another state, the resident may have such documents reviewed and revised (as necessary) by his/her legal counsel in this state before the facility may honor such directives.
Changes in Advance Directives	7. The Interdisciplinary Team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the residents Social Work annual assessment.
Notifying Attending Physician of Resident’s Advance Directives Informing Emergency Medical Personnel of Resident’s Advance Directives	8. Changes or revocations of a directive must be submitted in writing to the Attending Physician. The Attending Physician may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident medical file, care plan and Social Work documentation.
Staff In-Service Training	9. The Director of Nursing Services or his/her designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident’s medical record and plan of care.
	10. The Nurse Manager will be required to inform emergency medical personnel of a resident’s advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.
	11. The Staff Development Coordinator or his/her designee will be responsible for scheduling advance directive training classes for newly hired staff members as well as scheduling annual Advance Directive In-Service Training Programs to ensure that our staff remains informed

Community Training	<p>about the residents’ rights to formulate advance directives and facility policy governing such rights.</p> <p>12. Inquiries from the community relative to advance directives must be referred to the Social Work Director. Written information will be provided and will include, as a minimum, a summary of the state law outlining the rights of residents to formulate advance directives and a copy of our facility’s policies governing advance directives.</p>
Inquiries	<p>13. Inquiries concerning advance directives should be referred to the Administrator, Director of Nursing Services, and/or to the Social Services Director.</p>

References	
OBRA Regulatory Reference Numbers	483.10(b)(4) & (8); 483.20(k)(1); 483.20(k)(2)(i) &(ii); 483.25; 483.75(b). 489.100 – 489.104
Survey Tag Numbers	F155; F156; F279; F280; F309; F492
Related Documents	Translation and/or Interpretation of Facility Services

Advance Directives

Highlights	<p>Policy Statement</p> <p>The Idaho State Veterans Home makes provisions to inform and provide written information to the community, our staff, and all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. Individuals will not be discriminated against nor will the provision of cares be conditioned on whether or not the individual has executed an advance directive.</p> <p>Policy Interpretation and Implementation</p>
Provision to Inform	<ol style="list-style-type: none"> Residents will be provided written information concerning his/her rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. This information will be provided to residents/responsible party upon admission, contained in the Admission Handbook, posted within the home, and reviewed with the resident/responsible party yearly by the Social Worker.
Documentation	<ol style="list-style-type: none"> The Social Worker will document in the medical record whether or not the individual has executed an advance directive and a care plan will be in place directing staff to the resident’s written record for advance directive instruction.
Education	<ol style="list-style-type: none"> Information will be posted which provides for community and staff education regarding the right under State law to formulate an advance directive and the ISVH’s policy regarding the right to formulate an advance directive. Additionally, staff education is accomplished during the new employee Social Services segment of the orientation process.
References	
OBRA Regulatory Reference Numbers	483.10(b)(8)
Survey Tag Numbers	F155
Related Documents	POST, DPOA, LIVING WILL, Caring Connections “Idaho Advance Directive: Planning for Important Healthcare Decisions” Informational Packet

Advance Directive Information

It is the policy of the Idaho State Veterans Home to provide community, resident and staff education about Advance Directives. We provide written and verbal information concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. Our resident's will not be discriminated against nor will the provision of cares be conditioned on whether or not an advance directive has been executed.

Attached you will find written information explaining advance directives and your rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive. This information is provided to residents/responsible parties upon admission in our Admission Handbook and reviewed with our resident/responsible party yearly.

Please contact the Social Services Department should you desire any assistance or additional information about advance directives and the right to accept or refuse medical or surgical treatment.

09/28/2012

Assessments

Coordination with PASARR Program

Policy:

This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.

Policy Explanation and Compliance Guidelines:

1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.
 - a. PASARR Level I – initial pre-screening that is completed prior to admission
 - i. Negative Level I Screen – permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.
 - ii. Positive Level I Screen – necessitates a PASARR Level II evaluation prior to admission.
 - b. PASARR Level II – a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.
2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.
3. A record of the pre-screening shall be maintained in the resident's medical record.
4. Exceptions to the preadmission screening program include those individuals who:
 - a. Are readmitted directly from a hospital.
 - b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services.
5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days:
 - a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.
 - b. The Level II resident review must be completed within 40 calendar days of admission.
6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.

7. Recommendations, such as any specialized services, from a PASARR Level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.
8. Any level II resident and all other residents who experiences a significant change in status assessment will have their PASARR reviewed for accuracy and if indicated will be referred to the state mental health or intellectual disability authority for additional resident review.
9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level ii resident review. Examples include:
 - a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).
 - b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.
 - c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

Psychosocial

Highlights	Policy Statement
	<p>A psychosocial assessment shall be completed within fourteen (14) days of the resident's admission to the Idaho State Veterans Home.</p> <p>Policy Interpretation and Implementation</p>
Social Assessment	4. A psychosocial assessment will be completed to help identify the resident's personal strengths and goals, life histories and preference.
Contents of Assessment	5. Social Services staff will obtain information during the initial interview of the family and upon the resident's admission. The assessment will include as appropriate , an evaluation of the following areas:
Physical Factors	<ul style="list-style-type: none"> j. Physical factors with impact on function and quality of life including: <ul style="list-style-type: none"> 1. Sight. 2. Hearing. 3. Speech. 4. Loss of limbs or motor ability. 5. Terminal illness; and 6. Others as may be appropriate.
Cognitive Factors	<ul style="list-style-type: none"> k. Cognitive factors including: <ul style="list-style-type: none"> 1. Resident's orientation to self-identity and to time, place, and situations. 2. Short-term memory, long term memory and recall ability. 3. Cognitive skills for daily decision making. 4. Signs and symptoms of delirium; and 5. Recent onset of acute change in mental status.
Mood and Behavior	<ul style="list-style-type: none"> 1. Mood and behavioral factors, including: <ul style="list-style-type: none"> 1. Attitudes and feelings about: <ul style="list-style-type: none"> 1. Self and situation. 2. Family and others; and 3. Institutional environment. 2. Signs and symptoms of depression or anxiety. 3. Personal, family, and social supports. 4. Behavioral symptoms, including: <ul style="list-style-type: none"> 1. Psychosis. 2. Wandering. 3. Refusal of care; and 4. Recent changes in behavior.
Personal Information and Preferences	<ul style="list-style-type: none"> m. Personal information including:

Diseases, Conditions	1. Personal and family history. 2. Employment and professional history. 3. Hobbies and interests. 4. Personal preferences; and 5. Wishes about medical treatment and care, including any advance directives.
Functional Status	n. Active disease diagnosis and health conditions.
Need for Adaptive Equipment	o. Functional status, including: 1. Need for assistance with ADLs. 2. Need for mobility or adaptive devices.
Participation in Assessment and Goal Setting	p. Ability and willingness to participate in assessment and goal setting.
Financial Data	q. Financial information, including: 1. Present source of financial support. 2. Potential resources for financial support; and 3. Significance for the resident.
Purpose	6. The purpose of obtaining this data is to identify information to help staff develop a personalized plan of care that will utilize the individual's existing strengths, try to compensate for physical and functional deficits, optimize function and quality of life, and meet the individual's needs and preferences. The information will be shared with staff members caring for the resident and the assessment will be placed in the resident's chart.
Care Plan	7. Data obtained from the psychosocial assessment shall be used to develop all relevant portions of the care plan (e.g., social services, activities, end-of-life care, and ancillary services).

References	
OBRA Regulatory Reference Numbers	483.15(g)(1)-(3)
Survey Tag Numbers	F250; F251
Related Documents	Care Area Assessments

ISVH – Psychosocial History

A. History
1. Branch of Service
2. Birthplace
3. Marital Status
a. Married
b. Single
c. Divorced
d. Widow/Widower
4. Religious preference
5. Source of Information
a. Resident
b. Spouse
c. Child
d. Sibling
e. Friend
f. Physician/Caretaker
g. Other
Explain other:
6. Decision Maker
7. Last Residence
8. Resident Rights Reviewed: Yes _____
9. Siblings
e. Living
f. Deceased
g. Names/locations of surviving siblings:
10. Children
a. Living
b. Deceased
c. Names/locations of surviving children

B. Significant Life Experiences:
1. Early family history/relationships
2. Education
3. Marriage
4. Work/retirement history
5. Preferences: food, activity, hobbies
6. Socialization patterns
7. Family support
8. Reason(s) for admission
9. Mood/Cognition
10. Significant medical/psychiatric history
11. Triggers that alter mood
12. Discharge goal/preference
C. Discuss each of the above.

Brief Interview for Mental Status (BIMS)

Highlights	<p>Policy Statement</p> <p>In an effort to assist residents in attaining or maintaining the highest level of psychosocial wellbeing, Social Work Services will assess for cognition on an ongoing and as needed basis in collaboration with other departments.</p> <p>Policy Interpretation and Implementation</p>
Testing Schedule	<p>Frequency:</p> <ol style="list-style-type: none">Upon admission.The BIMS assessment will be administered quarterly on or within the CMS RAI Version 3.0 Manual guidelines.Social Work Services will address signs/symptoms of alteration in mood in the quarterly social work assessment for all residents.
Procedure	<p>The Brief Interview for Mental Status (BIMS) in Section C of the MDS 3.0 is intended to determine the resident’s attention, orientation and ability to register and recall new information. The items included in the BIMS are crucial factors in many care-planning decisions. When conducting and coding the BIMS, follows these coding tips from the <i>RAI User’s Manual</i>:</p> <ul style="list-style-type: none">Nonsensical responses should be coded as zero.Rules for stopping the BIMS before it is complete:<ul style="list-style-type: none">Stop the interview after completing (C0300C) “Day of the Week” if:<ul style="list-style-type: none">all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), orthere has been no verbal or written response to any of the questions up to this point, orthere has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.If the interview is stopped, do the following:<ul style="list-style-type: none">Code -, dash in C0400A, C0400B, and C0400C.Code 99 in the summary score in C0500.Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?Complete the Staff Assessment for Mental Status.When staff identify that the resident’s primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to this circumstance.

- Abrupt changes noted in cognitive status by the Social Worker will be immediately reported to the Nurse Manager and the Attending Physician.

References	
OBRA Regulatory Reference Numbers	
Survey Tag Numbers	F250, F272-276
Related Documents	Care Area Assessments, CMS RAI Version 3.0 Manual

PHQ-9

Highlights	<p>Policy Statement</p> <p>In an effort to assist residents in attaining or maintaining the highest level of psychosocial wellbeing, Social Work Services will assess for mood on an ongoing and as needed basis in collaboration with other departments.</p>													
Testing Schedule	<p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. Frequency: <ol style="list-style-type: none"> a. Upon admission. b. The PHQ 9 assessment will be administered quarterly within the CMS RAI Version 3.0 Manual guidelines. c. Social Work Services will address signs/symptoms of alteration in mood in the quarterly social work assessment for all residents. 													
Procedure	<p>The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is used in diagnosing depression as well as selecting and monitoring treatment. The Social Worker should discuss with the resident the reasons for completing the questionnaire and how to fill it out. After the resident has completed the PHQ-9 questionnaire, it is scored by the Social Worker.</p> <p>The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-V).</p> <p>When a depression is indicated, resident preferences will be considered by the physician, Social Worker, and nursing staff. Especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy. A standard of care is addressed below:</p> <table border="1" data-bbox="548 1375 1552 1831"> <thead> <tr> <th>PHQ-9 Score</th> <th>Provisional Diagnosis</th> <th>Treatment Recommendation</th> </tr> </thead> <tbody> <tr> <td>5-9</td> <td>Minimal Symptoms*</td> <td>Support, educate to call if worse; return in 1 month</td> </tr> <tr> <td rowspan="3">10-14</td> <td>Minor depression++</td> <td>Support, watchful waiting</td> </tr> <tr> <td>Dysthymia*</td> <td>Antidepressant or psychotherapy</td> </tr> <tr> <td>Major depression, <i>mild</i></td> <td>Antidepressant or psychotherapy</td> </tr> </tbody> </table>	PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation	5-9	Minimal Symptoms*	Support, educate to call if worse; return in 1 month	10-14	Minor depression++	Support, watchful waiting	Dysthymia*	Antidepressant or psychotherapy	Major depression, <i>mild</i>	Antidepressant or psychotherapy
PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation												
5-9	Minimal Symptoms*	Support, educate to call if worse; return in 1 month												
10-14	Minor depression++	Support, watchful waiting												
	Dysthymia*	Antidepressant or psychotherapy												
	Major depression, <i>mild</i>	Antidepressant or psychotherapy												

15-19	Major depression, <i>moderately severe</i>	Antidepressant or psychotherapy
≥ 20	Major depression, <i>severe</i>	Antidepressant <u>and</u> psychotherapy (especially if not improved on monotherapy)

References	
OBRA Regulatory Reference Numbers	
Survey Tag Numbers	F250, F272-276
Related Documents	Care Area Assessments, CMS RAI Version 3.0 Manual

Abnormal Movement Scale

Highlights	<p>Policy Statement</p> <p>An abnormal movement scale (AIMS) assessment shall be completed on all residents receiving/discontinuing anti-psychotic medications.</p> <p>Policy Interpretation and Implementation</p> <p>To assure that residents who are undergoing neuroleptic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on the following:</p> <ul style="list-style-type: none">• Tardive dyskinesia (TD)• Postural (orthostatic) hypotension• Cognitive/behavior impairment• Akathisia• Parkinsonism <p>The Social Worker in cooperation with Nursing will complete AIMS at the scheduled time.</p>
Testing Schedule	<p>A. Ongoing Testing: All individuals currently taking neuroleptic medication shall be assessed once every six (6) months or more frequently as necessary by symptom assessment or determined by the prescribing practitioner.</p> <p>B. Upon Admission: Any resident currently taking neuroleptic medication who is newly admitted to ISVH-B shall have an initial screening within one month of admission.</p> <p>C. Increase or Decrease of Neuroleptic Medication:</p> <ol style="list-style-type: none">1. Within one (1) month but not before seven days following the increase or decrease of the medication.2. Every six (6) months thereafter. <p>D. Discontinuance: Any resident whose neuroleptic medication is discontinued shall be screened after the discontinuation at the following intervals:</p> <ol style="list-style-type: none">1. One (1) month,2. Three (3) months, or3. Whenever the prescribing practitioner determines and documents that the individual does not have TD.

E. Individuals showing signs of TD will be referred to the physician for the purpose of evaluation, diagnosis, and treatment recommendations.

F. The AIMS testing form shall be placed in the “assessment” section of the resident’s medical record.

References	
OBRA Regulatory Reference Numbers	483.15(g)(1)-(3)
Survey Tag Numbers	F250; F251
Related Documents	Care Area Assessments

Suicide Threats

Highlights	<p>Policy Statement</p> <p>Resident suicide threats shall be taken seriously and addressed appropriately.</p> <p>Policy Interpretation and Implementation</p>
Threats of Suicide	8. Staff shall report any resident threats of suicide immediately to the Nurse Manager and the floor Social Worker. This includes statements shared with the Social Worker during administration of the PHQ-9.
Notification Process	9. The Nurse Manager and the Social Worker shall immediately assess the situation and shall notify the Director of Nursing Services of such threats.
Remaining with Resident	10. A staff member shall remain with the resident while evaluation is being made by Nursing and Social Work Services.
Notifying Attending Physician	11. After assessing the resident in detail, the Nurse Manager or Social Worker will notify the resident's Attending Physician and responsible party and shall seek further direction from the physician. Staff shall provide the physician with subjective/objective information about the resident's comments, his/her overall behavior, current medications, and other psychosocial factors.
Informing Nursing Service Personnel	12. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately.
Psychiatric Consultation	13. Based on the staff assessment, and the physician input, the physician may order a psychiatric consultation or transfer for an emergency psychiatric evaluation through the hospital emergency room.
Assessment/Care Plan	14. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. The home may provide one-to-one supervision, 15-minute checks, and/or alert law enforcement if the resident is dangerous to others.
Documentation of Incident	Staff shall document details of the situation objectively in the resident's medical record and contact the resident's designee listed on the resident's face sheet.

Suicide Threat References	
OBRA Regulatory Reference Numbers	483.10(b)(11)(i); 483.10(b)(11)(i)(B) -(D); 483.13(a); 483.13(b); 483.20(b)(2)(ii); 483.20(k)(1)-(2); 483.25(f)
Survey Tag Numbers	F157; F221; F222; F274; F279; F280; F319

Related Documents	Change in a Resident's Condition or Status (<i>Administrative Policies and Procedures</i>) Use of Restraints
-------------------	---

Care Plan Participation, Resident/Family

<p>Highlights</p>	<p>Policy Statement</p> <p>Each resident at the Idaho State Veterans Home and his/her family members are encouraged to participate in the development of the resident’s comprehensive assessment and care plan.</p>
<p>Resident/Family Participation</p> <p>Resident Assessment</p> <p>Advance Notice of Care Planning Conference</p> <p>Contact/Participation Records</p> <p>Policies Governing Care Plans</p>	<p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The resident and his/her family, and/or the legal representative (sponsor), are invited to attend and participate in the resident’s assessment and care planning conference. Furthermore, to ensure that the residents choice demonstrates his/her participation in care planning, and that participation is evident to caregivers, surveyors, and other interested parties each resident has the right to review and sign it after significant changes. We believe that the combination of these resident rights, with the responsibility of the facility to provide a summary of the baseline care plan and include the resident as a member of the interdisciplinary care team, will actively engage residents. 2. Resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission. A Comprehensive Care Plan is developed within seven (7) days of completing the resident assessment. 3. A seven (7) day advance notice of the care planning conference is provided to the resident and interested family members. Such notice is made by mail and/or telephone. 4. The Social Services Director or designee is responsible for contacting the resident’s family and for maintaining records of such notices. Notices include: <ol style="list-style-type: none"> r. The date of the conference. s. The time of the conference. a. The location of the conference. b. The name of each family member contacted. c. The date and time the family was contacted. d. The method of contacting the family (e.g., mail, telephone, email, etc.). 5. Administrative policies governing the development and use of care plans have been established by this facility.
References	
OBRA Regulatory Reference Numbers	483.10(b)(3) & (4); 483.15(b); 483.20(k)(2)(ii)

Survey Tag Numbers	F154; F155; F242; F280
Related Documents	Care Plans – Comprehensive

Discharge Summary and Plan

Policy Statement

When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.

Policy Interpretation and Implementation

6. When the Idaho State Veterans Home anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/MR, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment.
7. The **discharge summary** will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's:
 - e. Medically defined condition and prior medical history (medical history before entering the facility and current medical diagnoses, including any history of mental retardation and current mental illness).
 - f. Medical status measurement (objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests).
 - g. Physical and mental functional status (ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems. Includes determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility);
 - h. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence).
 - i. Nutritional status and requirements (weight, height, hematological and biochemical assessment, clinical observations of nutrition, nutritional intake, resident eating habits and preferences, and dietary restrictions).
 - j. Special treatments or procedures (treatments and procedures that are **not** part of basic services provided; for example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, and respiratory care).
 - k. Mental and psychosocial status (the resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood).
 - l. Discharge potential (the expectation of discharging the resident from the facility within the next three months).
 - m. Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances).
 - n. Activities potential (the resident's ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of ADLs which a person pursues in order to obtain a sense of well-

being. Includes activities which provide benefits in the areas of self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence, and the resident's normal everyday routines and lifetime preferences).

- o. Rehabilitation potential (the ability to improve independence in functional status through restorative care programs).
- p. Cognitive status (the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and
- q. Drug therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident).

8. The **post-discharge plan** will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum:

- r. A description of the resident's and family's preferences for care.
- s. A description of how the resident and family will access such services.
- t. A description of how the care should be coordinated if continuing treatment involves multiple caregivers.
- u. The identity of specific resident needs after discharge (i.e., personal care, sterile dressings, physical therapy, etc.); and
- v. A description of how the resident and family need to prepare for the discharge.

9. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge plan can be developed.

10. The Social Services Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place.

11. A copy of the post-discharge plan and summary will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records.

References
483.20(1)(1); 483.20(1)(2); 483.20(1)(3)
F283; F284

Trauma Informed Care

Policy:

It is the policy of this facility to ensure residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice.

Definitions:

"Trauma" is defined as an event, a series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.

Common sources of trauma may include, but are not limited to:

- a. Natural disasters
- b. Accidents
- c. War
- d. Physical, emotional, or sexual abuse at any age
- e. Rape
- f. Unexpected life events (death of a child, personal illness, etc.)

"Trauma-Informed Care" is defined as an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

"Cultural Competence" is defined as the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations. Policies, structures, practices, procedures, and dedicated resources can support this capacity. Cultural and linguistic competency occurs through adopting and implementing strategies to ensure appropriate awareness of, attitudes toward, and actions about diverse populations, cultures, and language.

Policy Explanation and Compliance Guidelines:

1. Each resident will be screened for a history of trauma upon admission.
2. The facility social worker or designee will conduct the screening in a private setting.
3. If the screening indicates that the resident has a history of trauma and/or trauma-related symptoms, a physician's order will be obtained for the resident to be evaluated by a mental health professional who is experienced in working with those exposed to trauma. The mental health professional should be licensed to assess, diagnose, and treat the resident accordingly.
4. Once the physician's order is received, the social worker or designee will place the referral to the mental health professional.
5. The facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

Potential causes of re-traumatization by staff may include, but are not limited to:

- a. Being unaware of the resident's traumatic history
- b. Failing to screen resident for trauma history
- c. Failing to screen resident for trauma history prior to treatment planning
- d. Challenging or discounting reports of traumatic events
- e. Endorsing a confrontational approach in counseling
- f. Labeling behaviors/feelings as pathological

Added 7-24-2019

Dementia Care – Grief

Policy:

It is the policy of this facility to provide appropriate treatment and services to meet each resident's higher practicable physical, mental, and psychosocial well-being. This policy addresses the unique needs of residents with dementia who may be grieving.

Policy Explanation and Compliance Guidelines:

1. Each resident's psychosocial, mood, and behavioral status will be assessed in accordance with the facility's assessment procedures.
2. The resident, to the extent possible, and/or the family/representative will be included in setting goals of care related to mental and psychosocial well-being.
3. The care plan will describe potential distress triggers that may exacerbate symptoms of depression or grief and will include strategies and approaches to address distress triggers or symptoms so that the level of distress can be minimized.
4. The following principles of grief will be considered when determining strategies and approaches to care:
 - a. Grief is a natural response to loss
 - b. People can grieve in very different ways.
 - c. Cultural beliefs and traditions can influence how someone expresses grief and mourns.
 - d. Persons with dementia are often unable to verbalize feelings. Emotions may be expressed by agitation, anger, crying, restlessness, or anxiety.
 - e. Grief in persons with dementia may be affected the state of dementia and their personal way of grieving.
5. A variety of approaches, may be utilized, keeping the resident as the center of care. Example non-pharmacological approaches for managing grief in a person with dementia include, but are not limited to:
 - a. Respond to the emotion (sadness, longing, fear, distress, suspicion, anger, concern) that you see. "You sound really angry to me. Let me help you with that."
 - b. Look for patterns in the behavior or symptom, such as the time of day they ask for a person who has died.
 - c. Look for an unmet need.
 - d. Provide meaningful activities.
 - e. Use distraction.
 - f. Answer questions as honestly as possible. Do not deliberately lie to the resident.
 - g. Support them with physical touch, such as a hug or holding hands.
 - h. Speak in past tense about a person who has died.
6. If psychotropic drugs, such as antidepressants, are initiated for managing grief and depression, the use of such drugs shall be in accordance with facility procedures.
7. The care plan interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised, as necessary.

8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e., physician, mental health provider, licensed counselor, pharmacist, social worker).
9. The Social Services Director shall serve as the facility's contact person for questions regarding this policy and behavioral health services provided by the facility or outside sources.

Added 12/12/2018

Bed Hold Policy

When a resident goes to the hospital or temporarily leaves the facility for any reason and wishes to come back to the same room, the resident/legal representative may request the facility hold the resident's room and bed until the resident returns. Except as otherwise approved by the Home Administrator, the transfer of a resident to the hospital or other care facility is a voluntary discharge unless the resident or legal representative requests a bed hold under this policy.

If the resident/legal representative does not choose to be voluntarily discharged and requests to have the resident's bed held:

- Private pay resident and Medicare beneficiaries will be charged the basic room rate and the current VA per diem rate for each day of the bed hold, unless the VA per diem is waived by the Home Administrator.
- If the resident is a Medicaid beneficiary and Medicaid agrees to pay for the bed hold, the facility will bill Medicaid up to a maximum number of bed hold days covered by Medicaid. The resident or legal representative will be billed for the resident's co-payment and current VA per diem rate, as applicable, unless the VA per diem is waived by the Home Administrator.
- Veteran resident's receiving VA benefits may have their bed held for up to 10 continuous days for any hospital stay, and up to 12 days per year, in aggregate, for any home/therapeutic leave, provided that the facility is maintaining 90% occupancy. Any resident taking leave beyond these requirements will be charged the current daily rate applicable and the current VA per diem rate, unless the VA per diem rate is waived by the Home Administrator.

In accordance with State, Federal and VA regulations, written notification of this policy will be provided to the resident/legal representative upon admission. Written notification will also be provided at the time the resident is immediately transferred or scheduled for hospitalization or therapeutic leave.

Bed hold provision are a complicated resident specific matter and should be discussed with the Business Office anytime the resident is away from the facility for hospitalization or therapeutic leave. To request bed hold for a leave of absence, please contact the Business Office or Social Service department. Overall agreements should be made with the Business Office or Social Service department within twenty-four (24) hours or the first working day after the weekend.

(2/12, 3/14), Added to NPM 12/17

Community Services File

Highlights	<p>Policy Statement</p> <p>The Idaho State Veterans Home Social Work Services department shall maintain a community resources.</p> <p>Policy Interpretation and Implementation</p>
Health Services File	1. Social Work Services will maintain a folder with community agencies available for resident transitioning to community or assisted living.
Maintaining File	2. Social Work Services staff will maintain the file and keep it as current as feasible with the understanding that community services change frequently due to a variety of reasons including government funding, private and charitable funding, needs assessment, etc.
Referrals	3. When a resident is discharged to home or elsewhere into the community, Social Work Services shall seek to identify agencies that could provide relevant services (e.g., in-home meals, nursing, or rehabilitative services). Prior to or upon discharge, that will help the resident and/or family identify and arrange appropriate services.
Documentation	4. Social Work Services staff will document in the medical record any such referrals.
References	
OBRA Regulatory Reference Numbers	483.15(g)(1)
Survey Tag Numbers	F250
Related Documents	

Council Meetings

Resident Council Meetings

Highlights	<p>Policy Statement</p> <p>The Idaho State Veterans Home recognizes that our residents have the right to organize and participate in resident groups within the home.</p> <p>Policy Interpretation and Implementation</p>
Facilitate the Resident Council	The Social Services Department will assist and facilitate the Resident Council on a regular basis to provide a forum for residents to discuss concerns, suggest changes, and identify and plan for desired social activities. The Veterans home will take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
Goal of the Resident Council	The goal of the Resident Council is to improve communication within the home, identify problems and solutions to problems, serve as a sounding board for new ideas, help individuals speak their concerns without fear of retaliation, and promote friendship among residents.
Attendees of the Resident Council	<p>Residents who are members of the Council hold the meetings and guide the Council efforts.</p> <p>Attendees that are not home residents are invited to the meeting by the Council, i.e. Dietary Manager, Administrator, Activities Director, etc. Departments may announce information such as upcoming maintenance projects, seasonal menu ideas, share the month’s calendar of events, etc.</p>
Response to Concerns	The Social Services Department will act as liaison to support the Council and respond to written requests/concerns arising from the Council meetings. The department will take minutes, distribute the minutes to the Council and to the Leadership Team, assure that issues are addressed to the Council’s satisfaction, arrange for member elections, and assist with scheduling the meeting.

References	
OBRA Regulatory Reference Numbers	483.13; 483.15; 483.25
Survey Tag Numbers	F223; F224; F225; F226
Related Documents	Resident Rights

Family Council Meetings

Policy Statement

The Idaho State Veterans Home recognizes that our resident family members have the right to organize and participate in groups with the families of other residents within the home.

Policy Interpretation and Implementation

The Social Services Department will assist and facilitate the Family Council on a regular basis to provide a forum for families to discuss concerns, suggest changes, gather information and participate in educational topics pertinent to long term care.

The goal of the Family Council is to improve communication within the home, identify problems and solutions to problems, serve as a sounding board for new ideas, help individuals speak their concerns without fear of retaliation, and educate.

The Social Services Department will act as liaison to support the Family Council and respond to written requests/concerns arising from the Council meetings. The department will take minutes, distribute the minutes to the Council and to the Leadership Team, assure that issues are addressed to the Council's satisfaction, arrange for presentations of interest, and assist with scheduling the meeting.

References

483.13; 483.15; 483.25

F223; F224; F225; F226

Resident Rights

Department Services -Social Services

Highlights	<p>Policy Statement</p> <p>Our facility provides medically related Social Services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being.</p> <p>Policy Interpretation and Implementation</p>
Responsibilities of the Director of Social Work Services	<ol style="list-style-type: none"> 1. The Director of Social Services is a qualified social worker and is responsible for: <ol style="list-style-type: none"> w. Consultation with other departments regarding program planning, policy development, and priority setting of social services. x. Consultation to allied professional health personnel regarding provisions for the social and emotional needs of the resident and family. y. Consultation and supervision to Social Services personnel. z. An adequate record system for obtaining, recording, and filing of Social Service data. aa. In-service training classes; and bb. Assistance in meeting the social and emotional needs of residents.
Social Work Services	<ol style="list-style-type: none"> 2. Medically-related Social Services is provided to maintain or improve each resident’s ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose).
Psychosocial Functioning	<ol style="list-style-type: none"> 3. Factors that have a potentially negative effect on psychosocial functioning include: <ol style="list-style-type: none"> cc. Institutional attitudes and practices which affect the resident’s dignity and sense of control. dd. The lack of family/social support system. ee. Problems in coping with grief. ff. Disability or loss of function. gg. Presence of a progressive, chronic disabling condition (i.e., Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Alzheimer’s disease, mental illness). hh. Incompatibility of roommate. ii. Behavioral problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes). jj. Poor interaction and socialization skills. kk. Financial needs or problems. ll. Legal service's needs.

Responsibilities of the
Social Services
Department

- mm. Substance abuse; and
- nn. Need for death and dying or bereavement services.

4. The Social Services department is responsible for:

- a. Obtaining pertinent social data about personal and family problems related to the resident's illness and care.
- b. Identifying individual social and emotional needs including administering the BIMS and PHQ-9 assessments at least quarterly or earlier if warranted.
- c. Assisting in providing corrective action for the resident's needs by developing and maintaining individualized social services care plans.
- d. Maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting.
- e. Compiling and maintaining up-to-date information about community health and service agencies available for resident referrals.
- f. Making referrals to social service agencies as necessary or appropriate.
- g. Maintaining appropriate documentation of referrals and providing social service data summaries to such agencies.
- h. Maintaining contact with the resident's family members, involving them in the resident's total plan of care.
- i. Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the resident's needs).
- j. Informing the resident or representative (sponsor) of the resident's personal and property rights as well as serving on the group council to assure that complaints and grievances are promptly answered/resolved.
- k. Working with individuals and groups in developing supportive services for residents according to their individual needs and interests.
- l. Participating in interdisciplinary staff conferences, providing social service information to ensure treatment of the social and emotional needs of the resident as a part of the total plan of care.
- m. Participating in the planning of the resident's admission, return to home and community, or transfer to another facility by assessing the impact of these changes and making arrangements for social and emotional support; and
- n. Developing and participating in in-service training programs and classes.

Inquiries

5. Inquiries concerning social services should be referred to the Director of Social Services and/or the floor social worker.

References	
OBRA Regulatory Reference Numbers	483.15(g)(1) & (2)
Survey Tag Numbers	F250; F251
Related Documents	

Pastoral Services

Highlights	<p>Policy Statement</p> <p>The religious needs of each resident at the Idaho State Veterans Home will be met.</p> <p>Policy Interpretation and Implementation</p>
Purpose	1. The purpose of our pastoral policies is to establish a uniform set of procedures to follow in providing religious services to residents, staff, and family members.
Objectives	2. The objectives of our Pastoral Services are: <ul style="list-style-type: none"> a. To meet the religious needs of residents. b. To encourage residents to participate in their religious beliefs, worship, devotions, ritual observations, and sacramental ministrations. c. To provide assurance and support in times of uncertainty and crisis. d. To maintain a tie with the community when the resident is separated from his/her normal life setting because of illness or infirmities. e. To provide visitation for prayer and consultation; and f. To assist the resident and family when decline and death are inevitable.
In-Room Visits	3. Ministers are encouraged to make in-room visits.
Privacy	4. Residents shall be allowed to visit with their minister, rabbi, or priest in private.
Ministerial Visitation	5. Ministers are encouraged to check with the Charge Nurse before visiting residents.
Confidentiality	6. Any information relating to a resident’s medical condition, medical treatment, etc., is confidential. Ministers are not permitted to discuss or release any information about the resident unless written authorization is obtained from the resident.
Information Requests	7. Ministers should refer requests for information to the Nurse Manager and Social Services Director.
Supervision	8. The home’s chaplain is supervised by the Social Services Director. The Chaplain arranges for and provides general supervision to any pastoral service assisting in the home.
References	
OBRA Regulatory Reference Numbers	483.15(b)(2); 483.15(d)
Survey Tag Numbers	F242; F245

Spiritual and Religious Activities

Highlights	<p>Policy Statement</p> <p>Spiritual and religious activities are provided for the Idaho State Veterans Home resident population by the home’s chaplain under the auspices of the Social Services Department.</p> <p>Policy Interpretation and Implementation</p>
Scheduling Spiritual and Religious Activities	<ol style="list-style-type: none"> 1. A variety of spiritual and religious activities are available and scheduled through local religious organizations. 2. Residents are encouraged to attend religious activities of their choice. 3. Spiritual and religious activities include activities that are relevant to specific religions. For example: <ol style="list-style-type: none"> a. Worship services. b. Singing. c. Bible study. d. Bible readings. e. Presentations or lectures by individuals of various religions. 4. Residents are given freedom of choice in attending spiritual and religious activities. They are not required to attend such activities. 5. Residents’ requests for private consultation with chaplain or clergy are honored. 6. When possible, alternative activity programs are scheduled simultaneously with religious services for those residents who wish to attend non-religious programs.
Resident Participation	
Types of Spiritual and Religious Activities	
Freedom of Choice	
Consultation with Clergy	
Alternative Activities	

References	
OBRA Regulatory Reference Numbers	483.15(b)(2); 483.15(d); 483.15(f)(1)
Survey Tag Numbers	F242; F245; F248

Grievances: Filing grievances/Complaints

Highlights	Policy Statement
	<p>The Idaho State Veterans Home will assist residents, their representatives (sponsors), other interested family members, or resident advocates file grievances or complaints when such requests are made.</p>
	<p>Policy Interpretation and Implementation</p>
Right to File Grievances/Complaints	1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form.
Resident Grievance/ Complaint Procedures	2. Upon admission, residents are provided with information on how to file a grievance or complaint. A copy of our grievance/complaint form is located in public areas on each floor and in the Social Work Services office.
Submitting Grievances/ Complaints	3. Grievances and/or complaints may be submitted orally or in writing or anonymously. Written complaints or grievances will be signed by the resident or the person filing the grievance or complaint on behalf of the resident.
Responsibility for Investigating Grievances	4. The Administrator has delegated the responsibility of grievance and/or complaint investigation to the Social Work Department.
Submitting Written Report of Findings to the Administrator	5. Upon receipt of a grievance and/or complaint, the Social Work Department will investigate the allegations and document the findings on the grievance form.
Review of Findings with Investigator	6. The Administrator or their designee, will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.
Informing the Person Filing the Grievance/Complaint of the Findings/Corrective Action	7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Social Worker will make such reports orally or in writing upon closure of the investigation.
Filing Complaints with Other Agencies When Resident Unsatisfied with Facility Findings/Actions	8. Should the resident not be satisfied with the result of the investigation, or the recommended actions, he or she will be reminded/informed that they may file a written complaint to the local ombudsman office or to the state survey and certification agency. (Note: Addresses and telephone numbers of these agencies are posted in public areas on each floor).

9. The facility will designate a grievance official responsible for oversight of grievance process. Will go to effort to educate Res, family and staff and visitors of grievance policy including. – Rights to file complaint orally, in writing.

References	
OBRA Regulatory Reference Numbers	483.10(b)(7)(iii) &(iv); 483.10(f)(1) & (2); 483.13(c)(3) & (4)
Survey Tag Numbers	F156; F165; F166; F224; F225; F226
Related Documents	Resident Grievance/Complaint Form (<i>Appendix A</i>) Resident Grievance/Complaint Procedures (<i>Appendix A</i>)

Grievances: Grievance Form

Highlights	<p>Policy Statement</p> <p>The disposition of all resident grievances and/or complaints will be filed in the Idaho State Veteran’s Home Resident Grievance Folder.</p> <p>Policy Interpretation and Implementation</p>
Grievance Form	1. The disposition of all written grievances and/or complaints in the past year must be maintained in the Resident Grievance Form Folder.
Maintenance of Forms	2. The Social Work Department will be responsible for maintaining the form(s).
Contents of Forms	3. The following information, as a minimum, will be recorded at the recorder's discretion. <ul style="list-style-type: none"> a. The date the grievance/complaint was received. b. The name of the resident filing the grievance/complaint. c. The name and relationship of the person filing the grievance/complaint on behalf of the resident. d. The date the alleged incident took place. e. The name of the person(s) investigating the incident. f. The date the resident, or interested party, was informed of the findings; and g. The disposition of the grievance (i.e., resolved, dispute, etc.).
Quarterly Review of Forms	4. The Resident Grievance forms will be reviewed by the Director of Social Work and the administrator prior to being maintained in the Residents Grievance form folder.

References	
OBRA Regulatory Reference Numbers	n/a
Survey Tag Numbers	n/a
Related Documents	Resident Grievance/Complaint Log (<i>Appendix A</i>)

Freedom from Abuse, Neglect & Exploitation

1. PURPOSE

Each resident at Idaho State Veterans Home –Boise has the right to be free from exploitation, verbal, sexual, physical and mental abuse, serious bodily injury, corporal punishment and involuntary seclusion. Further, each resident/patient at ISVH- Boise will be treated with respect and dignity at all times.

In accordance with Section 1150B of the Social Security Act as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010, ISVH-B requires all employees, managers, supervisors, agent, and contractors to report any reasonable suspicion of crimes committed against a resident. The Idaho State Veterans Home-Boise follows state and federal guidelines regarding resident care and works in collaboration with the Bureau of Facility Standards, the Veterans' Administration and local law enforcement to ensure rules and standards regarding resident/patient care are upheld. State and federal regulations require the ISVH-B to report certain events in accordance with 42 CFR § 483.12 (a) (i), and IDAPA 16.03.02.100.12 (c) and (f).

“CRIME” is defined by law of the applicable political subdivision where the Idaho State Veterans Home-Boise facility is located. The facility must coordinate with local law enforcement entities to determine what actions are considered crimes within their political subdivision. It has been determined that the following defined actions may be considered a crime and are reportable:

2. DEFINITIONS

“**ABUSE**,” is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.”

- a. “**MENTAL ABUSE**” is the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.
- b. “**VERBAL ABUSE**” may be considered a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.
- c. “**SEXUAL ABUSE**” is non-consensual sexual contact of any type with a resident.
- d. “**PHYSICAL ABUSE**” includes hitting, slapping, pinching, biting, kicking, etc. It also includes controlling behavior through corporal punishment.
- e. “**INVOLUNTARY SECLUSION**” means separation of a resident/patient from other residents or from his or her room against the resident’s will or the will of the resident’s Legal representative. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the residents’ needs.

- f. **“NEGLECT”** means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
- g. **“MISAPPROPRIATION OF RESIDENT PROPERTY”** means the deliberate misplacement or wrongful temporary or permanent use of a resident’s belongings or money without the resident's consent.
- h. **“INJURY OF AN UNKNOWN ORIGIN”** are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and the injury includes severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities does not meet this definition and need not be reported.
- i. **“EXPLOITATION”** means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
- j. **“EXPLOITATION THROUGH PHOTOGRAPHY OR VIDEOS”** To prevent the taking and use of photographs or video of residents that the resident (or their representative when they can't make their own decisions) have not granted consent or believes may be demeaning or humiliating. Taking or distributing of any photographs or video recordings of a resident or his/her private space without the resident's or designated representatives, written or verbal consent must not be done by any employees, consultants, contractors, volunteers, or other caregivers at Idaho State Veterans Home – Boise. Examples include, but are not limited to, staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), a resident eating in the dining room, or a resident participating in an activity in the common area. Should a photograph or video recording be taken unintentionally; they must be destroyed unless the resident (or their representative should the resident be unable to consent) provides consent. While residents may give consent for taking of photographs or videos, the use of those photographs must be consistent with the consent and cannot be demeaning or humiliating. Using photographs or video recordings in ways not covered by the consent may be inappropriate. Any photograph(s)/video(s) should ideally be shared with resident or their representative prior to use to make sure they do not find it humiliating or demeaning. Staff must report to their supervisor any unauthorized (or suspected to be unauthorized) taking of photographs or videos as well the sharing of such recordings in any medium. Violation of this policy may result in disciplinary actions including up to termination. All staff, consultants, contractors, volunteers and other caregivers will be educated about this policy as part of their orientation prior to providing services to residents.

*Note: written or verbal consent requires the resident to understand the implications of their consent. Also, residents (or their representative if they are unable to consent) may change their consent at any time, which should be documented.

3. IMPLEMENTATION AND SCREENING

- a. Residents of ISVH-Boise will not be subjected to any of the above defined crimes by anyone, including but not limited to, facility staff, other residents, consultants, contractors, volunteer staff, family members, friends or other individuals. The first person who has knowledge of any act of abuse, neglect, exploitation or misappropriation of resident property shall report such information to the Administrator either through a phone call or email immediately. Additionally, this person will notify their immediate supervisor or the Charge RN on duty, who shall immediately report such information to the DNS, Social Worker, and law enforcement if applicable. The reporting person will also fill out the Gold Suspected Abuse/Neglect/Exploitation Witness Report immediately located on each nursing unit.
- b. ISVH-B will not employ individuals who have been found guilty of abusing, mistreating, exploiting or neglecting residents by a court of law or individuals who have had a finding entered into the state Nurse Aide Registry concerning abuse, mistreatment or neglect. The Idaho Board of Nursing will be contacted for information on licensed nursing applicants. ISVH-B will also refrain from employing any individual who has been prohibited from working in a long-term care facility because of failure to report a suspicion of a crime against a resident of another long-term care facility. Further, no person shall be employed at ISVH- B who discloses, is found to have been convicted, or has a withheld judgment as an adult or juvenile of any of the disqualifying offenses as described in IDAPA 16.05.06, "Criminal History and Background Checks." Criminal history checks shall be completed on all staff employed at ISVH-B- per the Divisions' Criminal History Background Check Procedures.
- c. All alleged violations will be thoroughly investigated by the facility under the direction of the Home Administrator and in accordance with state law.
- d. Idaho State reporting requirements will be adhered to including reporting to the appropriate law enforcement agency. The Home Administrator or his designee shall report to the state licensing authority, Bureau of Facility Standards, all allegations of violations of this procedure and the results of the facility investigation. These shall be reported to the appropriate officials within the time frames established by the Bureau of Facility Standards.
- e. ISVH-B facility shall post conspicuously in an appropriate location a sign specifying the rights of employees under Section 1150B of the Social Security Act.

4. REPORTING REQUIREMENTS

- a. Facility reporting of all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult

protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Bureau of Facility Standards' Reporting Portal www.ltc-portal.com Bureau of Facility Standards (208) 334-6626

Bureau of Facility Standards' Facsimile (208) 364-1888 Boise City Police Department (208) 377-6790

Idaho Board of Nursing (208) 334-3110

- b. When employees, managers, supervisors, agent, and/or contractors (herein after referred to as "covered individuals") reasonably suspect a crime has occurred against a resident they must report the incident to the Bureau of Facility Standards and local law enforcement.
- c. Covered individuals can use the facility form to report a suspicion of a crime. However, there is no requirement to use the form.
- d. Covered individuals can either report the same incident as a single complaint or multiple individuals may file a single report that includes information about the suspected crime from each covered individual using the facility form.
- e. If, after a report is made regarding a particular incident, the original report may be supplemented by additional covered individuals who become aware of the same incident. The supplemental information may be added to the form and must include the name of the additional staff along with the date and time of their awareness of such incident or suspicion of a crime. However, in no way will a single or multiple person report preclude a covered individual from reporting separately. Either a single or joint report will meet the individual's obligation to report.
- f. Events causing reasonable suspicion of a crime (as defined above), must be reported by covered individuals as follows:
 1. Reasonable Suspicion with Serious Bodily Injury- 2-hour limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion;
 2. Reasonable Suspicion without Serious Bodily Injury- within 24 Hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion.

“SERIOUS BODILY INJURY” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.

- g. Covered individuals must also report the suspicion of a crime to the Administrator either through a phone call or email immediately. Additionally, the covered individual will notify their immediate supervisor or the Charge RN on duty, who shall immediately report such information to the DNS, Social Worker, and law enforcement if applicable. The covered individual will also fill out the Gold

Suspected Abuse/Neglect/Exploitation Witness Report immediately located on each nursing unit.

- h. Failure to report in the required time frames may result in disciplinary action, including up to termination.
- i. The Administrator or his/her designee is responsible for providing the Bureau of Facility Standards the completed investigation report within 5 working days of the alleged abuse.
- j. Retaliation against any individual who lawfully reports a reasonable suspicion of a crime under section 1150B of the Social Security Act is strictly prohibited.

5. TRAINING

- a. This procedure is mandatory reading for all new employees. They will receive a copy of this procedure at new employee orientation and will sign documentation to verify they have read and understand this procedure.
- b. ISVH-B will notify covered individuals annually of their individual reporting obligations to comply with section 1150B (b) of the Act and included herein these nursing procedures.
- c. Mandatory training will be provided to all staff at ISVH-B regarding the content of this procedure. The content of this training shall include identifying appropriate interventions in dealing with aggressive and/or catastrophic reactions of residents; the reporting requirements of this procedure and the ability to make such reports without the fear or concern of reprisal; recognizing signs of distress in employees that may lead to possible abuse; and the definition of what constitutes abuse, neglect, exploitation and misappropriation of resident property. All ISVH-B employees and ISVH contracted entities shall undergo this training at least on an annual basis.

“CATASTROPHIC REACTIONS” can be defined as reactions or mood changes of the resident. In response to what may seem to be minimal stimuli such as bathing, dressing, toileting, etc., that can be characterized by unusual responses such as weeping, anger, or agitation.

6. PREVENTION

- a. It is the Procedure of ISVH-B that prevention is the first line of defense against any inappropriate behavior directed toward residents. In addition to a pre-employment screening through criminal history checks, mandatory training, and mandatory reporting requirements, all employees are expected to be well informed of the elements of this policy and each employee shall certify that they have read the policy and are familiar with its content. Further, each resident, family member, or responsible party shall be notified in writing at the time of admission about how and to whom any report suspected incident of abuse, neglect, exploitation or misappropriation of property may be made. This information shall also include assurances that such reporting may be made without fear of retribution and that full protection shall be provided to the resident who may be the subject of alleged abuse during any investigative process that ensues.

- b. Staffing of direct care positions shall meet or exceed state minimums at all times on all shifts. Proper supervision of those staff will include direct observations during the provision of care with special attention given to any inappropriate behavior on the part of the caregiver such as using derogatory language, rough or improper handling, ignoring legitimate requests of residents, ignoring toileting needs, etc.
- c. Careful attention will be given to all residents during the assessment and care planning processes for residents who may have special needs because of behaviors such as aggressiveness, catastrophic reactions, self-injury, nonverbal communication, or those who require heavy or total nursing care. These residents are to be viewed as especially vulnerable and deserving ongoing protection.

7. IDENTIFICATION

- a. All events which warrant reporting via the facility Incident/Accident reporting system shall be tracked so as to be able to identify suspicious events, occurrences, patterns or trends that may constitute abuse or neglect. The Home Administration shall be responsible for monitoring this tracking system and shall determine when a preponderance of the data indicates that an investigation is necessary.

8. PROTECTION AND INVESTIGATION/EVALUATION

- a. All suspected cases of abuse, neglect, exploitation and misappropriation of resident property will be investigated following the guidelines set forth by the Bureau of Facility Standards. The Home Administrator of ISVH-B, or the Acting Administrator in his absence, shall be responsible for directing the investigation and complying with all reporting requirements. The Administrator may enlist the services of other professionals to assist with the investigation.
- b. Following receipt of an allegation, the facility will take appropriate measures to ensure that no further potential crime(s) will occur while the investigation is in process. Any employee under investigation for violation of this policy will be removed from the facility and may not work at any Idaho State Veterans Home until the investigation is completed. The employee may be also placed on Administrative Leave with Pay from employment for up to thirty (30) days under the provisions of IDAPA 15.04.01.109.02. If necessary, the thirty (30) day suspension period may be extended with written approval from the Administrator of the Idaho Division of Human Resources. If an employee is placed on administrative leave during the investigation, the employee will be notified in writing by the Administrator, explaining reason of employee leave and availability expectations during the investigation process.
- c. The following steps will be utilized to assist in ensuring a thorough investigation is completed related to the alleged incident:
 - i. After the covered individual has reported alleged incident to Administrator and the RN Charge or Nurse Manager, the RN Charge or Nurse Manager will immediately notify Director of Nursing and the Director of Social

Services. Other appropriate Department/Team Leaders will be notified if applicable to begin investigation of the alleged incident.

- ii. If the allegation is abuse, neglect, or exploitation related, Social Services or designee will take the lead. If the investigation is clinically related, i.e. fall with major injury, the Director of Nursing or Designee will take the lead. Reporting Requirements as outlined in this procedure under section 4 will be followed. During the investigation, the QI Director and the Administrator will be kept informed of the progress of the investigation.

The following steps will be taken with investigations:

1. Social Services and supervisors will conduct interviews with resident's and any resident witnesses identified in the investigation.
 2. Social Services and supervisors will conduct interviews and obtain written, dated and signed statements from direct care staff assigned to resident. Depending on the incident, it may be necessary to obtain statements from direct care staff one to two shifts prior.
 3. Social Services and supervisors will conduct interviews and obtain written, dated and signed statements from staff witnesses or other available witnesses, I.e. volunteers, agency, contractors, family members.
 4. For an employee who has been placed on administrative leave, Social Services and the employee's supervisor (or designee) will make arrangements to conduct a face-to-face interview either at ISVH or the Central Support Office conference room.
 5. The facility has five (5) business days to conclude the investigation with the allegation either being verified or not verified. Social Services will formulate a final detailed investigative report that will be submitted to Bureau of Facility Standards Reporting Portal no later than the fifth day of when the investigation began.
 6. If, at the conclusion of the investigation the employee placed on administrative leave is called to return to work, the employee will be provided with written notification by the Administrator outlining the results of the investigation, including disciplinary action and/or training, if any, necessary for corrective action. The employee will have the opportunity for Due Process. IDAPA 15.04.01.200.
- d. The nurse progress notes should reflect, but are not limited to, the following:
 1. Who was involved in the incident? Include staff, residents, and visitors.
 2. Where did the incident occur? Include physical location, was it cluttered, well lit, busy, etc.
 3. What was the time of the incident?
 4. What was the situation leading up to the incident?
 5. What was the situation immediately following the incident?
 6. Where was the staff prior to, during, and after the incident?
 7. What did the staff do immediately to ensure the safety of both residents?

8. Was there any physical injury and if so, how was the injury addressed?
9. What was the resident's emotional status?
 10. Who was notified: Administrator, DNS, DSS, family?
 11. Were there any changes in medication?
 12. Were there any recent changes in physical condition, i.e.: infection?
 13. Was the care plan amended?
- e. Nurse progress summary notes at the end of each shift for 72 hours may include:
 14. The emotional state of the resident(s).
 15. Any verbal or physical aggression towards others.
 16. Any change in medication.
 17. Any physical changes.
 18. Interventions used.
- f. The Administrator or his/her designee is responsible for providing the Bureau of Facility Standards the completed investigation report within 5 working days of the alleged abuse

11/00; Revised 10/03, 03/11, 09/11, 03/13, 03/15, 02/17, 05/17, 01/18, 06/19, 02/20

Abuse Prevention Program – Abuse Prevention Components

Policy Statement

The Idaho State Veterans Home is committed to protecting our residents from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Idaho State Veterans Home has a zero-tolerance policy for resident mistreatment, neglect, abuse, or misappropriation of resident property. The "key Components in the Prevention of Abuse Program" will provide an outline with procedures designed for the protection of our residents. Responsible staff include: ISVH Administrator, Director of Nursing Services, Director of Social Services and all ISVH staff.

Procedure

If you witness, suspect, have knowledge of, or take part in abuse, neglect, misappropriation of property, or injury of unknown source as defined in the Abuse Prevention Program, you are obligated to report the information immediately. First and foremost, ensure the immediate care and protection of the victim if applicable. Next, report the information to your supervisor or administrator and by following the procedure as addressed under Abuse Prevention Program – Seven Key Components, Reporting/Response. A thorough investigation will take place by the Administrator or the Administrator's designee.

Components of this Program:

1. Screening of all new staff personnel, volunteers, and potential admissions.
2. Training of all employees on what constitutes abuse/neglect, how to intervene with aggressive and/or catastrophic reactions or residents and families, and how to recognize frustration and stress in self and others.
3. Prevention through initial and ongoing training, reporting, analysis, adequate staffing patterns, and individualized care planning.
4. Identification of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitutes abuse.
5. Investigation by identifying the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities.
6. Protection of residents during investigation from harm or retaliation.
7. Reporting/response that informs the state agency and all other agencies as required and takes all necessary corrective actions depending on the results of the investigation.

<https://www.ltc-ortal.com/Portal/ProvideLogin.aspx>

Regulatory Reference Numbers: 483.10 (a)(2); 483.10 (b); 483.13 (c)(1)-(4); IDPA 16.03.02.100.12 (c) and (f). Refer to Informational Letter #2005-1. Section 1150B of the Social Security Act as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Elder Justice Act)

F151, F156, F223, F224, F225, F226

01/2018

Abuse Prevention Program Components 1 & 2

Screening & Training

Policy Statement

The Idaho State Veterans Home conducts a thorough screening of all new employees before they are hired. ISVH will not knowingly employ any individual who has been convicted of a crime that could adversely affect their relationship with fellow employees, residents, or families. All new staff personnel, volunteers, and potential admissions will be screened. Training on issues related to abuse prevention practices commences with the employees' orientation and continues on a regular basis throughout the employee's tenure at ISVH.

Policy Implementation

- A. Employee Screening, Prior to Employment:
 - a. A personal and professional reference check is initiated by the Team Leader.
 - b. All Nursing Services personnel are checked with the Nurse Aide Registry of the Idaho Board of Nursing, by nursing, to determine validated findings of resident abuse, neglect, mistreatment, or misappropriation of resident property.
 - c. The Human Resources Department and employee will complete a State of Idaho, Department of Law Enforcement, Bureau of Criminal Identification (BCI) Criminal History check per division procedures
- B. Employee Training
 - a. Orientation
 - b. Mandatory in-services included but are not limited to:
 - i. Resident Rights, confidentiality, dignity, privacy, advance directives, personal and property rights, and abuse, neglect, misappropriation of property prevention and reporting, Hand in Hand training (CMS)
 - ii. Weekly unit behavioral meetings
 - iii. Universal precautions
 - iv. Fire and Safety including emergency preparedness
- C. Voluntary In-Services
 - a. Offered on a regular basis and include training to increase staff knowledge of needs specific to certain residents.

Abuse Prevention Program Components 3 Prevention

Policy Statement

The Idaho State Veterans Home will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse.

Policy Interpretation Implementation

1. The facility's goal is to achieve and maintain an abuse-free environment.
2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following:
 - a. Training all staff and practitioners how to resolve conflicts appropriately.
 - b. Allowing staff to express frustration with their job, or in working with difficult residents.
 - c. Assisting or rotating staff working with difficult or abusive residents.
 - d. Informing residents and family members upon the resident's admission to the facility how and to whom to report complaints, grievances, and incidents of abuse.
 - e. Helping staff to deal appropriately with stress and emotions.
 - f. Training staff to understand and manage a resident's verbal or physical aggression.
 - g. Instructing staff about how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.
 - h. Monitoring staff on all shifts to identify inappropriate behaviors toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their clothing/beds, etc.); assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect;
 - i. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues.
 - j. Conducting background investigations to avoid hiring persons or admitting new residents who have been found guilty (by a court of law) of abusing, neglecting, or mistreating individual or those who have had a finding of such action entered into the state nurse aide registry or state sex offender registry;
 - k. Involving Attending Physicians and the Medical Director when findings of abuse have been determined.
 - l. Involving qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents.
 - m. Identifying areas within the facility that may make abuse and/or neglect more likely to occur (e.g. secluded areas) and monitoring these areas regularly.
 - n. Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met; and

- o. Encouraging all personnel, residents, family members, visitors, etc., to report any signs or suspected incidents of abuse to facility management immediately.
 3. Inquiries concerning our abuse prevention/intervention program should be directed to the Administrator, the Director of Social Work Services, or to the Director of Nursing Services.

OBRA Regulatory Reference Numbers: 483.13(b); 483.13(c)

See also state sex offender registries at <http://www.bvi.gov/hq/cid/cac/stateslhtm> and state nurse aide registries at <http://www.asisvcs.com/publicatins/pdf/079960.pdf>

Survey Tag Numbers: F223, F224, F225, F226

Abuse Prevention Program Components 4 & 5

Identification/Investigation

Policy Statement

The Idaho State Veterans Home investigates all reports of resident abuse, neglect and injuries of unknown origin.

Policy Interpretation Implementation

Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown origin be reported, the Administrator, or his/her designee, will appoint a member of management (in most cases the Social Work Services Department) to investigate the alleged incident. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation.

The individual conducting the investigation will, at a minimum:

1. Review the completed documentation forms.
2. Review the resident's medical record to determine events leading up to the incident.
3. Interview the person(s) reporting the incident.
4. Interview any witnesses to the incident.
5. Interview the resident (as medically appropriate).
6. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition.
7. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.
8. Interview the resident's roommate, family members, and visitors.
9. Interview other residents to whom the accused employee provides care or services; and
10. Review all events leading up to the alleged incident.
11. Each interview will be conducted separately and in a private location.
12. The purpose and confidentiality of the interview will be explained thoroughly to each person involved in the interview process.
13. Should a person disclose information that may be self-incriminating, that individual will be informed of his/her rights to terminate the interview until such time as his/her rights are protected (e.g., representation by legal counsel).
14. Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports.
15. The individual in charge of the abuse investigation will conduct notification in compliance with Idaho Code, Section 39-5303; the Bureau of Facility Standards Informational Letter 2005-1, and Section 1150B of the Social Security Act.
<https://.lhc-portal.com/ortal??ProviderLogin.aspx>
16. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents.
17. Employees of this facility who have been accused of resident abuse may be suspended from duty until the results of the investigation have been reviewed by the Administrator. (See policies governing employee sanctions and reporting requirements.)
18. The individual in charge of the investigation will consult daily with the administrator concerning the progress/findings of the investigation.

19. The administrator or designee will keep the resident and his/her representative (sponsor) informed of the progress of the investigation.
20. The results of the investigation will be recorded on approved documentation forms.
21. The investigator will give a copy of the completed documentation to the Administrator.
22. The Administrator or designee will inform the resident and his/her representative (sponsor) of the results of the investigation and corrective action taken upon timely completion of the investigation.

The administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency, and as appropriate, the local police department, the ombudsman and others as required by state or local law, within five (5) working days of the reported incident.

23. Should the investigation reveal that a false report was made/filed, the investigation will cease. Residents, family members, state agencies, etc., will be notified of the findings.
24. Inquiries concerning abuse reporting and investigation should be referred to the Administrator, Director of Social Services or the Director of Nursing Services.

Abuse Prevention Program Components 6 Protection

Policy Statement

The Idaho State Veterans Home will protect residents from harm during investigations of abuse allegations.

Policy Interpretation Implementation

1. During abuse investigations, residents will be protected from harm by the following measures:
 - a. Employees accused of participating in the alleged abuse will be removed from the facility and may not work at any Idaho State Veterans Home until the investigation is completed. The employee may also be placed on Administrative Leave with pay from employment for up to thirty (30) days under the provision of IDAPA 15.04.01.109.02 if necessary, the thirty (30) day suspension period may be extended with written approval from the Administrator of the Idaho State Veterans Home.
 - b. If the alleged abuse involves a resident's family member or visitor, such person(s) will not be permitted to have unsupervised visits with the resident.
 - c. If the alleged abuse involves another resident, the accused resident's representative and Attending Physician will be informed of the alleged abuse incident and that there may be restrictions on the accused resident's ability to visit other resident rooms unattended. If necessary, the accused resident's family members may be required to help meet this requirement.
2. With five (5) working days of the alleged incident, the facility will give the resident, the resident's representative (sponsor), state survey and certification agencies, etc., a written report of the findings of the investigation and a summary of corrective action taken to prevent such incident from recurring.
3. Should the results indicate that abuse occurred, appropriate authorities will be notified per "Abuse Prevention Program Component 7: Reporting/Response."

Abuse Prevention Program Components 7

Reporting/Response, Agencies

Policy Statement

All suspected an alleged violations and all substantiated incidents of abuse as defined in Policy Statement "Reporting Abuse to Facility Management" will be immediately reported to the Bureau of Facility Standards and to the Boise City Police Department as well as appropriate state agencies and other entities or individuals as may be required by law or considered as best practice in the residents interest. The Idaho State Veterans Home adheres to the guidelines of section 1150B of the Social Security Act, as established by section 6703(b)(3) of the Patient Protection and affordable Care Act of 2010 attached herein and according the Idaho Department of Health and Welfare (IDHW) Informational Letter #2005-1.

Policy Interpretation Implementation

1. Should a suspected violation or substantiated incident of mistreatment, misappropriation of resident property by staff or others, staff-family-visitor to resident abuse, neglect, injuries of an unknown source or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee will promptly notify the appropriate following persons or agencies (verbally and written) as described above.
 - a. The State licensing/certification agency responsible for surveying/licensing the facility.
 - b. The local/state Ombudsman/
 - c. The Resident's Representative (Sponsor) of records.
 - d. Adult Protective Services.
 - e. Law enforcement officials.
 - f. The resident's Attending Physician and
 - g. The facility Medical Director.
2. Contact and submitted information must be made to the Boise City Police Department (208-377-6790) and the Bureau of Facility Standards (208-364-1899) within twenty-four (24) hours of the occurrence of such incident. A reporting form attached herein may be utilized for these purposes. Idaho's Adult Protection law and the Social Security Act requires that when the facility has reasonable cause or suspicion of a crime resulting in serious bodily injury jeopardizing the life, health, or safety of a vulnerable adult , the facility must report this to law enforcement and the state licensing/certification agency within two (2) hours. Any person employed by the home or otherwise may report eh incident per the guidelines of section 1150B of the Social Security Act, as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 attached herein and according to the Idaho Department of Health and Welfare (IDHW) Informational Letter #2005-1.s without fear of reprisal.
3. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. The report will be faxed to the Bureau of Facility Standards and to Boise City Police Department.
4. Should the investigation reveal findings of abuse, such findings will be reported to the State Abuse Registry. The individual(s) involved in the incident will be notified of such

- findings, and such individual(s) will be suspended per state policy until the State Abuse Registry has investigated the claim and found the allegations to be true or unfounded.
5. Should the allegations be true, the employee(s) will be terminated from employment. Should the allegations be unfounded, the employee(s) will be reinstated to his/her/their former position.
 6. Records of all allegations will be filed in the accused employee's personnel record along with any statement by the employee disputing the allegation if the employee chooses to make one. Records concerning unfounded allegations may be destroyed or maintained in a file separate from the employee's personnel file.
 7. The State Abuse Registry will"
 - a. Notify the employee when he/she has been implicated in any investigation.
 - b. Inform the employee of the nature of the allegation.
 - c. Inform the employee of the time and date of occurrence.
 - d. Inform the employee of his/her right to a hearing.
 - e. Inform the employee of the state's intent to record findings of resident abuse into the abuse registry, and
 - f. Inform the employee of his/her right to file a statement disputing the allegation.
 8. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse.
 9. Any violation of this policy may result in disciplinary action.
 10. Inquiries concerning resident abuse should be referred to the Director of Nursing Services or to the Administrator.
 11. Inquiries concerning the reporting of abuse to state agencies should be referred to the Administrator.

Abuse Prevention Program Components 7 Reporting/Response, Facility Management

Policy Statement

It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management and as directed in policy "abuse Prevention Program Component 7, Reporting/Response, Agency.

Policy Interpretation Implementation

1. The Idaho State Veterans Home does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.
2. To help with recognition of incidents of abuse, the following definitions of abuse are provided:
 - a. **“ABUSE,”** is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.”
 - i. **“MENTAL ABUSE”** is the use of verbal or nonverbal conduct that causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.
 - ii. **“VERBAL ABUSE”** may be considered a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.
 - iii. **“SEXUAL ABUSE”** is non-consensual sexual contact of any type with a resident.
 - iv. **“PHYSICAL ABUSE”** includes hitting, slapping, pinching, biting, kicking, etc. It also includes controlling behavior through corporal punishment.
 - v. **“INVOLUNTARY SECLUSION”** means separation of a resident/patient from other residents or from his or her room against the resident’s will or the will of the resident’s Legal representative. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the residents’ needs.

- vi. **“NEGLECT”** means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
- vii. **“MISAPPROPRIATION OF RESIDENT PROPERTY”** means the deliberate misplacement or wrongful temporary or permanent use of a resident’s belongings or money without the resident's consent.
- viii. **“INJURY OF AN UNKNOWN ORIGIN”** are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and the injury includes severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities does not meet this definition and need not be reported.
- ix. **“EXPLOITATION”** means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
- x. **"EXPLOITATION THROUGH PHOTOGRAPHY OR VIDEOS"** To prevent the taking and use of photographs or video of residents that the resident (or their representative when they can't make their own decisions) have not granted consent or believes may be demeaning or humiliating. Taking or distributing of any photographs or video recordings of a resident or his/her private space without the resident's or designated representatives, written or verbal consent must not be done by any employees, consultants, contractors, volunteers, or other caregivers at Idaho State Veterans Home – Boise. Examples include, but are not limited to, staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), a resident eating in the dining room, or a resident participating in an activity in the common area. Should a photograph or video recording be taken unintentionally; they must be destroyed unless the resident (or their representative should the resident be unable to consent) provides consent. While residents may give consent for taking of photographs or videos, the use of those photographs must be consistent with the consent and cannot be demeaning or humiliating. Using photographs or video recordings in ways not covered by the consent may be inappropriate. Any photograph(s)/video(s) should ideally be shared with resident or their representative prior to use to make sure they do not find it humiliating or demeaning. Staff must report to their supervisor any unauthorized (or suspected to be unauthorized) taking of photographs or videos as well the sharing of such recordings in any medium. Violation of this policy may result in disciplinary actions including up to termination. All staff, consultants, contractors, volunteers and other caregivers will be educated about this policy as part of their orientation prior to providing services to residents.
 *Note: written or verbal consent requires the resident to understand the implications of their consent. Also, residents (or their representative if they are unable to consent) may change their consent at any time, which should be documented.

- 3. All personnel, residents, family members, visitors, etc., are mandated to report incidents of resident abuse or suspected incidents of abuse and any reasonable suspicion of a crime

committed against an individual who is a resident of, or receiving care from the Idaho State Veterans Home. Such reports may be made without fear of retaliation from the facility or its staff.

4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to their supervisors, the Administrator, or the Director of Nursing Services.
5. The following information should be reported is possible:
 - a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred.
 - b. The date and time that the incident occurred.
 - c. Where the incident took place.
 - d. The name(s) of the person(s) allegedly committing the incident, if known.
 - e. The name(s) of any witnesses to the incident.
 - f. The type of abuse that was committed (i.e. verbal, physical, sexual, neglect, etc.); and
 - g. Any other information that may be requested by management.
6. Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information.
7. Staff members and person affiliated with this facility shall not knowingly.
 - a. Attempt, with or without threats or promises of benefit, to induce another to fail to report an incident of mistreatment or other offense.
 - b. Fail to report an incident of mistreatment or other offense.
 - c. Alter, change without authorization, destroy or render unavailable a report made by another; and/or
 - d. Screen reports or withhold information to reporting agencies.
8. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged an informed of such incident.
9. When an incident of a crime against a resident is reasonable suspected or confirmed, the incident must be immediately reported to facility management within two (2) hours of knowledge or witness of the act. Reporting procedures should be followed as outlined in this policy and in Policy Statement "Reporting Abuse/Reasonable Suspicion of a Crime Against a Resident to State Agencies and Other Entities/Individuals."
10. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. (Note: If sexual abuse is suspected, DO NOT, bathe the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately.)

11. The person performing the examination must document the examination findings on approved forms, and obtain a written, signed, and dated statement from the person reporting the incident.
12. A completed copy of documentation forms and written statements from witnesses, if any, will be provided to the Administrator.
13. Upon receiving information concerning a report of abuse, a representative of the Social services Department will monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation.
14. The Social Services Department will give the Administrator and the Director of Nursing Services a written report of his/her findings.
15. All phases of the investigation will be kept confidential in accordance with the facility's policies governing the confidentiality of medical records.
16. Administrative policies governing the notification of the resident's representative (sponsor) and Attending Physician are located in our facility's resident rights policies/procedures, and the admission consent form.
17. Inquiries concerning abuse reporting and investigation should be referred to the Administrator, Director of Social Services, and/or to the Director of Nursing Services.

Reasonable Suspicion of a Crime - Against a Resident Reporting From

<p>INSTRUCTIONS: Contact and submit this completed form to the Bureau of Facility Standards and Boise City Police Department within 2 hours (if there is serious bodily injury) or 24 hours (if there is not serious bodily injury) of forming a reasonable suspicion that a crime may have been committed against any individual who is a resident of the Idaho State Veterans Home – Boise.</p> <p><u>IDAHO STATE VETERANS HOME CONTACT:</u> Rick Holloway, Administrator 320 Collins Road, Boise, ID 83702 Phone: (208) 780-1600 Fax: (208) 780-1601 Email: rick.holloway@veterans.idaho.gov</p>		
Reported to the State Survey Agency? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Reported: ____/____/____ Time: _____ BUREAU OF FACILITY STANDARDS CONTACT: 3232 Elder Street, PO Box 83720, Boise, ID 83720 Reporting Portal www.ltc-portal.com	Reported to the Local Law Enforcement? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Reported: ____/____/____ Time: _____ BOISE CITY POLICE DEPARTMENT CONTACT: 333 N. Mark Stall Place, Boise, ID 83704 Phone: (208) 377-6790 – Non-Emergency Dispatch (208) 570-6000 – General Information 911 – Emergency General Fax – 570-6732	
<p>Provide a summary of the suspected crime including the resident name and date of birth, as well as a brief description of the location of the incident and, if available, the names of any individuals involved in the suspected crime. (Attach additional sheets if necessary. No. of pages attached __)</p> <p>Resident Name: _____ DOB: _____ SSN#: _____</p> <p>Description & Location of Incident:</p> <p>Was there serious bodily injury as a result of the incident? No ___ YES ___ (must be reported within 2 hours)</p>		
INDIVIDUAL[S] REPORTING		
THIS REPORT IS MADE BY THE FACILITY ON BEHALF OF ALL COVERED INDIVIDUALS LISTED BELOW.		
Name:	Date/time individual became aware of suspected crime	
1.	Date: ____/____/____	Time: _____
2.	Date: ____/____/____	Time: _____
3.	Date: ____/____/____	Time: _____
4.	Date: ____/____/____	Time: _____
5.	Date: ____/____/____	Time: _____
6.	Date: ____/____/____	Time: _____
7.	Date: ____/____/____	Time: _____
8.	Date: ____/____/____	Time: _____

NOTE: This report is required by law where a suspicion a crime has occurred and is in no way an admission by the person(s) submitting the report that a crime has actually occurred.

Revised: 01/2014, 04/16, 05/17, 01/18

Resident-to-Resident Altercations

Policy Statement

All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Director of Social Services, Nurse Manager, the Director of Nursing Services and to the Administrator.

Policy Interpretation and Implementation:

1. Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the Nurse Manager, Director of Nursing Services, and to the Administrator.
2. If two residents are involved in an altercation, staff will:
 - a. Separate the residents, and institute measures to calm the situation.
 - b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation.
 - c. Notify each resident's representative (sponsor) and Attending Physician of the incident.
 - d. Review the events with the Nurse Manager and Director of Nursing, including interventions to try to prevent additional incidents.
 - e. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem.
 - f. Make any necessary changes in the care plan approaches to any or all of the involved individuals.
 - g. Document in the resident's clinical record all interventions and their effectiveness.
 - h. Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Care Planning Team
 - i. Complete an Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record
 - j. If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident; and
 - k. Report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy.
3. Inquiries concerning resident-to-resident altercations should be referred to the Director of Social Services, Director of Nursing and the Administrator.

OBRA Regulatory Reference Numbers: 483.13(b), 483.13(c), 183.25(h); IDAPA 16.03.02.100.12 (c) and (f). Refer to Informational Letter #2005-1. Section 1150B of the Social Security Act as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Elder Justice Act)

Survey Tag Numbers: F223, F224, F225, F226, F323

Mood/Behavior Medication Review Committee

<p>Highlights</p> <p>Purpose</p> <p>Committee Members</p> <p>Committee Structure</p> <p>Documentation</p>	<p>Policy Statement</p> <p>The Mood/Behavior Committee identifies and evaluates the use of medication for behavior/mood, determines clinically appropriate interventions, and ensures appropriate consents and medical orders are obtained, care plans are updated, and documentation is complete. (Guidelines: 483.25(1), (2), (i), and (ii). The committee additionally follows the guidelines as referenced in S&C: 13-35-NH.</p> <p>Policy Interpretation and Implementation</p> <p>The committee is comprised of the RN Manager, Assigned Social Worker, Pharmacist and MD.</p> <ol style="list-style-type: none"> 1. Frequency, Location, Time and Place <ol style="list-style-type: none"> A. Will meet quarterly B. Meetings will occur on the unit reviewed C. Social Work Services to coordinate time and date. D. All residents prescribed an antipsychotic, antianxiety, or other medication for behavior will be reviewed at least quarterly. Residents prescribed an antidepressant medication will be reviewed yearly unless dosage adjustments have been made within the year. E. Social Work Services will chair the meeting. 2. Quarterly Psychoactive Medication Review Form <ol style="list-style-type: none"> A. Social Work Services will complete the form with the information requested. B. The information contained on the form will be reviewed by the committee. C. Any additional information will be presented at the review meeting and documented. D. The committee will make recommendations and those recommendations documented. E. All attendees at the meeting will sign the review. F. Changes including MD orders, Care Plan Revisions will be made prior to the adjournment of the meeting. G. Social Work Services will document in the Social Work Services Progress Notes that the meeting took place and place the form in the Social Services section of the Resident Medical file.
References	
OBRA Regulatory Reference Numbers	483.25 (1), (2)
Survey Tag Numbers	F329
Related Documents	CMS Informational Letter S&C: 13-35-NH

Behavioral Health Services

Policy: It is the policy of this facility that all residents receive necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.

Definitions:

"Mental disorder" is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

"Substance use disorder" is defined as recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment, such as health problems or disability.

"Non-pharmacological intervention" refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.

"Mental and psychosocial adjustment difficulty" refers to the development of emotion and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms.

Policy Explanation and Compliance Guidelines:

1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes:
 - a. PASARR screening.
 - b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health.
 - c. MDS and care area assessments.
 - d. Ongoing monitoring of mood and behavior.
 - e. Care plan development and implementation, and
 - f. Evaluation.
3. The resident and family are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as appropriate. The care plan shall:
 - a. Be person-centered,
 - b. Provide for meaningful activities which promote engagement and positive, meaningful relationships.
 - c. Reflect the residents' goals for care,
 - d. Account for the resident's experiences and preferences, and
 - e. Maximizes the resident's dignity, autonomy, privacy, socialization, independence, and safety.

4. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment. Topics of training may include, but are not limited to:
 - a. Implementing non-pharmacological interventions.
 - b. Communication and interpersonal skills that promote mental and psychosocial well-being.
 - c. Promoting residents' independence.
 - d. Respecting residents' rights.
 - e. Caring for the residents' environment and providing an atmosphere that is conducive to mental and psychosocial well-being.
 - f. Mental health and social service needs, and
 - g. Care of cognitively impaired residents.
5. Interventions shall be evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.
6. Behavioral health care and services shall be provided in an environment that promotes emotional and psychosocial well-being, supports each resident's needs and includes individualized approaches to care.
7. Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated.
8. The facility may utilize individualized, non-pharmacological interventions to help meet behavioral health needs. Examples may include, but not limited to:
 - a. Ensuring adequate hydration and nutrition (e.g. enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite).
 - b. Exercise.
 - c. Pain relief.
 - d. Individualized sleep and dining routines.
 - e. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation.
 - f. Adjusting the environment to be more individually preferred or homelike.
 - g. Consistent staffing to optimize familiarity.
 - h. Supporting the resident through meaningful activities that match his/her individual abilities, interests, and needs.
 - i. Utilize techniques such as music, art, massage, aromatherapy, reminiscing.
 - j. Assisting residents with substance use disorders to access counseling program to the fullest degree possible.
9. Behavioral health care plans shall be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.
10. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists.

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F740 – Behavioral Health Services. 42 C.F. R. §483.40

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F741 – Behavioral Health Services. 42 C.F. R. §483.40

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F742 – Behavioral Health Services. 42 C.F. R. §483.40

7-24-2019

Use of Psychotropic Drugs

Policy:

Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical records, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

Policy Explanation and Compliance Guidelines:

1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics.
2. The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological approaches, will be determined by:
 - a. Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment.
 - b. Identification of underlying causes (when possible).
3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regime in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team.
4. The indications for use of any psychotropic drug will be documented in the medical record.
 - a. Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility.
 - b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician.
 - i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed.
 - ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation.
5. Residents and/or representatives shall be education on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. Consents will be obtained for the above psychotropics.
6. Residents who use psychotropic drugs shall receive gradual dose reductions. Unless clinically contraindicated, in an effort to discontinue these drugs.
7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs.
8. PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days).

- a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F758 – Pharmacy Services. 42 C.F.R. §483.45(c)(3) (e)(1)-(5)

Added 12/12/2018

Individualized Care and Services for Residents with Dementia and the Use of Antipsychotic Medication in Residents with Dementia

Highlights	<p>Policy Statement</p> <p>The Idaho State Veterans Home is committed to providing individualized care and services for residents with dementia and to administer antipsychotic medication to residents with dementia judiciously.</p>
Dementia Care Principles	<p>Policy Interpretation and Implementation</p> <p>The home utilizes an interdisciplinary approach that focuses on the needs of the resident as well as the needs of the other residents in the home. To accomplish this the home has in place key principles, including:</p> <p>Person-Centered Care: residents are provided with a supportive environment recognizing individual needs and preferences</p> <p>Quality Staff and Quantity of Staff: staff provide direct care, supervision, and quality to meet the needs of residents based upon their individual plan of care</p> <p>Thorough Evaluation of New or Worsening Behaviors: residents with BPSD are evaluated by the interdisciplinary team and all contributing factors to behaviors are identified, addressed, and treated</p> <p>Individualized Approaches to Care: as described below to reduce behavioral expressions of distress</p> <p>Critical Thinking Related to Antipsychotic Drug Use: a thorough assessment is completed, and medication is only given if clinically indicated and is then monitored in an effort to reduce/discontinue</p> <p>Engagement of our Resident and/or Representative in Decision-Making: the resident and their representative is involved in the discussion of potential approaches to address behavioral symptoms</p>
Individualized Care and Services for Residents with Dementia	<p>All residents are provided individualized care by:</p> <p>Information obtained from a thorough Psychosocial History Assessment</p> <p>Information obtained from the Activity Assessment</p> <p>Interviews with the resident, family, caregivers, and others familiar with the resident preferences</p> <p>Prior/Present psychiatric/psychological/medical information</p> <p>Observation</p> <p>BIMS and PHQ 9 assessments</p> <p>Staff training such as “Hand in Hand,” “Person Centered Care,” “Behavioral Symptoms of Dementia,” “Resident Rights,” Resident Abuse and Misappropriation of Property,” “Bathing Without a Battle,” “Music and Memory,” etc.</p> <p>And any additional information that will assist staff in formulating a personalized plan of care.</p>
Care Process	<p>The home follows a systematic care process for a resident with dementia to provide the highest quality of care possible. The approach includes the aforementioned dementia care principles along with:</p>

Interdisciplinary Care Planning	<p>Recognition and Assessment: comprehensive psychosocial and medical information about the resident</p> <p>Cause identification and diagnosis: utilization of knowledge gained about the resident to identify causes of behavior and related symptoms</p> <p>Development of a comprehensive care plan: developing a well-defined problem with measurable objectives and individualized interventions</p> <p>Individualized approaches and treatment: implementation of the care plan interventions to address the needs of the resident through staff training and an interdisciplinary approach</p> <p>Monitoring, follow-up and oversight: the resident's progress toward defined goals and interventions are reviewed, monitored, and modified as needed</p> <p>Quality assessment and assurance tools: QAA tools are utilized, updated to meet current standards of care, and reflective of the delivery of care and services for all residents</p>
	<p>The home adjusts interventions as needed by modifying the care plan and obtaining input from team members and the resident and representative as able. This collaborative approach involves nursing, pharmacy, the physician, VA Medical Center Behavioral Health Services, activity staff, food services, and administration in any concerns related to the effectiveness or adverse consequences of the resident's treatment program.</p>
	<p>The home is furthermore committed to the effective and appropriate use of psychopharmacological medications. By following the key principles and gathering information for individualized person centered care, such medications are used judiciously and only as necessary for the health and well-being of the individual, the safety of the individual and of others, and for quality of life enhancement. Additionally, medical, physical, functional, psychological, emotional, psychiatric, social or environmental causes for behaviors are addressed prior to initiating a discussion of psychopharmacological medication intervention. While some of these issues may be the impetus for certain expressions of behavior and can be addressed, it is recognized that some individuals benefit from medication intervention.</p>
Antipsychotic Medication Use in Residents with Dementia	<p>The home monitors antipsychotic medications and all medications prescribed for mood and behavior by:</p> <p>Evaluation of any resident who does not require PASRR screening and is admitted on an antipsychotic medication</p> <p>Following Psychotropic Medication Justification Tracking and Charting guidelines</p> <p>Mood/Behavior Medication Committee Meetings held quarterly</p> <p>Pharmacy review</p> <p>VA Medical Center Behavioral Health Services consultation</p> <p>Monitoring side effects on the Medication Administration Record</p> <p>Abnormal Movement Scale Assessment</p> <p>Following PRN Guideline Use</p>
Monitoring Psychopharmacological Interventions	

Alerting Parties of Antipsychotic Side Effects

Mood/Behavior Documentation and Review

Interviews with the resident, family, caregivers, and others familiar with the resident

As addressed, all residents/families/representatives are involved in discussions about potential approaches to address behaviors. If antipsychotic medication is warranted, education about the potential risks and benefits of the medication will be addressed, the proposed course of treatment, expected duration of use of the medication, use of individualized approaches, plans to evaluate the effects of the treatment, and pertinent alternatives. A signed consent including this information and the FDA black box warnings will be obtained and located in the resident record indicating that a discussion of this involvement has occurred.

References	
OBRA Regulatory Reference Numbers	483.25
Survey Tag Numbers	F309; F329; F154; F155; F242; F279; F280
Related Documents	Psychotropic Medication Justification Tracking & Charting; Informed Consent for Atypical Antipsychotic Drug Use in Dementia Residents and Antipsychotic Use for Approved Diagnoses

Psychotropic Medication Justification Tracking & Charting

Idaho State Veterans Home Social Work Department follows the guidelines as described in F329 for Unnecessary Medications-Medication Regimen Review

The following diagnosis is necessary for antipsychotic medication use as meets the definition in the DSM IVR

Schizophrenia	Schizo-affective
Delusional disorder	Psychotic disorder
Mood disorders	Schizophreniform disorder
Psychosis NOS	Atypical psychosis
Acute/Brief Psychosis	Dementing illnesses with associated behavioral symptoms
Medical illnesses or delirium with manic or psychotic symptoms and or treatment related psychosis or mania.	

The above diagnoses must also meet at least one of the following criteria:

- The symptoms are identified as being due to mania or psychotic (auditory, visual, or other hallucinations); delusions (such as paranoia or grandiosity).
- The behavioral symptoms present a danger to the resident or to others.
- The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (fear, continuously yelling, screaming, distress associated with end of life, crying), significant decline in function, difficulty receiving needed care (e.g. not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).

Diagnoses for anxiolytic medication justification

Generalized anxiety disorder Panic disorder

Sleep disorders Situational anxiety (significant anxiety in response to a situational trigger)

Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder

Delirium, dementia, and other cognitive disorders with associated behaviors that are documented, persistent, are not due to preventable or correctable reasons, constitute clinically significant distress or dysfunction to the resident or represent a danger to the resident or others.

Used for neuromuscular syndromes

Used for end of life situations

Factors to r/o for antipsychotic, hypnotics, anti-anxiety medication:

Environment-heat, cold, noise, lighting

Facility routines not accommodating resident's individual routines and preferences

Depression, dementia, anxiety

Inadequate physical activity

Diet-caffeine, non-compliance with prescribed diet, etc.

Abuse issues not addressed

Infection

Non-pharmacologic interventions utilized and r/o for antipsychotic, hypnotics, anti-anxiety medication written under care plan for Mood/Behavior

Outcome of interventions: Care tracker documentation and progress notes summarized with # of incidents, time of day, situation, etc.

Benefit of psychotropic medication to resident psychosocially: increased participation in life of facility, increased acceptance of care beneficial to resident's health and well-being, increased socialization, decline in paranoia, absence of hallucinations, decreased anxiety, etc.

Potential detriment to resident psychosocially: medication s/e profile, interactions with other medications,

Risk versus benefit: resident agitation results in a decreased quality of life, anxiety increases his isolation and participation in cares, resident demonstrating or expressing paranoia, etc.)

Resident/Family: obtain the residents and/or the family input toward care planning, approaches, results of the medications used. Their perception of positive/negative outcome of the medication.

Two or more antidepressants utilized: if for the same diagnosis, justify by discussing the expected benefits that outweigh the associated risks.

*All medications utilized for the aforementioned reasons, psychotropic or otherwise, are reviewed by the Psychotropic Drug Review Committee (Medical Director, Attending Physician, Pharmacist, Nurse Manager, Social Worker) at least quarterly with the exception of anti-depressants which are reviewed at least yearly. Documentation is located in the Social Work section of the resident chart.

Informed Consent for Psychotropic Medication Non-Antipsychotic

It is the facility policy to involve our residents and their families/significant others in the decision to use psychotropic medication. The interdisciplinary team has met and based upon a comprehensive assessment it has been determined that _____ will benefit from the use of _____. Prior to making this recommendation, the following modes of treatment, where applicable, were attempted without success:

- Environment and/or staff changes
- Medical review to rule out medication interaction, infection, bowel/bladder problems, pain, etc.
- Positive redirection and staff interaction
- Individual therapy
- 1:1 staffing
- Behavior intervention techniques
- Interventions not applicable due to Dementia with related psychosis

Residents are closely monitored, and trial reductions are implemented on a regular basis to ensure that the minimal amount of medication is administered to achieve the clinical benefits necessary. There are potential benefits and potential risks for treatment associated with psychotropic medications that include the following:

Potential Benefits:

- Prevention of injury to self or others
- Increased acceptance of medical treatment plan
- Increased involvement and socialization
- Decreased agitation, anxiety, and greater sense of well-being

Potential Risks:

- Loss of balance resulting in injury from falls
- Increased need for assistance with ADL's and treatments
- Decrease in cognitive skills
- Side effects common: sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain/loss, edema, sweating, loss of appetite, urinary retention/incontinence

I have read and weighed the above benefits and risks and evaluation the need for treatment as described. I agree to the use of the prescribed treatment. My consent permits the does to be changed without signing another consent. I understand that I will be notified verbally of a change in the existing order.

Signature of Resident/Representative, Date

Signature of Health Care Professional, Date

Specific Order:

Informed consent for Antipsychotic drug use in Dementia Residents and Antipsychotic Use for Approved Diagnoses

Resident Full Name: _____ Date: _____

Resident Date of Birth: _____

Dear Resident (or Resident's Legal Medical Decision Maker acting on behalf of resident),

Your physician or primary care provider has prescribed a type of medication for you which I sin the class of medications called antipsychotic medication. These drugs are approved by the FDA for several chronic psychiatric conditions, including schizophrenia, manic depression/bipolar disorder, Tourette's Syndrome, and Huntington's disease. You may be prescribed an antipsychotic for one of these diagnoses.

Physicians and other licensed care providers sometimes also prescribe antipsychotics for behavioral and psychiatric symptoms related to dementia, even though the FDA has not approved their use for these reasons. This is called "off-label prescribing," which is something Physicians and other licensed primary care providers are allowed to do, and which they do very commonly with all kinds of different medication. However, for those residents prescribed antipsychotics for the treatment of behavioral and psychiatric symptoms related to dementia, there is certain information that you should be aware of so that you can decide whether to give your consent to treatment with antipsychotic medication.

Alzheimer's dementia and vascular dementia (from hypertension/strokes), and dementia associated with Parkinson's disease are the three most common dementias within the nursing home setting. Dementia is a loss of cognition characterized by memory deficits; comprehension deficits; and unsettling emotional and psychological behaviors. At times, the person with dementia may be agitated (screaming out, crying or laughing for no apparent reason), or combative (striking out) with necessary daily care (bathing, dressing, toileting, incontinent care, eating). Behaviors observed may include pushing away a caregiver while they are assisting the resident with feeding or showing irritation toward a fellow resident who is in close proximity.

Facility staff are trained to address agitation and combative behaviors with non-drug interventions whenever possible, and every effort is made to avoid using antipsychotic medication to treat agitation and combativeness. Staff are trained to look for any possible treatable causes, among which could be: Physical conditions or needs (pain, infections, illness, dehydration, constipation, medication side effects); psychological conditions or needs (loneliness, boredom, anxiety, worry, fear, emotional state, depression, delirium, psychosis, and mental illness); and environmental causes (noise, lighting, odors, caregivers actions/appearance/approach). In addition to evaluation by their primary physician, residents may also be evaluated by a psychiatrist or other appropriate specialist. The goal of the facility staff is always to resolve behaviors which cause the resident distress, or which impair the resident's ability to function at their highest practical level of well-being.

If facility staff are unable to resolve the above behaviors with non-medication approaches (such as behavior modification, supportive therapy, 1:1, validation, music therapy, re-directing activities, aroma therapy, pet therapy, and other resident preferred activity), antipsychotic medications may be indicated. Examples of these medications are aripiprazole (Abilify), risperidone (Risperdal), quetiapine (Seroquel), or olanzapine (Zyprexa). These medications, if warranted, would always be started at the lowest possible dose and be monitored daily for adverse side effects. The

justifications for these medications are that the resident presents with one or more of the following issues:

- The resident's behavior presents a danger to self or others
- The resident is inconsolable or suffering in persistent distress
- The resident's behavior causes a significant decline in function

Antipsychotic medications can have adverse effects in some residents. Research has indicated a slight increase in the number of heart attacks, strokes and deaths when these medications are used in the setting of dementia. The FDA has recommended these drugs not be used in the elderly dementia patient and the Centers for Medicare & Medicaid Services (CMS) is working to decrease the use of these drugs in nursing homes. CMS has launched an initiative aimed at improving behavioral health and safeguarding residents in nursing homes from unnecessary antipsychotic medications. Our facility's medical director and attending physicians support these initiatives and are committed to using antipsychotic medications only as a last resort in residents with dementia. Here is the FDA's warning:

FDA BLACK BOX WARNING FOR ANTIPSYCHOTIC MEDICATIONS
WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (median duration of 10 weeks) largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5% compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infections (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristics(s) of the patient is not clear.

Your primary doctor or license care provide, and this facility's medical director have reviewed your medical condition. At the present time, your primary doctor or licensed care provider believes that the benefits of using antipsychotic medication outweigh the know potential risks. They will, or have already, attempted a gradual dose reduction with the goal of discontinuing antipsychotic medication when it is no longer providing a clear benefit which outweighs the potential risks. We ask you to complete the consent form attached indicating your preference regarding antipsychotic medication use.

Any resident who remains on antipsychotic medications will be periodically evaluated by the treatment team. The team's goal during these periodic evaluations will be to reduce the dose of antipsychotic medications as much as possible, and to discontinue them when the clear benefit of the drug no longer outweighs potential risks and to monitor for adverse side effects of these medications until it is possible to discontinue them.

Thank you,

Quarterly Psychotropic Medication Review

Resident: _____ Date: _____

A. Review Committee information:

1. Date of meeting: _____
2. Committee members present:
 - i. Physician: Yes _____ No _____
 - ii. Social Worker: Yes _____ No _____
 - iii. Pharmacist: Yes _____ No _____
 - iv. Nurse Manager: Yes _____ No _____
 - v. Other:
 1. If other, please list:
 - a. _____
 - b. _____
 - c. _____

B. Current Psychotropic Medication(s)

1. Psychotropic #1 (dose and frequency)

- i. Drug Class
- ii. Diagnosis
- iii. Target symptoms for this medication
- iv. Date of initiation of medication
- v. If medication dosage has changed: when, increase/decrease and reasons for change (inadequately controlled symptoms, side effects, attempted DGR, other)
- vi. Frequency of targeted symptoms over past 30 days (POC Task Review)
- vii. Trend in targeted signs and symptoms from PCC/POC and observations/interviews.
 1. Increase: _____
 2. Decrease: _____
 3. Stable: _____
- viii. GDR Contraindicated
 1. Yes: _____
 2. No: _____
- ix. Reasons for contraindication of GDR
 1. Due to proven effectiveness
 2. Due to risk of decompensation
 3. Due to severity of prior symptoms
 4. Due to other psychotropic medications being changed at this time
- x. Committee recommendations for this medication:
- xi. Is consent in place?
 1. Yes: _____
 2. No: _____
- xii. If antipsychotic medication, date of AIMS assessment?

- xiii. Care plan in place for psychotropic #1?
 - 1. Yes: _____
 - 2. No: _____

2. Psychotropic #2 (dose and frequency)

- i. Drug Class
- ii. Diagnosis
- iii. Target symptoms for this medication
- iv. Date of initiation of medication
- v. If medication dosage has changed: when, increase/decrease and reasons for change (inadequately controlled symptoms, side effects, attempted DGR, other)
- vi. Frequency of targeted symptoms over past 30 days (POC Task Review)
- vii. Trend in targeted signs and symptoms from PCC/POC and observations/interviews.
 - 1. Increase: _____
 - 2. Decrease: _____
 - 3. Stable: _____
- viii. GDR Contraindicated
 - 1. Yes: _____
 - 2. No: _____
- ix. Reasons for contraindication of GDR
 - 1. Due to proven effectiveness
 - 2. Due to risk of decompensation
 - 3. Due to severity of prior symptoms
 - 4. Due to other psychotropic medications being changed at this time
- x. Committee recommendations for this medication:
- xi. Is consent in place?
 - 1. Yes: _____
 - 2. No: _____
- xii. If antipsychotic medication, date of AIMS assessment?
- xiii. Care plan in place for psychotropic #1?
 - 1. Yes: _____
 - 2. No: _____

3. Psychotropic #3 (dose and frequency)

- i. Drug Class
- ii. Diagnosis
- iii. Target symptoms for this medication
- iv. Date of initiation of medication
- v. If medication dosage has changed: when, increase/decrease and reasons for change (inadequately controlled symptoms, side effects, attempted DGR, other)
- vi. Frequency of targeted symptoms over past 30 days (POC Task Review)

- vii. Trend in targeted signs and symptoms from PCC/POC and observations/interviews.
 - 1. Increase: _____
 - 2. Decrease: _____
 - 3. Stable: _____
- viii. GDR Contraindicated
 - 1. Yes: _____
 - 2. No: _____
- ix. Reasons for contraindication of GDR
 - 1. Due to proven effectiveness
 - 2. Due to risk of decompensation
 - 3. Due to severity of prior symptoms
 - 4. Due to other psychotropic medications being changed at this time
- x. Committee recommendations for this medication:
- xi. Is consent in place?
 - 1. Yes: _____
 - 2. No: _____
- xii. If antipsychotic medication, date of AIMS assessment?
- xiii. Care plan in place for psychotropic #1?
 - 1. Yes: _____
 - 2. No: _____

4. Psychotropic #4 (dose and frequency)

- i. Drug Class
- ii. Diagnosis
- iii. Target symptoms for this medication
- iv. Date of initiation of medication
- v. If medication dosage has changed: when, increase/decrease and reasons for change (inadequately controlled symptoms, side effects, attempted DGR, other)
- vi. Frequency of targeted symptoms over past 30 days (POC Task Review)
- vii. Trend in targeted signs and symptoms from PCC/POC and observations/interviews.
 - 1. Increase: _____
 - 2. Decrease: _____
 - 3. Stable: _____
- viii. GDR Contraindicated
 - 1. Yes: _____
 - 2. No: _____
- ix. Reasons for contraindication of GDR
 - 1. Due to proven effectiveness
 - 2. Due to risk of decompensation
 - 3. Due to severity of prior symptoms
 - 4. Due to other psychotropic medications being changed at this time

- x. Committee recommendations for this medication:
- xi. Is consent in place?
 - 1. Yes: _____
 - 2. No: _____
- xii. If antipsychotic medication, date of AIMS assessment?
- xiii. Care plan in place for psychotropic #1?
 - 1. Yes: _____
 - 2. No: _____

5. Psychotropic #5 (dose and frequency)

- i. Drug Class
- ii. Diagnosis
- iii. Target symptoms for this medication
- iv. Date of initiation of medication
- v. If medication dosage has changed: when, increase/decrease and reasons for change (inadequately controlled symptoms, side effects, attempted DGR, other)
- vi. Frequency of targeted symptoms over past 30 days (POC Task Review)
- vii. Trend in targeted signs and symptoms from PCC/POC and observations/interviews.
 - 1. Increase: _____
 - 2. Decrease: _____
 - 3. Stable: _____
- viii. GDR Contraindicated
 - 1. Yes: _____
 - 2. No: _____
- ix. Reasons for contraindication of GDR
 - 1. Due to proven effectiveness
 - 2. Due to risk of decompensation
 - 3. Due to severity of prior symptoms
 - 4. Due to other psychotropic medications being changed at this time
- x. Committee recommendations for this medication:
- xi. Is consent in place?
 - 1. Yes: _____
 - 2. No: _____
- xii. If antipsychotic medication, date of AIMS assessment?
- xiii. Care plan in place for psychotropic #1?
 - 1. Yes: _____
 - 2. No: _____

C. Additional recommendations:

Risk versus Benefit of the use of Certain Medications for Dementia Residents and their Agents

I have been given a copy of the letter addressing the benefit and risk to

_____.

Specific Order:

Signature of Resident/Representative

Date

Signature of Health Care Professional

Date

Date	Change(s) in existing order	Resident/Family Notified (Y/N)	Staff Initial

Resident Name: _____

Quality of Life: Accommodation of Needs

Policy Statement

The Idaho State Veterans Home's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being.

Policy Interpretation and Implementation

1. The resident's individual needs, and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.
2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.
3. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations may include:
 - a. Providing access to assistive devices, such as grab bars in the bathroom.
 - b. Installing mirrors at a height at which a wheelchair-bound resident can see.
 - c. Labeling toiletry items with large print so a visually impaired resident can distinguish one from another.
 - d. Installing adaptive handles or providing assistive devices so that drawers are easily opened and closed.
 - e. Installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible.
 - f. Moving furniture or large items in rooms and common areas that may obstruct the path of a resident using a walker.
 - g. Providing a variety of types (for example, chairs with and without arms), sizes (height and depth), and firmness of furniture in rooms and common areas so that residents with varying degrees of strength and mobility can independently arise to a standing position; and/or
 - h. Arranging furniture as the resident requests, providing the arrangement is safe, his or her roommate agrees, and space allows.
4. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes.
 - i. Staff shall interact with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains dignity. (For example, staff shall

face the resident and speak to him or her at eye level if the resident is hearing impaired and can read lips.)

- j. Staff shall arrange toiletries and personal items so that they are in easy reach of the resident.
- k. Staff shall help to keep hearing aids, glasses and other adaptive devices clean and in working order for the resident.

References	
483.15; 483.15(e)	
F240; F246	

Quality of Life: Dignity

Highlights	Policy Statement
	<p>Each resident of the Idaho State Veterans Home shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.</p> <p>Policy Interpretation and Implementation</p>
Dignity and Respect	1. Residents shall be treated with dignity and respect at all times.
“Treated with Dignity”	2. “Treated with dignity” means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.
Grooming Preferences	3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).
Clothing Preferences	4. Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns.
Choice of Activities	5. Residents shall be assisted in attending the activities of their choice, including activities outside the facility.
Respect of Private Space and Property	6. Residents’ private space and property shall be respected at all times. <ul style="list-style-type: none"> a. Staff will knock and request permission before entering residents’ rooms. b. Staff will not handle or move a resident’s personal belongings (including radios and televisions) without the resident’s permission.
Respectfully Addressing the Resident	7. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not “labeling” or referring to the resident by his or her room number, diagnosis, or care needs.
Keeping Resident Informed and Oriented to Environment	8. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed, and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings.
Confidentiality of Clinical Information	9. Staff shall maintain an environment in which confidential clinical information is protected, for example: <ul style="list-style-type: none"> a. Verbal staff-to-staff communication (e.g., change of shift reports) shall be conducted outside the hearing range of residents and the public. b. Signs indicating the resident’s clinical status or care needs shall not be openly posted in the resident’s room unless specifically requested by the resident or family member. Discreet posting of important

Bodily Privacy During Care and Treatment	<p>clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door).</p> <ul style="list-style-type: none"> c. In the interest of public health, posting the resident’s isolation status or Transmission-Based Precautions is permissible as long as the type of infection remains confidential. d. The display of the resident’s name on the door or the presence of memorabilia among the resident’s belongings is not considered a violation of the resident’s privacy or dignity.
Promotion of Resident Dignity	<p>10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>11. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by:</p> <ul style="list-style-type: none"> e. Helping the resident to keep urinary catheter bags covered. f. Promptly responding to the resident’s request for toileting assistance; and g. Allowing residents unrestricted access to common areas open to the public unless this poses a safety risk for the resident.
Treatment of Cognitively Impaired Residents	<p>12. Staff shall treat cognitively impaired residents with dignity and sensitivity, for example:</p> <ul style="list-style-type: none"> h. Addressing the underlying motives or root causes for behavior; and i. Not challenging or contradicting the resident’s beliefs or statements.

References	
OBRA Regulatory Reference Numbers	483.15; 483.15(a); 483.15(b)
Survey Tag Numbers	F240; F241; F242
Related Documents	

Quality of Life: Self Determination and Participation

Highlights	Policy Statement
	<p>The Idaho State Veterans Home respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life.</p>
	<p>Policy Interpretation and Implementation</p>
Freedom of Choice in Activities/Schedules/Health Care	<ol style="list-style-type: none"> 1. Each resident shall be allowed to choose activities, schedules and health care that are consistent with his or her interests, assessments and plans of care, including: <ol style="list-style-type: none"> a. Sleeping, eating, exercise and bathing schedules. b. Personal care needs, such as bathing methods, grooming styles and dress; and c. Health care scheduling, such as times of day for therapies and certain treatments.
Facilitation of Resident Choices	<ol style="list-style-type: none"> 2. In order to facilitate resident choices, staff shall: <ol style="list-style-type: none"> d. Inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation in preferred activities. e. Gather information about the resident's personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; and f. Include information gathered about the resident's preferences in the care planning process.
Encouragement to Make Choices	<ol style="list-style-type: none"> 3. The resident shall be encouraged to make choices about aspects of his or her life in the facility, including: <ol style="list-style-type: none"> g. Rooming with the person of his or her choice, providing both individuals consent to the choice; and h. Whether or not to smoke. (Note: The facility may determine designated smoking areas, but the resident must be able to access these areas freely.)
Provision of Assistance	<ol style="list-style-type: none"> 4. Residents shall be provided assistance as needed to engage in their preferred activities on a routine basis. For example: <ol style="list-style-type: none"> i. If the resident enjoys reading, the facility shall provide access to books (in large print if needed); and
Community Interaction	

- j. If the resident enjoys regular exercise, he or she will be assisted in attending exercise classes or given access to open areas for walks.
5. Residents shall be encouraged to interact with members of the community, both inside and outside the facility.

References	
OBRA Regulatory Reference Numbers	483.15; 483.15(b)
Survey Tag Numbers	F240; F242
Related Documents	

Quality of Life: Communication Services, Title VI

Highlights	Policy Statement
Title VI of the Civil Rights Act	<p>The Idaho State Veterans Home will act in accordance with the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. All residents are informed orally and in writing in a language and/ or in a form of communication that the resident understands of their rights and responsibilities prior to admission, during their stay in the facility, when a facility policy affecting a resident is amended, and of all rules, regulations, and benefits from federally-assisted programs and activities.</p>
Identification of Need	<p>Policy Interpretation and Implementation</p> <p>Prospective residents will be identified upon interview and application to the Idaho State Veterans Home whether interpreters or other assistive services are needed. For Spanish speaking LEP individuals, a Spanish translation of the Idaho State Veterans Home’s resident rights and responsibilities, including the right to make medication treatment decisions, and admission, discharge, and transfer rights, are provided to individuals and/or their representatives. In the case of less commonly encountered foreign languages, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to his/her acknowledgement of receipt. Should additional assistance be required for translation/interpretation, ISVH will utilize the services of Multi-Care Staffing and Home Health, Inc., Meridian, Idaho. ISVH may also utilize Language Line Services Interpretation Service @ 1-800-752-6096 on a “pay as you go” basis.</p>
Hearing Impaired Residents	<p>For hearing impaired residents who communicate by signing and for LEP persons, with or without a representative, the ISVH will provide an interpreter from Multi-Care Staffing and Home Health, Inc., Meridian Idaho for visually impaired residents, large print text is available. Additionally, Idaho State Veterans Home utilizes telephone handset amplifiers, telephones compatible with hearing aids, assistive listening devices, and access to TTY (text telephone) numbers, communication boards, and occupational/physical therapy services.</p>
Posting Information	<p>The Idaho State Veterans Home will prominently display information about how assistive services, interpreters, and the services that are accessible to persons with disabilities may be obtained and utilized.</p>

Quality of Life: Experimental Research

Highlights	Policy Statement
	Residents at the Idaho State Veterans Home have the right to refuse participation in experimental research.
	Policy Interpretation and Implementation
Refusal to Participate	1. Residents may refuse to participate in any experimental research. (Note: Collective resident statistics that do not identify individual residents may be used for studies without obtaining residents' permission.)
Definition of Experimental Research	2. "Experimental Research" is defined as development and testing of clinical treatments, such as an investigational drug or therapy that involve treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research.
Informing Residents of Experimental Research Project	3. Any resident being considered for participation in experimental research must be fully informed, by the service performing the research, of the nature of the research (i.e. medication, treatment, etc.) and the resident must fully understand the possible consequences of the experiment. When the resident lacks decision making capacity, an appropriate substitute decision maker may exercise the resident's right to participate or to refuse, based on careful consideration of the resident's best interests.
Adverse Consequences	4. The facility staff any physician will monitor for, and identify, situations where the resident may be suffering adverse consequences from participating in experimental research and will advise the Administrator and the resident and/or family.
Modifying/Stopping Research Activity	5. The Administrator, Director of Nursing, and Medical Director/Attending Physician maintain the right to recommend that any research activity be modified or stopped if they have valid clinical reason to believe that participants in a study may be adversely affected.
Written Consent	6. A copy of a signed consent form will be filed in the resident's medical record prior to participation in an experimental research project.
Inquiries	7. Inquiries concerning experimental research activities should be referred to the Administrator, the Director of Nursing Services, or to the Medical Director, as appropriate.
References	
OBRA Regulatory Reference Numbers	483.10(b)(4)
Survey Tag Numbers	F155

Quality of Life: Mail

Highlights	<p>Policy Statement</p> <p>Residents at the Idaho State Veterans Home are allowed to communicate privately with individuals of their choice and may send and receive their personal mail unopened unless otherwise advised by the Attending Physician and documented in the residents' medical records.</p> <p>Policy Interpretation and Implementation</p>
Receiving Mail Unopened	1. Mail will be delivered to the resident unopened unless otherwise indicated by the Attending Physician and documented in the resident's medical record.
Opening Mail for Resident	2. Staff members of this facility will not open mail for the resident unless the resident requests them to do so. Such request will be documented in the chart (i.e., on the resident's plan of care).
Giving Mail to Family	3. The facility will not give mail to members of the resident's family unless the resident (or the representative/sponsor) authorizes the facility to do so.
Mail Delivery and Pick-Up	4. Mail will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries). The resident's out-going mail will be picked up by USPS postal carriers and/or delivered to the postal service within twenty-four (24) hours of deposit of such mail with the facility, except when there is no regularly scheduled postal delivery and pick-up service.
Obtaining Supplies	5. Activities and/or Social Services Personnel will help residents obtain stationery, postage, and writing implements. (Note: The cost of such supplies may be charged to the resident.)

References	
OBRA Regulatory Reference Numbers	483.10(i)(1) & (2)
Survey Tag Numbers	F170; F171
Related Documents	

Quality of Life: Personal Property

Highlights	<p>Policy Statement</p> <p>Residents of the Idaho State Veterans Home are permitted to retain and use personal possessions and appropriate clothing, as space permits.</p> <p>Policy Interpretation and Implementation</p>
Closet Space	6. Each resident’s room is equipped with private closet space that includes clothes racks and shelving and that permits easy access to the resident’s clothing. Each room also comes equipped with an LCD wall mounted television.
Home-Like Environment	7. The resident is encouraged to maintain his/her room in a home-like environment by bringing personal items (i.e., photographs, knickknacks, etc.) to place on nightstands, shelving units, etc.
Room Furnishing Guidelines	8. The resident is permitted to bring room furnishings if: <ul style="list-style-type: none"> k. The room is large enough to accommodate the furniture. l. The furniture does not infringe upon the rights of others; and m. The furniture does not violate current life safety code requirements.
Notification of Guidelines	9. A representative of the admitting office will advise the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room.
Inventory of Resident’s Personal Belongings	10. The resident’s personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. If discharge or death occurs, the inventory will be reviewed and signed by the appropriate parties removing the belongings and the inventory will remain in the residents closed chart. The Social Worker will investigate any discrepancies brought forth as indicated in “Grievance Procedures.”
Misappropriation of Resident’s Personal Property	11. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

References	
OBRA Regulatory Reference Numbers	483.10(l); 483.13(c); 483.13(c)(1)(ii)(A) &(B); 483.13(c)(2)-(4); 483.15(e)(1); 483.15(h)(1) & (4); 483.70(d)(2)(iv)
Survey Tag Numbers	F224; F225; F226; F246; F252; F461
Related Documents	

Quality of Life: Resident Right to Share a Room

Policy:

It is the policy of this facility to support and facilitate a resident's right to share a room with the roommate of choice when practicable and to the extent possible.

Policy Explanation and Compliance Guidelines:

1. The facility will permit a resident to share a room with his or her spouse, when married residents live in the same facility and both spouses consent to the arrangement.
2. The facility will permit a resident to share a room with another resident when practicable, if both residents live in the same facility and consent to the arrangement.
3. If and when a resident expresses a desire to share a room with another resident, the Social Service Designee, or another designated staff member, will ensure both residents are in agreement regarding the desire to share a room.
4. If and when a resident expresses a desire to share a room with another resident, and both residents consent to the arrangement, the facility will provide a shared room as quickly as possible.
5. The facility will take into account payment sources, certified beds, and distinct certified parts of the facility when seeking to provide a shared room for residents who desire to share a room.
6. The facility will not compel another resident to relocate to accommodate a resident sharing a room with his/her spouse or another resident.
7. The facility will provide a resident receiving a new roommate as much advance notice as possible.

Added 05/2020

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) **F559** – Choose/Be Notified of Room/Roommate Change. 42 C.F.R. §483.10(e).

Quality of Life: Change of Room or Roommate

Policy:

It is the policy of this facility to conduct room changes or roommate assignments when considered to be necessary by the facility and/or when requested by the resident or resident representative.

Policy Explanation and Compliance Guidelines:

1. The facility reserves the right to make resident room changes or roommate assignments when found to be necessary by the facility or when requested by the resident.
2. Reasons for a change in room or roommate could include, but are not limited to:
 - a. Incompatibility of residents in a shared room;
 - b. Medical conditions which prohibit certain room sharing (e.g., infection control for isolation);
 - c. Provision of a more accommodating environment to help the resident reach his/her rehab goals; or a request by the resident.
 - d. If a temporary transfer is needed to make repairs or renovations. The resident has a right to return as soon as the repairs or renovations are completed.
 - e. If the resident no longer needs specialized rehab or medical equipment that cannot be moved from the resident's room, or another resident needs access to that equipment.
3. Requests for changes in room or roommate should be communicated to the Social Service Designee.
4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible.
5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required.
6. The social service staff can assist the resident to adjust to the new room or roommate by:
 - a. Informing the resident and family as soon as possible of the room or roommate change.
 - b. Involving the resident in the decision and selection of a room or roommate when possible.
 - c. Allowing the resident to ask questions about the move.
 - d. Showing the resident where the room is located.
 - e. Introducing the resident to his/her new roommate and sharing information about the new roommate while maintaining confidentiality regarding medical information in order to help the resident become acquainted.
 - f. Introducing the resident to the employees who will be providing care.
 - g. Explaining to the resident why the change is necessary; reassuring the resident his/her personal possessions will be safeguarded.
7. The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate.

8. A resident has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate a resident from the Medicare section of the facility to a non-Medicare section of the facility solely for financial or change in payer status reasons.
9. The facility may make an emergency change in room or roommate assignment should it become necessary for the safety, health and well-being of the resident.

Added 05/2020

References:

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F559 – Resident Rights. 42 C.F.R. §483.10.

Quality of Life: Telephones, Resident Use of

Highlights	<p>Policy Statement</p> <p>Residents at the Idaho State Veterans Home shall have easy access to telephones.</p> <p>Policy Interpretation and Implementation</p>
Availability of Telephones	<ol style="list-style-type: none"> 1. Designated telephones are available to residents to make and receive private telephone calls. The telephones at the nursing stations should ordinarily be reserved for staff use unless no other alternative is available. Residents should use telephones at the nursing stations for as brief a period as possible.
Private Telephone Area	<ol style="list-style-type: none"> 2. Telephones will be in areas that offer privacy and accommodate the hearing impaired and wheelchair bound residents.
Telephone Messages	<ol style="list-style-type: none"> 3. The resident will be given telephone messages when he or she is unable to take incoming calls.
Telephone Assistance	<ol style="list-style-type: none"> 4. Residents who need and/or request help in getting to or using telephones will be provided with such assistance.
Location of Resident Telephones	<p>Resident wireless telephones are located on each floor.</p>
Private Telephone Lines	<p>A private telephone line may be available or installed in the resident's room. All expenses relating to the installation, billing, etc. will be billed to the resident or representative (sponsor). The facility will not be responsible for paying for private telephone lines. Residents are responsible for all long-distance and local toll charges.</p>
Inquiries Concerning Room Telephones	<ol style="list-style-type: none"> 5. Inquiries concerning the installation of room telephones should be referred to the Social Services Department. The local telephone company will not accept orders or make changes to service from other than the responsible party receiving the billing statement.
References	
OBRA Regulatory Reference Numbers	483.10(c)(8)(ii)(A); 483.10(k)
Survey Tag Numbers	F162; F174

Quality of Life: Telephone Accessibility

Highlights	<p>Policy Statement</p> <p>The Idaho State Veterans Home has telephones accessible to residents, visitors and employees.</p> <p>Policy Interpretation and Implementation</p>
Public Telephones	1. Public telephones are located near the main lobby or area designated by the facility for employee, resident, and visitor use.
Resident Room Telephone Installation	2. Residents may have telephones installed in their rooms or may use cellular phones. The resident or his/her responsible party must pay for such service, including monthly fees and line service.
Facility Telephone Usage	3. Facility phone lines are used for the purpose of conducting day-to-day business and may not be used for private calls.
Telephones for the Hearing Impaired	4. Designated resident phones are located on each unit and are equipped with volume levels for the hearing impaired. Residents may make calls and receive calls on these phones.
Long Distance Calls	5. Only personnel authorized by the Administrator may make long-distance telephone calls. In some situations, a resident may need to make a long-distance call. The Social Worker assigned to the resident will assist with long distance calls and other calls as needed.

References	
OBRA Regulatory Reference Numbers	483.10(c)(8)(ii)(A); 483.10(k)
Survey Tag Numbers	F162; F174
Related Documents	

Quality of Life: Pets, Animals, and Plants

Highlights

Policy Statement

The Idaho State Veterans Home has resident cats that provide companionship and therapy to our secure care unit and nursing care unit residents on a permanent basis. Only domesticated household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted to reside in the Idaho State Veterans Home per the approval of the Home Administrator.

Although residents are not allowed to have personal pets living in the facility, relatives and friends of residents are encouraged to bring a pet in to visit residents through the Idaho State Veterans Home pet visitation program.

Through this program, current pet vaccination records must be provided to the facility Activities Department prior to visitation, and all animals must be kept on a leash and under the control of the trainer at all times.

Pets and other animals participating in facility-sponsored activities/therapy/recreation programs shall be restricted in order to prevent the spread of microorganisms/infections resulting from contact with animals.

Policy Interpretation and Implementation

Approval of Animal Visitation

6. The Administrator has the authority to allow or prohibit animal visitation in the facility.

Health of Animals

7. Animals participating in animal visitation programs must be in good health and have proof of vaccination for animal-borne diseases and negative tests for enteric parasites.

Minimal Contact

8. All personnel and residents will minimize contact with animal saliva, dander, urine and feces.

Hand Hygiene

9. Employees will practice hand hygiene after contact with animals.

Non-human Primates/Reptiles

10. Non-human primates and reptiles will not be used in animal-assisted activities/therapies or resident programs.

Safety Issues/Known Allergies

11. Nursing staff will record any safety issues and known allergies on resident care plans relative to animal visitation programs.

Resident Pets

12. Visits by pets owned by residents or family members of residents will be considered individually and must be strictly supervised at all times by a member of the Recreational/Activity Department staff, volunteers or Nursing Service department.

Contact with Residents

Seeing Eye Dogs

13. Animals may not come into contact with any resident who does not give verbal permission for such contact.

Accompanying Animals

Food/Treatment Areas

Contact with Equipment

Plants/Flowers

Hand Hygiene

14. Visits by a person(s) using a seeing-eye dog will be permitted. The animal's movement must be limited and strictly supervised by the owner or handler.
15. Visiting animals must be attended while on the premises. A staff member, volunteer, or other designated individual must accompany animals at all times. Large animals must be on a leash and/or restrained while in the facility.
16. Animals will not be allowed in food preparation, dining areas or treatment areas.
17. Equipment that has been in substantial (i.e., more than incidental) contact with animals must be cleaned and disinfected before reuse.
18. Plants and flowers will be cared for by staff not directly involved in resident/patient care, when practical.
19. Direct care staff must wear gloves to care for plants and flowers and perform hand hygiene after removing gloves.

[Pet Therapy/Visitation Policy](#)

The Idaho State Veterans Home has resident cats that provide companionship and therapy to residents on a permanent basis. Only domesticated household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted to reside in the Idaho State Veterans Home per the approval of the Home Administrator.

Although residents are not allowed to have personal pets living in the facility, relatives and friends of residents are encouraged to bring a pet in to visit residents through the Idaho State Veterans Home pet visitation program.

Through this program, current pet vaccination records must be provided to the facility Activities Department prior to visitation, and all animals must be kept on a leash and under the control of the trainer at all times.

In addition, the presence of pets shall not interfere with the health and rights of other individuals (i.e. noise, odor, allergies and interference with the free movement of individuals about the facility). Pets will not be allowed in food preparation or storage areas or any other area if their presence would pose a significant risk to residents, staff or visitors. More specifically, animals are not allowed in the kitchen, dining room, and canteen areas.

Service Animals. In areas that are not used for food preparation, certified “service animals” that are controlled by a disabled employee or person may be allowed in the guest sitting/standing areas (i.e. dining and canteen areas), as long as a health or safety hazard will not result from the presences or activities of a “service animal.”

Any question or concerns related to this policy should be addressed with the Social Services Department.

References	
OBRA Regulatory Reference Numbers	483.65(a) See also CDC’s Guidelines for Environmental Infection Control in Healthcare Facilities at: www.cdc.gov/mmwr/PDF/rr/rr5210.pdf
Survey Tag Numbers	F441

Quality of Life: Smoking

Purpose

Smoking procedures for this facility are necessary for ensuring the safety of each resident, staff member, and visitor. The Administrator has the ultimate responsibility for enforcing the facility smoking procedure; however, it is the responsibility of each staff member to be aware of the smoking privileges provided to EACH resident and assist in ensuring they are in compliance with the procedure.

Procedure

Resident smoking is allowed only in designated smoking areas around the facility. No other area is available for smoking by anyone.

Residents will be assessed for their safety and ability to handle their own smoking materials. Residents will be allowed smoking materials based on this assessment. Staff, family and friends will be informed regarding the facility's procedure, if the resident is allowed to have smoking items (including matches or lighter) at the bedside or whether these items will be located at the nurses' station, the level of supervision and the use of any safety enablers such as a smoking apron. Residents who wish to smoke will be assessed using the BVH Smoking Classification Assessment in Point Click Care (PCC) Assmnts tab. Based on the responses and consultation with facility staff, the RN Manager or designee will determine appropriate level of supervision. Residents will be classified into one of the following four categories:

1. WITHOUT SUPERVISION:

- a. These residents will be allowed to keep cigarettes and matches/lighters in a safe area. This area must be in a location so that other residents will not have access to them.
- b. These residents have the ability to:
 1. Ensure their oxygen is turned off and that the portable oxygen device is not taken into the smoking area, either by consistently doing this for themselves or by consistently asking staff to complete the task. The portable oxygen device may be left in the resident's room or placed in the designated portable oxygen device "parking spot".
 2. Don a fireproof smoking apron, if appropriate, either by consistently doing this for themselves or by consistently asking staff to complete the task.
 3. Smoke in the appropriate place.
- c. These residents will be allowed to come and go from the smoking areas unattended.

2. SUPERVISION:

- d. These residents have been assessed and it has been determined that they may be allowed to keep their smoking materials in a safe area, or the smoking materials may be kept at the nurses' station.
- e. They may light their own cigarette or ask staff to light the cigarette for them.
- f. These residents have been assessed and it has been determined that their smoking materials are to be kept at the nurses' station.
- g. They may ask staff to light the cigarette for them or may light the cigarette for themselves before returning the lighter/unused matches to nursing staff.

- h. Staff will ensure that:
 - 1. Resident is assisted to appropriate designated smoking area.
 - 2. Portable oxygen is turned off and the portable oxygen device is not taken into the smoking area. The portable oxygen device may be left in the resident's room or placed in the designated portable oxygen device "parking spot".
 - 3. Resident is wearing a fireproof smoking apron, if appropriate.
 - 4. When these residents are in the smoking area, staff must observe them no less than every fifteen (15) minutes.

4. EXTENSIVE SUPERVISION:

- i. When these residents wish to smoke, they will need to ask staff members for the supplies and staff will accompany them to the smoking area and light the cigarette for them.
- j. While these residents are in the smoking area staff must observe them and/or assist as needed, including turning off oxygen and ensuring that the portable oxygen device is not taken into the smoking area. The oxygen companion may be left in the resident's room or placed in the designated oxygen companion "parking spot".
- k. **Residents will remain in line of sight of staff.**
- l. Residents' care plans will be developed or adjusted to reflect their smoking assessment and classification, along with other related smoking interventions.

Resident's smoking abilities will be re-assessed in the event of a change of condition, change in function of any kind, a start or change in portable oxygen use that would affect their safety with the smoking program or at least quarterly, in conjunction with the focus charting guidelines utilizing the BVH – **Quarterly** Smoking Assessment in Point Click Care (PCC) Assmnts tab.

All residents who are smokers and utilize a portable oxygen device will have a Fire Safe Cannula Valve as a precautionary measure.

Staff and visitors must smoke in the designated areas only.

Revised 2/03, 6/06, 5/07, 01/09, 11/10, 04/12, 09/14

Smoking Classification Assessment

- A. It is the desire of this facility to allow a resident to smoke cigarettes, cigars, pipes, etc. if they wish to do so and do not have any physician's orders prohibiting smoking.
- B. The following assessment must be completed by the RN Unit Manager or designee on all residents wishing to smoke.
- C. Assessment will be completed upon admission, following event of a change of condition, change in function of any kind, a start or change in portable oxygen use that would affect their safety with the smoking program, or annually in conjunction with the RAI process. Until such time as the assessment can be completed and the findings communicated to the appropriate persons, a newly admitted resident will be classified With Close Supervision.
- D. Care Plan will be developed to reflect the assessment, classification, and other appropriate interventions related to the resident's smoking activities.

Does the resident know the location(s) of the designated areas for smoking? YES NO

Can the resident get to these areas independently? YES NO

When observed, can the resident independently light smoking materials safely? YES NO
 (If NO, explain) _____

Does mental function vary over the course of the day? YES NO

Does the resident have Parkinson's or similar disease that would cause upper limbs to shake? YES NO

Does the resident have Diabetes or other disease that would make wound healing difficult? YES NO

Does the resident fall asleep while smoking? YES NO

Can the resident extinguish smoking materials completely in appropriate receptacle? YES NO
 (If NO, explain) _____

Can the resident dispose of ashes appropriately? YES NO
 (If NO, explain) _____

Has the resident had any past accidents / incidents with smoking materials? YES NO
 (If YES, explain) _____

Are there any visible burn marks on the resident's clothing / coat/ w/c cushion cover? YES NO

Does the resident utilize portable O2? YES NO
 IF YES, Can the resident turn off O2 and remove the portable O2 device independently prior to entering smoking area? YES NO (IF NO, explain) _____

This resident requires a fire- proof smoking apron while smoking: YES NO

All smoking materials will be kept at the nurses' station: YES NO
 (IF YES, explain) _____

Based on the assessment responses the resident is classified to smoke as follows: (circle most appropriate)

WITHOUT SUPERVISION SUPERVISION LIMITED SUPERVISION EXTENSIVE SUPERVISION

Assessment completed by: _____ Date: _____

Resident's Name _____ Room Number _____

Smoking Assessment Worksheet – Quarterly and PRN

RE-EVALUATION

Has there been a change in the resident's cognitive or physical status in the past 3 months? No Yes

If yes, please explain _____

Has there been an incident or other event that might indicate a need to re-evaluate the resident's smoking classification? No Yes If yes, please explain _____

Based on the above information and any other evaluations, are changes in the resident's Smoking Classification warranted? No Yes If yes, complete the Smoking Classification Assessment.

Signature Nurse Evaluator _____ Date _____

RE-EVALUATION

Has there been a change in the resident's cognitive or physical status in the past 3 months? No Yes

If yes, please explain _____

Has there been an incident or other event that might indicate a need to re-evaluate the resident's smoking classification? No Yes If yes, please explain _____

Based on the above information and any other evaluations, are changes in the resident's Smoking Classification warranted? No Yes If yes, complete the Smoking Classification Assessment.

Signature Nurse Evaluator _____ Date _____

RE-EVALUATION

Has there been a change in the resident's cognitive or physical status in the past 3 months? No Yes

If yes, please explain _____

Has there been an incident or other event that might indicate a need to re-evaluate the resident's smoking classification? No Yes If yes, please explain _____

Based on the above information and any other evaluations, are changes in the resident's Smoking Classification warranted? No Yes If yes, complete the Smoking Classification

Agreement for Safe Smoking

The following conditions must be followed to maintain the safety and well-being of all residents and staff at the Idaho State Veterans Home, Boise.

I agree to the following guidelines for cigarette use:

- I will smoke only in areas designated for smoking and understand where those areas are located.
- I will not request cigarettes from peers, staff or visitors at any time.
- I will not give lighters, matches or cigarettes to other residents.
- If I am assessed as needing a smoking apron during unsupervised or supervised smoking, I agree to wear a smoking apron when I smoke.
- If I require oxygen and am assessed to smoke independently, I agree to not enter the smoking area with my portable oxygen device. I will turn off the portable oxygen device and leave the device in my room or in the designated portable oxygen device “parking spot”.
- If it is determined that I need limited supervision while smoking, I agree to allow my smoking materials to be managed by the nursing staff and administered based on my individual smoking plan. I understand that while I am smoking, staff will check on me no less than every fifteen minutes.
- If I am assessed as requiring extensive supervision while smoking, I agree to smoke only in the presence of a staff member who will be assigned to supervise my smoking. My smoking materials will be maintained on the nursing cart and provided to me by staff.
- I agree that if I do not adhere to this safe smoking agreement the following steps will be taken:

Policy violation #1

Conference with resident, family/responsible party, staff and review of policy & subsequent steps.

Policy violation #2

Supervised smoking as described above.

Policy violation #3

Discharge or transfer from the home: per IDAPA 21.01.01 may be “necessary to protect the health and safety of other residents or staff.”

Signature of Resident/Responsible Party

Printed Name

Date

Resident Name: _____ Physician Name: _____

Revised 4/10/2012

Resident Rights

Highlights	<p>Policy Statement</p> <p>All residents at the Idaho State Veterans Home have rights guaranteed to them under Federal and State Law. These rights include a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility.</p>
Posting of Resident Rights	<p>Policy Interpretation and Implementation</p> <p>Upon admission all residents and their families will receive a detailed copy of the “Resident Rights (attached).” A copy of the resident rights is posted throughout the facility. Resident rights are also reviewed regularly in the resident council meetings with our residents.</p>
Staff Education	<p>Staff is educated about resident rights and provided with a copy of resident rights through:</p> <ol style="list-style-type: none"> 1. Orientation of new staff members 2. Education of all staff by Social Work Services at regularly scheduled intervals during the year. 3. On an individual basis as needed.
Resident Rights	<p>All residents have the right to:</p> <ul style="list-style-type: none"> *Exercise his or her rights *Be informed about what rights and responsibilities he or she has *If he or she wishes, have the facility manage his personal funds *Choose a physician and treatment and participate in decisions and care planning *Privacy and confidentiality *Receive Advance Directive information *Voice grievances and have the facility respond to those grievances *Examine survey results *Work or not work *Privacy in sending and receiving mail *Visit and be visited by others from outside the facility *Use a telephone in privacy *Retain and use personal possessions to the maximum extent that space and safety permit *Share a room with a spouse if that is mutually agreeable

*Self-administer medication if the interdisciplinary care planning team determines it is safe

*Refuse a transfer from a distinct part, within the institution

References	
OBRA Regulatory Reference Numbers	483.15; 483.15(a); 483.15(b)
Survey Tag Numbers	F240; F241; F242
Related Documents	

A Resident's Bill of Rights

As a resident of the Idaho State Veterans Home, residents have the right to a dignified existence, self-determination, and communication with and access to persons inside and outside the facility. The Idaho State Veterans Home protects and promotes the rights of each resident, including each of the following:

A. Exercise of Rights

1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the US.
2. The resident has a right to be free of interference, coercion, discrimination and reprisal from the facility management in exercising his or her rights
3. The resident has a right to freedom from chemical or physical restraint.
4. In the case of a resident determined incompetent under the laws of a state by a court of jurisdiction, the rights of the resident are exercised by the person appointed under the state law to act on the resident's behalf.
5. In the case of a resident who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by the state law.

B. Notice of Rights and Services

1. The resident will be informed both orally and in writing (in a language that the resident understands) of his or her rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility. Such notification must be made prior to or upon admission.
2. The resident or legal representative has the right:
 - i. Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and
 - ii. After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request and 2 working days of advance notice to facility management.
3. The right to be fully informed in a language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
4. The resident has the right to refuse treatment and to refuse to be involved in experimental research and to formulate an advance directive.
5. The resident has the right to be informed at the time of admission and periodically during the resident's stay of services available in the facility and of charges for those services to be billed to the resident.
6. The resident has a right to be furnished with a written description of his/her legal rights to include:
 - i. A description of the manner of protecting personal funds
 - ii. A description of the requirements and procedures for establishing Medicaid eligibility including the right to request an eligibility assessment to

- determine the extent of the couple's non-exempt resources and establish the community spouse's equitable share of resources for their personal needs.
- iii. Residents will be informed of the items and resources covered by Medicaid for which they will not be charged. They will be informed of the items and services for which they may be charged and of the cost of those services. They will be informed of when charges are made for all of the above services.
 - iv. A posting of names, addresses, and telephone numbers of all state client advocacy groups such as the State Survey and Licensing Board, the State Ombudsman Program, and the Medicaid Fraud Control Unit.
 - v. A statement that the resident may file a complaint with any of the above advocacy groups regarding abuse, neglect, and misappropriation of funds.
7. The facility must comply with requirements maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
8. The resident has a right to be informed of the name and way of contacting the primary physician responsible for his or her care.
9. The resident, legal representative, interested family member, and physician will be notified/ consulted regarding the following changes:
- i. An accident involving the resident which results in injury and has the potential for requiring physician's intervention.
 - ii. A significant change in the resident's physical, mental, or psychosocial status.
 - iii. A need to alter treatment significantly.
 - iv. A decision to transfer or discharge the resident from the facility.
 - v. The facility management must also promptly notify the resident and/ or legal representative of a change in room or roommate assignment. (The facility should attempt to adapt room arrangements to accommodate resident's preferences, desires, and needs.)
 - vi. A change in resident rights under state or federal regulations. Receipt of such must be documented in writing.

- vii. The facility must record and update the address and phone number of the resident's legal representative or interested family member.

C. Protection of Resident Funds:

1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility.
2. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.
3. The resident has a right to receive interest on all funds in excess of \$50 in the resident's trust account and will receive a quarterly accounting of the funds in his or her trust account. Upon the resident's death the trust account will have a final accounting of funds which will be distributed to the individual or probate jurisdiction administering the resident's estate. The facility must purchase a surety bond or provide assurance of security of all personal funds deposited with the facility.
4. The resident has a right to receive a list of services not covered by Medicare/Medicaid or the facility, which will be billed to the resident.

D. Free Choice

1. Choose a personal attending physician.
2. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.
3. Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

E. Privacy and Confidentiality

1. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.
2. Except in the case of transport to another health care facility or record release as required by law, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

F. Grievances

1. The resident has the right to voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received. Grievance forms are located on each floor.
2. The resident has the right to prompt efforts by the facility to resolve grievances the

resident may have, including those with respect to the behavior of other residents.

G. Examination of Survey Results

1. The resident has the right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.
2. The resident has the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies.

H. Work

1. The resident has the right to refuse to perform services for the facility.
2. The resident has the right to perform services for the facility, if he or she chooses when:
 - i. The facility has documented the need or desire for work in the plan of care.
 - ii. The care plan specifies the nature of the services performed and whether the services are voluntary or paid.
 - iii. Compensation for paid services is at or above prevailing rates.
 - iv. The resident agrees to the work arrangement in the plan of care.

I. Mail - The resident has the right to privacy in written communications, including the right to:

1. Send and promptly receive mail that is unopened unless related to payment for care and facility is payee/fiduciary.
2. Receipt of mail is medically contraindicated per care plan.
3. Have access to stationery, postage and writing implements at the resident's expense.

J. Access and Visitation Rights

1. The resident has the right to be visited by:
 - i. Any representative of the Under Secretary for Health.
 - ii. Any representative of the State.
 - iii. Physicians of the resident's choice.
 - iv. The State long-term care ombudsman.
 - v. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.
 - vi. Agency responsible for protection or advocacy for developmentally disabled or mentally ill individuals; and
 - vii. All who are visiting are subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time.
2. The facility management must provide reasonable access to any resident by any

entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

3. The facility management must allow representatives of the State Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

K. Telephone

1. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.

L. Personal Property

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

M. Married Couples

1. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

N. Self-Administration of Drugs

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

O. Admission, Transfer and Discharge Rights

1. Transfer and discharge includes movement of a resident to a placement out of the facility.
4. The resident has the right to refuse a transfer/discharge unless:
 - i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home.
 - ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home.
 - iii. The safety of individuals in the facility is endangered.
 - iv. The health of individuals in the facility would otherwise be endangered.
 - v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.
 - vi. The nursing home ceases to operate.
 - vii. The resident has a right to refuse transfer to another room in the facility.
5. Documentation – When a facility discharges or transfers a resident, the primary physician must document in the resident's chart.
6. Notice before transfer - The facility must:

- i. Notify the resident and representative of the transfer/discharge and the reasons for it in writing in a language and manner they understand.
 - ii. Record the reasons in the chart.
7. Timing of notice – The notice must be made at least 30 days before transfer or discharge except when:
 - i. The safety of individuals in the facility would be endangered.
 - ii. The health of individuals in the facility would be otherwise endangered.
 - iii. The resident’s health improves sufficiently so they no longer require services provided by the nursing home.
 - iv. The resident’s needs cannot be met in the nursing home.
8. Contents of the notice – The written notice must include the following:
 - i. The reason for transfer or discharge.
 - ii. The effective date of transfer or discharge.
 - iii. The location to which the resident is transferred or discharged.
 - iv. A statement that the resident has the right to appeal the action to the State official designated by the State; and
 - v. The name, address, and telephone number of the State Long Term Care Ombudsman.
9. Orientation for transfer or discharge – A member of the facility management will provide sufficient preparation to ensure safe and orderly transfer or discharge from the facility.
10. Notice of bed-hold policy and readmission – Before a resident is transferred the facility management will provide written information regarding the length of the bed-hold policy during which the resident may return to the facility.
11. Permitting resident to return to facility – The facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:
 - i. Requires the services provided by the facility; and
 - ii. Is eligible for Medicaid nursing facility services.
12. The facility management maintains identical policies regarding transfer and discharge and service provision to all individuals regardless of the payment source.
13. Admissions policy for payment – The facility must not require a third party to guarantee payment to the facility as a condition of admission; however, it may require an individual who has legal access to the resident’s income to pay the facility from the resident’s income or resources. The facility must not require residents to waive their right to Medicare or Medicaid. The facility will not discriminate against individuals entitled to Medicaid.

P. Resident Behavior and Facility Practices.

1. The resident has the right to be free of any chemical or physical restraints imposed for restraint purposes of discipline or convenience and not required to treat the resident’s medical symptoms.
 - i. A chemical restraint is the inappropriate use of psychotropic drugs to

- manage or control behavior.
 - ii. A physical restraint is any method of physically restraining a person's movement, physical activity, or access to his/her body.
- 2. The resident has the right to be free of physical, mental, sexual, and verbal abuse or neglect, corporal punishment, or involuntary seclusion.
 - i. Mental abuse includes humiliation, harassment, and threats of punishment or deprivation.
 - ii. Physical abuse includes hitting, slapping, pinching, or kicking.
 - iii. Sexual abuse includes sexual harassment, coercion, and assault.
 - iv. Neglect is any impaired quality of life because of the absence of minimal services or resources to meet basic needs (food, hydration, clothing, medical care and good hygiene).
 - v. Involuntary seclusion is separation from other residents or from the resident's room against his/her will or the will of their legal representative.
- 3. Staff treatment of Residents
 - i. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
 - ii. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with Federal and State Law. The facility management must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse.

Q. Quality of Life

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

- 1. Dignity

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
- 2. Self-determination and participation

The resident has the right to:

 - i. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.
 - ii. Interact with members of the community both inside and outside the facility; and
 - iii. Make choices about aspects of his or her life in the facility that are significant to the resident.
- 3. Participation in resident and family groups.
 - i. A resident has the right to organize and participate in resident groups in the facility.
 - ii. A resident's family has the right to meet in the facility with the families of

- other residents in the facility.
 - iii. The facility must provide a resident or family group, if one exists, with private space.
 - iv. Staff or visitors may attend the meetings at the group's invitation.
 - v. The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.
 - vi. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.
4. Participation in other activities.
A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.
5. Accommodation of needs.
A resident has the right to:
- i. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
 - ii. Receive notice before the resident's room or roommate in the facility is changed.

Sexual Expression of Residents

Policy:

It is the policy of this facility to respect all residents and their rights. This policy applies to individuals who exhibit intact cognitive decision-making capacity. Residents residing in the facility will be allowed to express themselves in the way they prefer, given they have the mental capacity to make informed decision.

Policy Explanation and Compliance Guidelines:

1. The staff will document observation of residents engaging in intimacy and/or sexual activity and notify social services and the Director of Nursing.
2. The social services staff will notify the interdisciplinary team.
3. The social services staff will educate the resident about any disease processes and the residents' rights.
 - a. Residents with decisional capacity have the right to seek out and engage in consensual intimacy and/or sexual expression.
 - b. Residents with decisional capacity have a right to privacy, including private space for sexual expression.
 - c. Residents with decisional capacity have a right to confidentiality.
4. The physician will be notified regarding all residents participating in sex for a clinical and cognitive evaluation to determine intact cognitive decision-making-capacity and capacity to give consent.
5. The decision to conduct a cognitive re-assessment will be made by the interdisciplinary team and based upon noticing a change in a resident's behavior or demeanor.
6. Care plan meetings with the interdisciplinary team shall be scheduled as soon as possible form initial notification of the social services staff.
 - a. The interdisciplinary team shall conduct a review of situations and accounts of sexual expression among or between residents or with visitors to determine a solution that best meets the needs of and protects those involved.
 - b. Outcomes of the interdisciplinary team review will be shared with the residents involved and documented in the plan of care.
7. Based on the plan of care, intimacy and sexual expression shall be permitted if both parties consent, and the risks do not exceed the benefits.
8. The facility will ensure the resident's right to privacy, including providing a private place for intimacy and/or sexual expression.
9. The staff will re-direct residents engaging in intimacy and/or sexual expression in public areas.
10. Residents who express the desire to be sexually active will receive education on the definition of abuse, sexual assault, and who to contact to report any issues.
11. If, at any time, either resident is heard or observed by staff saying no and they desire to stop, the staff will intervene as needed to protect the resident's rights and safety and will place the resident in another location until an investigation can be completed, to include notifications of the appropriate person(s).

12. The facility shall provide initial staff orientation and ongoing staff training regarding abuse, intimacy and/or sexual expression as well as sensitivity awareness about residents' sexual rights and staff documenting and reporting responsibilities.
13. The facility shall obtain consultation regarding intimacy and/or sexual expression in cases that are deemed complex or controversial.
14. All infection control precautions to be followed as per facility protocols. Sexual expression should be prevented where the potential for transmission of sexually transmitted infection exists.
15. Staff should immediately report suspected sexual abuse to immediate supervisor and follow reasonable suspicion of a crime and elder justice act guidelines.

References:

Centers for Medicare & Medicaid Services, Dept. of Health and Human Services. State Operations Manual (SOM): appendix PP guidance to surveyors for Long Term Care Facilities. (November 2017 Revision) F-550 – Resident Rights. 42 C.F.R. §483.10

Centers for Medicare & Medicaid Services, Dept. of Health and Human Services. State Operations Manual (SOM): appendix PP guidance to surveyors for Long Term Care Facilities. (November 2017 Revision) F-600 – Free from Abuse and Neglect. 42 C.F.R. §483.12

Added 10/10/2018