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I ADVANCE DIRECTIVES

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

IF YOU WOULD LIKE A COPY OF THIS INFORMATION, PLEASE TAKE ONE FROM THE BACK OF THIS FOLDER. OR, THE SOCIAL SERVICES DEPARTMENT WILL BE HAPPY TO ASSIST YOU.

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POLICY STATEMENT

Highlights Policy Statement

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.

Policy Interpretation and Implementation

Provision to Inform

Documentation

Education

1. 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.
2. 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.
3. 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 F578

Related Documents

POST, DPOA, LIVING WILL, Caring Connections “Idaho Advance Directive: Planning for Important Healthcare Decisions” Informational Packet

Policy

Revised

Date: 01/13/2020 By: _____

Date: _____ By: _____

Date: _____ By: _____

Date: _____ By: _____

INTERPRETATION AND IMPLEMENTATION

Highlights Policy Statement

Advance directives will be respected in accordance with state law and Idaho

State Veterans Home-Pocatello facility policy.

Policy Interpretation and Implementation

Provision of Written

Information Relative to

Advance Directives

Discrimination

Inquiry of Advance

Directives

Documentation in Medical

Record

OBRA Definitions

Relative to Advance

Directives

Living Will

POST

Do Not Resuscitate

Do Not Hospitalize

Organ Donation

Autopsy Request

Feeding Restrictions

Medication Restrictions

Other Treatment

Restrictions

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.

2. Each resident 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.

3. Prior to or upon admission of a resident, the Admissions Coordinator or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives.
4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.
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:
 - a. Living Will — A document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis.
 - b. POST— Physicians Order For Scope of Treatment
 - 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.
 - 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.
 - e. Organ Donation — Indicates that the resident wishes his or her organs to be available for transplantation upon his or her death.
 - f. Autopsy Request — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) has requested an 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.
 - 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.
 - h. Medication Restrictions — Indicates that the resident, legal guardian, health care proxy, or representative (sponsor) does not wish for the resident to receive lifesustaining medications (e.g., antibiotics, chemotherapy, etc.).
 - 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. continues on next page

Out-of-State Documents

Annual Review of

Resident's Advance

Directives

Changes in Advance

Directives

Notifying Attending

Physician of Resident's

Advance Directives

Informing Emergency

Medical Personnel of

Resident's Advance

Directives

Staff In-Service Training

Community Training

Inquiries

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.

7. The Interdisciplinary Team will review annually with the resident and/or his or her representative his/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.

8. Changes or revocations of a POST directive require that a new directive be completed and submitted to the residents Attending Physician. The Interdisciplinary 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.

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 or his/her designee 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 Social Worker 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 about the residents' rights to formulate advance directives and facility policy governing such rights.

12. Inquiries from the community relative to advance directives must be referred to Social Services. 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.

13. Inquiries concerning advance directives should be referred to the Administrator, Director of Nursing Services, and/or to Social Services.

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

Policy

Revised

Date: _____ By: _____

Date: _____ By: _____

Date: _____ By: _____

Date: _____ By: _____

II ASSESSMENTS

SOCIAL WORK ASSESSMENT GUIDE

Assessments can be written in a narrative format with the following topics addressed. Examples of assessments below contain the topics for learning purposes and are not written within the actual quarterly, yearly, or admission assessment.

Quarterly Assessment includes:

- a) New issues during the quarter impacting psychosocial well being (UTI, surgeries, hospitalizations, etc.)
- b) Diagnosis
- c) Psychotropic medications: side effects, efficacy, consent present for anti-psychotic.
- d) Pain: Problematic, controlled, resident able to express/pinpoint if pain is present.
- e) Cognition, including BIMS results and any significant change from prior score.
- f) Mood including PHQ9 results and any significant change from prior score.
- g) Behaviors: Use care tracker, if on antipsychotics/anxiety document #'s & Interventions.
- h) Nursing needs, toileting, hygiene, transfers, bathing, side rail use, alarms, mobility (self propels, cane, walker, etc.)
- i) Diet – including weight and weight differentiation since the last assessment. Discuss if in NAR and/or followed by RD.
- j) Therapies
- k) Hearing, vision, dental
- l) Activity involvement
- m) Advance Directives, code status, POA, guardianship
- n) New preferences or needs, "Is there anything you need or want that we can do for you?" Discussion during the 1:1, roommate compatibility.
- o) Plan of care, update or continue with the POC.
- p) Discharge consideration

Annual Assessments include:

- a) Same information as quarterly plus:
- b) Resident's veterans' status, age, original admission date and where admitted from.
- c) Review of major health changes.
- d) Change in family constellation.
- e) Change in advance directives.

Admission Assessments include:

- a) Resident's veterans' status, age, admission date and where admitted from, prior living situation.
- b) MD and diagnosis
- c) Psychotropic medications prescribed on admit
- d) Pain medications prescribed at admit and resident's ability to express/pinpoint if pain present.
- e) Cognition observations: BIMS results if done prior to admission assessment.
- f) Mood observations: PHQ9 results if done prior to admission assessment.
- g) Nursing needs with toileting, hygiene, transfers, bathing, side rail use, alarms, mobility (self propel, cane, walker, etc.)
- h) Diet including admission weight
- i) Therapies ordered upon admission
- j) Hearing, vision, dental (glasses, hearing aids, dentures – partials or own teeth
- k) Advance Directives, code status, POA, guardianship.
- l) What SW will do: complete psychosocial history, contact family/POA, explain role of SW to resident, family, POA, and any special needs noted during admission interview.
- m) Tentative plan of care
- n) Tentative DC plans

PSYCHOSOCIAL HISTORY FORM

Psychosocial History

Admit Date: Residents Name: Sex: Age:

Branch of Service: DOB: Birthplace:

Marital Status: Spouse Name:

Religious Preference:

Source of Information: Decision Maker:

Last Residence: Residents Rights Reviewed:

Siblings: Living - / Deceased

-

Children: Living - / Deceased -

Names/Locations of Surviving

Siblings:

Names/Locations of Surviving

Children:

Significant Life Experiences. Discuss each of the following:

- Early Family History
- Family Relationships
- Education
- Marriage
- Work/Retirement History
- Psychosocial

status/preference

- Socialization Patterns
- Family support
- Reason for Admission
- Current Emotional Status
- Discharge Goal/Preference
- Significant Medical and

Psychiatric History

Signature/Title of Person completing form:

Date:

PSYCHOSOCIAL ASSESSMENT

Highlights Policy Statement

A psychosocial assessment shall be completed within fourteen (14) days of the resident's admission to the Idaho State Veterans Home.

Policy Interpretation and Implementation

Social Assessment

Contents of Assessment

Physical Factors

Cognitive Factors

Mood and Behavior

Personal Information and

Preferences

1. A psychosocial assessment will be completed to help identify the resident's personal strengths and goals, life histories and preferences.
2. 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:

A) Physical factors with impact on function and quality of life including:

- (1) Sight;
- (2) Hearing;
- (3) Speech;
- (4) Loss of limbs or motor ability;
- (5) Terminal illness; and
- (6) Others as may be appropriate.

B) Cognitive factors including:

- (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.

C) Mood and behavioral factors, including::

- 1) Attitudes and feelings about:
 - a. Self and situation;
 - b. Family and others; and
 - c. Institutional environment.
- 2) Signs and symptoms of depression or anxiety.
- 3) Personal, family, and social supports.
- 4) Behavioral symptoms, including:
 - a. Psychosis;
 - b. Wandering;
 - c. Refusal of care; and
 - d. Recent changes in behavior.

D) Personal information including:

- (1) Personal and family history;
 - a. Employment and professional history;
 - b. Hobbies and interests;
 - c. Personal preferences; and
 - d. Wishes about medical treatment and care, including any advance directives.

Diseases, Conditions

Functional Status

Need for Adaptive

Equipment

Participation in

Assessment and Goal

Setting

Financial Data

Purpose

Care Plan

E) Active disease diagnosis and health conditions.

F) Functional status, including:

(1) Need for assistance with ADLs.

(2) Need for mobility or adaptive devices.

G) Ability and willingness to participate in assessment and goal setting.

H) Financial information, including:

(1) Present source of financial support;

(2) Potential resources for financial support; and

(3) Significance for the resident.

3. 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.

4. 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

Policy

Revised

Date: 01/2018 - Reviewed By: _____

Date: _____ By: _____

Date: _____ By: _____

Date: _____ By: _____

(BIMS) BRIEF INTERVIEW FOR MENTAL STATUS

Highlights Policy Statement

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.

Policy Interpretation and Implementation

Testing Schedule

Procedure

Frequency:

- A. Upon admission.
- B. The BIMS assessment will be administered quarterly on or 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.

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 RAI User's Manual:

- Nonsensical responses should be coded as zero.
- Rules for stopping the BIMS before it is complete:
 - o Stop the interview after completing (C0300C) "Day of the Week" if:
 - all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), or
 - there has been no verbal or written response to any of the questions up to this point, or
 - there 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:
 - o Code -, dash in C0400A, C0400B, and C0400C.
 - o Code 99 in the summary score in C0500.
 - o Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
 - o 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

Policy

Revised

Date: _____ By: _____

Date: _____ By: _____

IDAHO STATE VETERANS HOME – POCATELO

SOCIAL SERVICES PROCEDURE MANUAL

7

PHQ-9 ASSESSMENT

Highlights Policy Statement

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.

Policy Interpretation and Implementation

Testing Schedule

Procedure

1. Frequency:

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.

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.

The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-V).

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++

Dysthymia*

Major depression, mild

Support, watchful waiting

Antidepressant or psychotherapy

Antidepressant or psychotherapy

15-19 Major depression, moderately

severe

Antidepressant or psychotherapy

≥ 20 Major depression, severe Antidepressant and psychotherapy

(especially if not improved on
monotherapy)

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:

PHQ 9 ASSESSMENT

ABNORMAL MOVEMENT SCALE

Highlights Policy Statement

An abnormal movement scale (AIMS) assessment shall be completed on all residents receiving/discontinuing anti-psychotic medications.

Policy Interpretation and Implementation

Testing Schedule

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:

- ☒ Tardive dyskinesia (TD)
- ☒ Postural (orthostatic) hypotension
- ☒ Cognitive/behavior impairment
- ☒ Akathisia
- ☒ Parkinsonism

The social worker in cooperation with nursing will complete AIMS at the scheduled time.

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.

B. Upon Admission: Any resident currently taking neuroleptic medication who is newly admitted to ISVH-L shall have an initial screening within one month of admission.

C. Increase or Decrease of Neuroleptic Medication:

1. Within one (1) month but not before seven days following the increase or decrease of the medication.
2. Every six (6) months thereafter.

D. Discontinuance: Any resident whose neuroleptic medication is discontinued shall be screened after the discontinuation at the following intervals:

1. One (1) month,
2. Three (3) months, or
3. 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.

SUICIDE THREAT

Highlights Policy Statement

Threats of Suicide Resident suicide threats shall be taken seriously and addressed appropriately.

Policy Interpretation and Implementation

Notification Process

Remaining With Resident

Notifying Attending

Physician

Informing Nursing Service

Personnel

Psychiatric Consultation

Assessment/Care Plan

Documentation of Incident

1. 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.
2. The Nurse Manager and the Social Worker shall immediately assess the situation and shall notify the Director of Nursing Services of such threats.
3. A staff member shall remain with the resident while evaluation is being made by Nursing and Social Work Services.
4. 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.
5. 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.
6. 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.

7. 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.

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

CARE PLAN PARTICIPATION, RESIDENT & FAMILY

Highlights Policy Statement

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.

Policy Interpretation and Implementation

Resident/Family

Participation

Resident Assessment

Advance Notice of Care

Planning Conference

Contact/Participation

Records

Policies Governing Care

Plans

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:

- a. The date of the conference;
- b. The time of the conference;
- c. The location of the conference;
- d. The name of each family member contacted;
- e. The date and time the family was contacted;
- f. 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.

Care Plan Participation, Resident & Family

DISCHARGE SUMMARY AND PLAN

Highlights 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

Discharge Summary and

Plan

Content of the

Discharge Summary

1. 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.

2. 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:

- a. 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);
- b. 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);
- c. 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);
- d. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence);
- e. Nutritional status and requirements (weight, height, hematological and biochemical assessment, clinical observations of nutrition, nutritional intake, resident eating habits and preferences, and dietary restrictions);
- f. 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);
- g. 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);
- h. Discharge potential (the expectation of discharging the resident from the facility within the next three months);
- i. 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);

Content of Post

Discharge Plan

Notice of Discharge

Responsibility of Social

Services Department

Availability of

Discharge Summary and

Plan

j. 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);

k. Rehabilitation potential (the ability to improve independence in functional status through restorative care programs);

l. Cognitive status (the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and

m. 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).

3. 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:

a. A description of the resident's and family's preferences for care;

b. A description of how the resident and family will access such services;

c. A description of how the care should be coordinated if continuing treatment involves multiple caregivers;

d. The identity of specific resident needs after discharge (i.e., personal care, sterile dressings, physical therapy, etc.); and

e. A description of how the resident and family need to prepare for the discharge.

4. 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.
5. The Social Services Department will review the plan with the resident and family before the discharge is to take place.
6. 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.

Discharge Summary and Plan

III BED HOLD POLICY

IDAHO STATE VETERANS HOME

BED HOLD POLICY

United States Department of Veterans Affairs (USDVA) and the policy of the Idaho State Veterans Home currently permits the payment of a per diem amount while holding a veteran resident's bed for up to 10 continuous days of any hospital stay, and for up to 12 days per year, in aggregate, for any therapeutic/voluntary leave, provided the facility is maintaining 90% occupancy.

However, USDVA policy does not permit the payment of a per diem amount while holding a nonveteran resident's bed. Recognizing that the Idaho State Veterans Homes contain both veteran

and non-veteran residents, resident bed hold charges will be billed as follows:

THERAPY/VOLUNTARY LEAVE

If a resident has taken more than 12 days in a calendar year of therapeutic/voluntary leave; and the daily occupancy of the Home is equal to or greater than 90% the following applies:

1. Beginning with the 13th day through the 30th day of therapeutic/voluntary leave, the resident will be billed a daily bed-hold charge equal to the USDVA Per Diem rate in effect at that time.

2. Beginning on the 31st day of therapeutic/voluntary leave, the resident will be billed a daily bed-hold charge equal to the applicable facility's maximum daily rate in effect at that time.

HOSPITAL LEAVE

Residents will be billed for a bed-hold charge if the following conditions are met:

If a resident has incurred more than 10 days in a calendar year of hospital leave that is not eligible for USDVA per diem payments and the daily occupancy of the Home is equal to or greater than 90% the following applies:

1. Beginning with the 11th day through the 30th day of hospital leave, the resident will be billed a daily bed-hold charge equal to the USDVA per diem rate in effect at that time.

2. Beginning on the 31st day of hospital leave, the resident will be billed a daily bed-hold

charge equal to the applicable facility's maximum daily rate in effect at that time.

There will be no bed hold available for residents whose care at the facility is being covered by Medicare or Medicaid at the time of hospitalization or therapeutic leave.

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. To request a Bed Hold for a leave of absence, please contact the Social Services Department. Overall agreements should be made with the Business Office or Social Services Department.

Revised 10/7/19

IV COMMUNITY SERVICES FILE

Highlights Policy Statement

Health Services File The Idaho State Veterans Home Social Work Services department shall maintain a community services file.

Policy Interpretation and Implementation

Maintaining File

Referrals

Documentation

1. Social Work Services will maintain a folder with community agencies available for resident transitioning to community or assisted living.
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.
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.
4. Social Work Services staff will document in the medical record any such referrals.

Community Services File

V COUNCIL MEETINGS

RESIDENT COUNCIL MEETINGS

Highlights Policy Statement

The Idaho State Veterans Home recognizes that our residents have the right to organize and participate in resident groups within the home.

Policy Interpretation and Implementation

Facilitate the Resident

Council

Goal of the Resident

Council

Attendees of the

Resident Council

Response to Concerns

The Social Services Department or designee will assist and facilitate the Resident Council on a regular basis to provide a private space, a forum for residents to discuss concerns, suggest changes, and identify and plan for desired social activities.

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.

Residents who are members of the Council hold the meetings and guide the Council efforts.

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.

The Social Services Department or designee (approved by resident council) 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.

Resident Council Meetings

FAMILY COUNCIL MEETINGS

Highlights 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

Facilitate the Family

Council

Goal of the Family Council

Response to Concerns

The Social Services Department or designee will assist and facilitate the Family Council on a regular basis to provide a private space, 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 or designee (approved by resident council) 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.

Family Council

VI DEPARTMENT SERVICES SOCIAL SERVICES

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. The Director of Social Services is a qualified social worker and is responsible for:
 - a. Consultation with other departments regarding program planning, policy development, and priority setting of social services;
 - b. Consultation to allied professional health personnel regarding provisions for the social and emotional needs of the resident and family;
 - c. Consultation and supervision to Social Services personnel;
 - d. An adequate record system for obtaining, recording, and filing of Social Service data;

- e. In-service training classes; and
 - f. Assistance in meeting the social and emotional needs of residents.
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).
3. Factors that have a potentially negative effect on psychosocial functioning include:
- a. Institutional attitudes and practices which affect the resident's dignity and sense of control;
 - b. The lack of family/social support system;
 - c. Problems in coping with grief;
 - d. Disability or loss of function;
 - e. Presence of a progressive, chronic disabling condition (i.e., Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Alzheimer's disease, mental illness);
 - f. Incompatibility of roommate;
 - g. Behavioral problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes);
 - h. Poor interaction and socialization skills;
 - i. Financial needs or problems;
 - j. Legal service needs;
 - k. Substance abuse;
 - l. 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.
5. Inquiries concerning social services should be referred to the Director of Social Services and/or the floor social worker.

PASTORAL SERVICES

POLICY STATEMENT:

The religious needs of each resident at the Idaho State Veterans Home will be met.

POLICY INTERPRETATION AND IMPLEMENTATION:

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.
2. The objectives of our Pastoral Services are:
 - 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.
3. Ministers are encouraged to make in-room visits.
 4. Residents shall be allowed to visit with their minister, rabbi, or priest in private.
 5. Ministers are encouraged to check with the Charge Nurse before visiting residents.
 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.
 7. Ministers should refer requests for information to the Nurse Manager and Social Services Director.
 8. The home's chaplain is supervised by the Administrator or assigned designee. The Chaplain arranges for and provides general supervision to any pastoral service assisting in the home.

SPIRITUAL AND RELIGIOUS ACTIVITIES

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

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:

- 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.

VII GRIEVANCES

FILING GRIEVANCES AND COMPLAINTS

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

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, discrimination or reprisal in any form.
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.
3. Grievances and/or complaints may be submitted orally, anonymously, or in writing. Written complaints or grievances will be signed by the resident or the person filing the grievance or complaint on behalf of the resident.
4. The Administrator has delegated the responsibility of grievance and/or complaint investigation to the Social Work Department.
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.
6. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.
7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings within 5 working days of the investigation and the actions that will be taken to correct any identified problems. The Social Worker will make such reports orally upon closure of the investigation. The resident has the right to obtain a written decision regarding his or her grievance.
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, emails and telephone numbers of these agencies are posted in public areas).
9. The facility will designate a grievance official responsible for oversight of grievance

process. Will educate resident, family, staff and visitors of grievance policy including rights to file complaint orally, anonymously or in writing.

GRIEVANCE FORMS

POLICY STATEMENT:

The disposition of all resident grievances and/or complaints will be filed in the Idaho State Veteran's Home Resident Grievance Folder.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. The disposition of all written grievances and/or complaints in the past year must be maintained in the Resident Grievance Form Folder.
2. The Social Work Department will be responsible for maintaining the form(s).
3. The following information, as a minimum, will be recorded:
 - 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 in 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
 - g. The disposition of the grievance (i.e., resolved, dispute, etc.).
4. The Resident Grievance forms will be reviewed by the Director of Social Work Services at least quarterly and will be maintained in the Resident Grievance Folder.

SUGGESTIONS/GRIEVANCE FORM

This form is to be used by our residents/family members or on behalf of a resident to report suggestions/grievances, including missing items

Please forward to the Social Work Services Department

DATE: _____

NAME: _____ REPORTED TO: _____

DESCRIPTION OF

SUGGESTION/GRIEVANCE: _____

STAFF

INVESTIGATION: _____

RESOLUTION (including resident/family response to the resolution):

Staff Signature Date

Person reporting this notified of follow up on: _____ revised: 05/22/2019

IDAHO STATE VETERANS HOME – POCTELLO

SOCIAL SERVICES PROCEDURE MANUAL

4

RESIDENT SUGGESTION/GRIEVANCE PROCEDURE POSTING

Important Information – Please Do Not Remove From Bulletin Board

Resident Suggestion/Grievance Procedures

A resident, his or her representative (sponsor), family member, visitor or advocate may file a verbal, written or anonymous suggestion/grievance concerning treatment, abuse, neglect, harassment, medical care, behavior of other residents or staff members, missing property, etc., without fear of threat, discrimination or reprisal in any form.

You are requested to follow the procedures outlined below when filing a written grievance or complaint:

1. Obtain a Resident Suggestion/Grievance Form, which is posted in the following areas: north dining area, canteen, activity room, and staff break room or from the Social Work Services office.
2. Complete, and be sure to sign and date the form, providing contact information.
3. Give the completed form to the Social Work Department or nurse on duty.
4. The resident, or person filing the grievance on behalf of the resident will be informed, within 5 working days, of the progress &/or resolution of the investigation and the actions

that will be taken to correct any identified problems. Residents have the right to obtain a written decision regarding his or her suggestion/grievance.

5. Should you disagree with the findings, recommendations, or actions taken, you may meet with the Social Worker, Administrator, or you may file a complaint with any of the advocacy agencies listed in the main hallway including Ombudsman & Bureau of Facility Standards.

6. It is the policy of the Idaho State Veterans Home to assist you in filing a grievance or complaint. Should you feel that our staff has not assisted you in this matter, or you feel that you are being discriminated against for taking such steps, you are encouraged to report such incidents to the Social Work Department at once.

7. Policies governing our abuse prevention/reporting program are available from the Social Work Department.

Suggestions/Grievance Forms

Any resident, his or her representative (sponsor), family member, visitor, or advocate may file a written, verbal or anonymous suggestion/grievance concerning treatment, abuse/neglect, harassment, medical care, behavior of other residents or staff members, misappropriation/missing resident property, etc., without fear of threat or reprisal in any form.

VIII QUALITY OF LIFE

SELF DETERMINATION & PARTICIPATION

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

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:
 - a. Sleeping, eating, exercise and bathing schedules
 - b. Personal care needs, such as bathing methods, grooming styles and dress
 - c. Health care scheduling, such as times of day for therapies and certain treatments.
2. In order to facilitate resident choices, staff shall:

- a. Inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation in preferred activities.
 - b. Gather information about the resident's personal preferences, strengths and needs on initial assessment and periodically thereafter, and document these preferences in the medical record.
 - c. Include information gathered about the resident's personal & cultural preferences in the care planning process.
3. The resident shall be encouraged to make choices about aspects of his or her life in the facility, including:
- a. Rooming with the person of his or her choice, providing both individuals consent to the choice and is practicable.
 - b. Whether or not to smoke. (Note: The facility may determine designated smoking areas, but the resident must be able to access these areas freely.)
4. Residents shall be provided assistance as needed to engage in their preferred activities on a routine basis. For example:
- a. If the resident enjoys reading, the facility shall provide access to books (in large print if needed);
 - b. 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.

ACCOMODATION 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.

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

BEHAVIORAL HEALTH SERVICES

Behavioral Health Services

Date

Implemented:

Date Reviewed/

Revised: Aug 2019 Reviewed/

Revised By:

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 emotional 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 resident's goals for care,

d. Account for the resident's experiences and preferences, and

e. Maximize 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. Individualizing 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 programs 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.

TRAUMA INFORMED CARE

Trauma Informed Care

Date

Implemented:

Date Reviewed/

Revised:

Reviewed/

Revised By:

Policy:

It is the policy of this facility to ensure residents who are trauma survivors receive 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 wellbeing. 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:

11. Each resident will be screened for a history of trauma upon admission.
12. The facility social worker or designee will conduct the screening in a private setting.
13. 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.
14. Once the physician’s order is received, the social worker or designee will place the referral to the mental health professional.
15. 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 prior to treatment planning
- c. Challenging or discounting reports of traumatic events
- d. Endorsing a confrontational approach in counseling
- e. Labeling behaviors/feelings as pathological
- f. Failing to provide adequate safety
- g. Minimizing, discrediting or ignoring resident responses
- h. Obtaining urine specimens in a non-private setting

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) F699 – Trauma Informed Care 42 C.F.R. §483.25(m).

Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. www.samhsa.gov. Accessed May 2019.

Department of Health and Human Services, Office of Minority Health. www.minorityhealth.hhs.gov. Accessed May 2019.

DIGNITY

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. Residents shall be treated with dignity and respect at all times.
2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.
3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).
4. Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns.
5. Residents shall be assisted in attending the activities of their choice, including activities outside the facility.
6. Residents' private space and property shall be respected at all times.
 - 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.
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.
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.
9. Staff shall maintain an environment in which confidential clinical information is protected, for example:
 - 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 clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door).
 - 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.

10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

11. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by:

- a. Helping the resident to keep urinary catheter bags covered;
- b. Promptly responding to the resident's request for toileting assistance; and
- c. Allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident.

12. Staff shall treat cognitively impaired residents with dignity and sensitivity; for example:

- a. Addressing the underlying motives or root causes for behavior; and
- b. Not challenging or contradicting the resident's beliefs or statements.

COMMUNICATION SERVICES – TITLE VI

POLICY STATEMENT:

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.

Policy Interpretation and Implementation:

Prospective residents will be identified upon interview and application to the Idaho State Veterans Home whether interpreters or other assistive services are needed. In the case of 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 Community Action Partnership 2980743-5580.

For hearing impaired residents who communicate by signing and for LEP persons, with or without a representative, the ISVH will provide an interpreter from Community Action Partnership 208-743-5580. 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.

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.

EXPERIMENTAL RESEARCH

POLICY STATEMENT:

Residents at the Idaho State Veterans Home have the right to refuse participation in experimental research.

POLICY INTERPRETATION AND IMPLEMENTATION:

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.)
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.
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.
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.
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.
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.
7. Inquiries concerning experimental research activities should be referred to the Administrator, the Director of Nursing Services, or to the Medical Director, as appropriate.

MAIL

POLICY STATEMENT:

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.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. Mail will be delivered to the resident unopened unless otherwise indicated by the Attending Physician and documented in the resident's medical record.
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).
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.
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.
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.)

MISSING/DAMAGED PERSONAL ITEMS

Missing/Damaged Personal Items

Date

Implemented:

Date Reviewed/

Revised: 12/17 Reviewed/

Revised By: KA

Procedure:

It is the procedure of this facility that we do not take total responsibility of all missing or damaged personal resident items to include dentures but will determine responsibility on a case-by-case basis. Once a thorough investigation is completed, a determination will be made as to the responsibility of replacing the missing or damaged item lays with the facility or the resident. This facility will make reasonable efforts to safeguard resident's property and assist with searching or replacing of missing or damaged personal items.

Procedure Explanation and Compliance Guidelines:

Missing/Damaged Personal Items

16. The facility will not be responsible for lost or broken personal items unless it is determined that it was the fault of the facility.

- a. The facility shall determine responsibility for the loss or damage of resident personal items on a case-by-case basis, considering the circumstances surrounding the loss/damage, resident characteristics, and the resident's plan of care.
- b. A blanket procedure of facility non-responsibility for the loss or damaged items is prohibited.

Missing/Damaged Dentures

1. For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days.

- a. Direct care staff are responsible for notifying supervisors or Social Services department of the loss or damage of dentures during the shift that the loss or damage was noticed, or as soon as practicable.
- b. The Social Services department, or designee, shall make appointments and arrange transportation.
- c. The Nursing Department shall assist the Social Services Department or designee in making appointments as needed.
- d. The resident and/or resident representative shall be kept informed of all arrangements.

2. In the case of an acute dental condition or loss/damage of dentures, the facility will take measures to ensure residents are still able to eat and drink while awaiting dental services.

Interventions include, but are not limited to:

- a. Notifying physician of pain or other needs.
- b. Modifying diet consistency (i.e. chopped meats).
- c. Providing room temperature liquids for heat/cold sensitivity.
- d. Referring to dietician for food preferences during the interim.
- e. Referral to speech therapist for chewing or swallowing problems.

3. For residents or resident representatives who do not wish to be referred for dental services:

- a. The physician shall be notified.
- b. The dietician shall be consulted to assess for any necessary change in diet.
- c. The resident's plan of care will be revised to reflect preferences.

4. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record.

PERSONAL PROPERTY

POLICY STATEMENT:

Residents of the Idaho State Veterans Home are permitted to retain and use personal possessions and appropriate clothing, as space permits.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. 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 a television.
2. 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.
3. The resident is permitted to bring room furnishings if:
 - a. The room is large enough to accommodate the furniture;
 - b. The furniture does not infringe upon the rights of others; and
 - c. The furniture does not violate current life safety code requirements.
4. 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.
5. 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."
6. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

RESIDENT RIGHT TO SHARE A ROOM

POLICY STATEMENT:

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 INTERPRETATION AND IMPLEMENTATION:

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.

06/09/20

IDAHO STATE VETERANS HOME – POCATELO

SOCIAL SERVICES PROCEDURE MANUAL

17

ROOM CHANGE/ROOMMATE ASSIGNMENT

POLICY STATEMENT:

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 INTERPRETATION AND IMPLEMENTATION:

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.

06/09/20

TELEPHONE ACCESSIBILITY

POLICY STATEMENT:

The Idaho State Veterans Home has telephones accessible to residents, visitors and employees.

POLICY INTERPRETATION AND IMPLEMENTATION:

1. Public telephones are located near the main lobby or area designated by the facility for employee, resident, and visitor use.
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.
3. Facility phone lines are used for the purpose of conducting day-to-day business and may not be used for private calls.
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.
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.

TELEPHONES, RESIDENT USE OF

POLICY STATEMENT:

Residents at the Idaho State Veterans Home shall have easy access to telephones.

POLICY INTERPRETATION AND IMPLEMENTATION:

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.
2. Telephones will be in areas that offer privacy and accommodate the hearing impaired and wheelchair bound residents.
3. The resident will be given telephone messages when he or she is unable to take incoming calls.
4. Residents who need and/or request help in getting to or using telephones will be provided

with such assistance.

5. Resident wireless telephones are located at the nursing station.

6. Each resident room has a telephone(s) installed for resident local use. Residents are responsible for all long-distance charges. Residents requiring assistance with long distance are to be referred to the Social Service Department.

PETS, ANIMALS, PLANTS

POLICY STATEMENT:

The Idaho Home Veterans Home has domesticated fish and birds that reside in the ISVH-L.

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:

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

2. 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.

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

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

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

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

7. 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.

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

9. 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.

10. 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.

11. Animals will not be allowed in food preparation, dining areas or treatment areas.

12. Equipment that has been in substantial (i.e., more than incidental) contact with animals must be cleaned and disinfected before reuse.

13. Plants and flowers will be cared for by staff not directly involved in resident/patient care, when practical.

14. Direct care staff must wear gloves to care for plants and flowers and perform hand hygiene after removing gloves.

PET THERAPY/VISITATION POLICY:

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.

SMOKING

PURPOSE:

Smoking procedures for this facility are necessary for ensuring the safety of each resident, staff, 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. A copy of the Smoking Policy will be distributed to resident on admission.

PROCEDURE:

- A. Resident smoking is allowed only in designated smoking areas around the facility.
- B. Smoking materials, both tobacco and electronic, will be kept at the Nurses' Station in a locked cupboard.
- C. Residents who wish to smoke will be assessed using the Smoking Classification Assessment tool located in PCC. The IDT team will review the assessment and resident history to make an informed decision as to which category the resident needs to be placed in.
- D. Individuals who wear oxygen and smoke tobacco products must remove oxygen prior to smoking. Individuals who do not wear oxygen and smoke tobacco products will not smoke by a resident who is wearing oxygen

Without Supervision:

- 1. These residents will be given cigarettes and/or electronic cigarette upon request.
- 2. These residents will be allowed to come and go from the smoking areas unattended.
- 3. These residents have scored 12-15 on the BIMS.

Supervision & Limited Supervision:

- 1. Assist resident to smoking area.
- 2. Assist with donning of smoking apron as appropriate.
- 3. Ensure no resident with Oxygen is within 10 feet of the resident smoking.
- 4. Assist to remove oxygen tank and secure if necessary.
- 5. Assist resident to light cigarette.

Extensive Supervision:

- 1. The facility will talk with the family and resident in regard to the facility smoking schedule. They will encourage family to assist resident with complying with the policy set above. One staff member will observe and assist those residents that fall in this category during scheduled smoking times. Staff will monitor that no resident who is wearing oxygen is within 10 feet of the smoking area.
- 2. Resident's care plan will be adjusted to reflect their smoking assessment and classification, along with other related smoking interventions.
- 3. Resident's smoking abilities will be re-assessed in the event of a change of condition or at least quarterly. Staff and visitors must smoke outside the facility in designated areas only.

IX ABUSE AND NEGLECT

SIGNS AND SYMPTOMS OF ABUSE/NEGLECT

POLICY STATEMENT:

The Idaho State Veterans Home will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately.

POLICY INTERPRETATION AND IMPLEMENTATION:

A. "Abuse" is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

B. "Neglect" is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness.

C. The following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that should be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. When in doubt, report it.

1. Signs of/Actual Physical Abuse:

- a. Welts or bruises;
- b. Abrasions or lacerations;
- c. Fractures, dislocations or sprains of questionable origin;
- d. Black eyes or broken teeth;
- e. Improper use of restraints;
- f. Sexual exploitation;
- g. Rape;
- h. Excessive exposure to heat or cold;
- i. Involuntary seclusion;
- j. Multiple burns or human bites.

2. Signs of/Actual Physical Neglect:

- a. Malnutrition and dehydration (unexplained weight loss);
- b. Poor hygiene;
- c. Inappropriate clothing (soiled, tattered, poor fitting, lacking, inappropriate for season);
- d. Decayed teeth;
- e. Improper use/administration of medication;
- f. Inadequate provision of care;
- g. Caregiver indifference to resident's personal care and needs;

- h. Failure to provide privacy;
 - i. Leaving someone unattended who needs supervision.
3. Possible signs/symptoms of psychological abuse/neglect:
- a. Resident clings to abuser/caregiver;
 - b. Paranoia;
 - c. Depression;
 - d. New or increasing confusion or disorientation;
 - e. Withdrawal;
 - f. Inconsistent injury explanation;
 - g. New or more frequent expressions of low self-esteem or self-worth;
 - h. Anger;
 - i. Suicidal ideation.

FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION

1. PURPOSE

Each resident at Idaho State Veterans Home –Pocatello 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- Pocatello 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-L requires all employees, managers, supervisors, agent, and contractors to report any reasonable suspicion of crimes committed against a resident. The Idaho State Veterans Home-Pocatello 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-L 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-Pocatello 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 – Pocatello. 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-Pocatello 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-L 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-L 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- L 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-L- 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-L 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

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-L 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-L 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-L 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-L 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-L, 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.

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.

The following steps will be taken with investigations:

1. Interviews and obtains 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 1-2 shifts prior.

2. Interviews and obtains written, dated and signed statements from staff witnesses or other available witnesses.

3. If a staff member is implicated in the incident, the person will be instructed to discuss situation with the Administrator or the Director of Nursing.

4. Continued facility investigation may occur, as needed, over the next 24-48 hours.

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.

1. 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?

a. What did the staff do immediately to ensure the safety of both residents?

b. Was there any physical injury and if so, how was the injury addressed?

7. What was the resident's emotional status?

8. Who was notified: Administrator, DNS, DSS, family?

9. Were there any changes in medication?

10. Were there any recent changes in physical condition; i.e.: infection?

11. Was the care plan amended?

e. Nurse progress summary notes at the end of each shift for 72 hours may include:

12. The emotional state of the resident(s).

13. Any verbal or physical aggression towards others.

14. Any change in medication.

15. Any physical changes.

16. 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, 03/20

REASONABLE SUSPICION OF A CRIME AGAINST A RESIDENT

REPORTING FORM

INSTRUCTIONS: Contact and submit this completed form to the Bureau of Facility Standards and Pocatello 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 – Pocatello.

IDAHO STATE VETERANS HOME CONTACT:

Josiah Dahlstrom, Administrator

1957 Alvin Ricken Drive , Pocatello, ID 83201

Phone: (208) 235-7800

Fax: (208) 235-7801

Email: Josiah.dahlstrom@veterans.idaho.gov

Reported to the State Survey Agency? Yes No

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 No

Date Reported: ___/___/___ Time: _____

POCATELLO CITY POLICE DEPARTMENT CONTACT:

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 _____)

Resident Name: _____ DOB: _____ SSN#: _____

Description & Location of Incident:

Was there serious bodily injury as a result of the incident? No ___ YES ___ (must be reported within 2 hours)

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, 12/17

FIRST RESPONSE GUIDE FOR ABUSE REPORTING

Witness observes abuse

taking place, or has

reasonable suspicion that

abuse is taking place

(abuse is physical, verbal, financial,

mental, neglect) and informs

supervisor or charge

nurse immediately

Supervisor informs

administrator and

administrator designee

(SWS) determines if

reasonable suspicion of

abuse has occurred. If

substantiated, SWS

proceeds to:

Witness completes

form for SWS to fax

to law enforcement

and SWS calls L&C

with 7 steps. Both

completed within 2

hours or 24 hours

pending degree of

harm.

Administrator and DNS

notified of reasonable

suspicion to proceed

with investigation
which is initiated and
completed and faxed to
L&C within five days.

Revised: 3/1/13

X 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 (ISVH) 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.

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 constitute 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 investigations 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. Regulatory references include 483.13(b) and (c), and IDAPA 16.03.02.100.12 (c) and (f). Refer to Informational Letter #2005-1.

SCREENING & TRAINING (COMPONENT #1/#2)

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 admission will be screened. Training on issues related to abuse prevention practices commences with the employee's orientation and continues on a regular basis throughout the employee's tenure at ISVH.

POLICY IMPLEMENTATION

1. 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.

2. Employee Training

a. Orientation

b. Mandatory in-services include but are not limited to:

- 1) Resident rights, confidentiality, dignity, privacy, personal and property rights, and abuse, neglect, misappropriation of property prevention and reporting.
- 2) Weekly unit behavioral meetings
- 3) Universal precautions
- 4) Fire and Safety including emergency preparedness

3. Voluntary In-Services

- a. Offered on a regular basis and include training to increase staff knowledge of needs

specific to certain residents.

PREVENTION (COMPONENT #3)

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 AND 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.);
 - i. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect;
 - j. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues;
 - k. 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 individuals or those who have had a finding of such action entered into the state nurse aide registry or state sex offender registry;

- l. Involving Attending Physicians and the Medical Director when findings of abuse have been determined;
 - m. Involving qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents;
 - n. 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;
 - o. Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met; and
 - p. 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.

IDENTIFICATION/INVESTIGATION (COMPONENT #4/#5)

POLICY STATEMENT

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

POLICY INTERPRETATION AND 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, as 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;
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.
Important telephone numbers for reporting purposes are as follows:
Bureau of Facility Standards' Hotline (208) 364-1899
Bureau of Facility Standards (208) 334-6626
Bureau of Facility Standards' Facsimile (208) 364-1888
Idaho Board of Nursing (208) 334-3110
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 will be removed from the facility and may not work at any ISVH until the investigations is completed.
(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.
23. 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.

24. 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.

25. Inquiries concerning abuse reporting and investigation should be referred to the Administrator, Director of Social Services, or the Director of Nursing Services.

PROTECTION (COMPONENT #6)

POLICY STATEMENT

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

POLICY INTERPRETATION AND 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 ISVH until the investigation is completed and reviewed by the Administrator.

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. Within 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 6, Reporting/Response.

REPORTING/RESPONSE, FACILITY MANAGEMENT (COMPONENT #7)

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 AND IMPLEMENTATION

- a. 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.
- b. To help with recognition of incidents of abuse, the following definitions of abuse are provided:
 - c. "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
 - d. "Physical Abuse" includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.
 - e. "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability.
 - f. "Sexual abuse" is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
 - g. "Involuntary seclusion" is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative (sponsor). (Note: Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.)
 - h. "Mental abuse" is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services.
 - i. "PSYCHOSOCIAL HARM" involves, but is not limited to, extreme embarrassment, ongoing humiliation, degradation as a human being, and fear or panic at the thought of the public or unknown persons accessing the information. This would include using any

type of equipment (e.g. cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs or audio/video recordings of a resident on multimedia messaging platforms or on social media networks/platforms. More specifically, unless authorized by the Home Administrator, covered individuals are prohibited from taking, keeping, using, or distributing photographs or audio/video recordings of any resident, resident living space, or resident belonging. Furthermore, photographs or recordings of any resident(s), or in a manner that it is used, that demeans or humiliates the resident(s) (regardless of whether the resident provided consent and regardless of the resident's cognitive status) is prohibited. Employees must also comply with IDVS Personnel Policies concerning Electronic Communications and Social Media Usage (Section 3C4).

j. "Neglect" is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

k. "Injury of unknown source" is defined as an injury that meets both of the following conditions:

1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
2. The injury is suspicious because of: the extent of the injury; or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or the number of injuries observed at one particular point in time; or the incidence of injuries over time.

"Misappropriation of resident property" is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

1. 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.
2. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to their supervisor, the Administrator, or the Director of Nursing Services.
3. The following information should be reported if 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.
4. 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.
5. Staff members and persons affiliated with this facility shall not knowingly: Attempt, with or without threats or promises of benefit, to induce another to fail to report an incident of mistreatment or other offense; Fail to report an incident of mistreatment or other offense; Alter, change without authorization, destroy or render unavailable a report made by another; and/or Screen reports or withhold information to reporting agencies.
6. 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 and informed of such incident.
7. When an incident of a crime against a resident is reasonably 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."
8. 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.)
9. 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.

10. A completed copy of documentation forms and written statements from witnesses, if any, will be provided to the Administrator.
11. 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.
12. The Social Services Department will give the Administrator and the Director of Nursing Services a written report of his/her findings.
13. All phases of the investigation will be kept confidential in accordance with the facility's policies governing the confidentiality of medical records.
14. 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.
15. Inquiries concerning abuse reporting and investigations should be referred to the Administrator, Director of Social Services, and/or to the Director of Nursing Services.

Revised 10/16

ABUSE INVESTIGATION STEPS PACKET

1. Verification Form, Step 1-abuse verified, proceed , Steps 2-6
2. Abuse Notification, reporting form faxed and call to L&C
3. Investigation Report/Synopsis of Event
4. Investigation Details
 - a. Interviews
 - b. Records Review
 - c. Records Review, significant information summary
 - d. Physical Evidence Review
 - e. Physical Evidence Review, significant information summary
 - f. Recreate the Event, summarize what occurred
5. Conclusion
6. Investigation of Resident Abuse Form faxed to Bureau of Facility Standards with attachments

STEP 1 – VERIFICATION FORM

STEP #1 VERIFICATION FORM

Date: Time: Res #

Name of person completing verification:

Put an "X" by each questions. Answer "yes" if you do not know whether an event could fit the criteria.

Yes No

A. Abuse is alleged or reported

1. Deprivation of goods or services
2. Inappropriate sexual contact
3. Inappropriate physical contact (pushing, hitting, biting, etc.)
4. Unreasonable confinement
5. Intimidation or punishment
6. Bad remarks (written or verbal)
7. Resident was humiliated, harassed or threatened

Yes No

B. Neglect is alleged or reported

1. Failure to provide goods or services
2. Failure to provide timely, consistent or adequate treatment or care
3. Repeated resident-to-resident assaultive behavior
4. Repeated failure to follow a care plan
5. Harm occurred because of failure to follow a care plan

Yes No

C. Misappropriation of Resident Property is alleged or reported without resident permission resident property was

1. Taken
2. Misplaced
3. Destroyed
4. Hidden
5. Used without consent

Yes No

D. Injury of Unknown Source is alleged or reported

1. Injury was not observed, or the resident could not explain what happened,
or
2. The injury is suspicious because of its extent, location or number (s)

Totals

If there are one (1) or more "yes" answers, you must begin an abuse investigation and continue with the clinical track. If all the

answers are "no," no abuse investigation need be initiated. Continue only with the clinical track. However, if at any time during

your review you find that the event could or does match any of the criteria, notify the facility administrator or designee according

to facility policy and begin an abuse investigation.

Notified Administrator or designee according to facility policy

Investigation began on date: By (Name)

Signature: Date: Time:

STEP 2 – ABUSE NOTIFICATIONS

If you determine that an abuse investigation is warranted, you must

assure that the Reasonable Suspicion of a Crime Against a Resident

Reporting Form is completed and faxed as instructed on the form.

Then call the following information to the Bureau of Facility Standards

hotline number @ 364-1899

(Fax form and call within 2 hours of a reasonable suspicion with a serious bodily injury or within

24 hours if a reasonable suspicion without serious bodily injury)

The Hotline requires the following information:

1. Facility Name & City
2. Name of reporter and title
3. Date and Time of incident
4. Name(s) of resident(s) and name spelled out loud
5. Social Security # of resident(s)
6. Outline of incident
7. Description of any injuries

IDAHO STATE VETERANS HOME- Pocatello

REASONABLE SUSPICION OF A CRIME AGAINST A RESIDENT REPORTING FORM

INSTRUCTIONS: Call the Bureau of Facility Standards hotline number below and provide the information requested on the recording. Call the Pocatello City Police Department using the number below and request a fax number. Fax this completed form

to the Pocatello City Police Department. The call to the Bureau of Facility Standards and then fax to the Pocatello City Police Department must be made 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 – Pocatello.

IDAHO STATE VETERANS HOME CONTACT:

Josiah Dahlstrom, Administrator

1957 Alvin Ricken Drive, Pocatello, Id 83201

Phone: (208) 235-7800

Fax: (208) 235-7801

Called to the State Survey Agency? Yes No

Date Reported: ___/___/___ Time: _____

BUREAU OF FACILITY STANDARDS CONTACT:

3232 Elder Street, PO Box 83720, Boise, ID 83720

Hotline: (208)364-1899

Faxed to the Local Law Enforcement? Yes No

Date Reported: ___/___/___ Time: _____

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 _____)

Resident Name: _____ DOB: _____ SS#: _____

Description & Location of Incident:

Was there serious bodily injury as a result of the incident? No ___ YES ___ (must be reported within 2 hours)

INDIVIDUAL[S] REPORTING

THIS REPORT IS MADE BY THE FACILITY ON BEHALF OF ALL COVERED INDIVIDUALS LIST 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: _____

STEP 3 – SYNOPSIS OF EVENT

Investigator name and title:

Date: Time:

STEP 3 – SYNOPSIS OF EVENT

Resident's Name:

Resident's Unit: Room:

When was the event discovered? Date: Time:

Admission Date: DOB:

Date of incident report: Date: Time:

Resident's Diagnosis:

Who reported Event-First Responder:

First Person of Authority on the scene:

Verification done by:

Where discovered?

What time discovered?

What was discovered?

Brief description of event:

Who was the resident involved?

Who discovered or reported the event?

When did the alleged event occur or when was it discovered?

Where was the event discovered or where did the person reporting it say it happened?

What was discovered?

How was the event discovered or how did the reporter say it happened?

Investigation ID

STEP 4 – INVESTIGATION DETAILS

STEP 4-Investigation Details

Employees Interviewed Date Time Res #

E-1:

E-2:

E-3:

E-4:

E-5:

E-6:

(Continue list on next page if more space is needed)

Residents Interviewed Date Time Res #

R-1:

R-2:

R-3:

R-4:

R-5:

R-6:

(Continue list on next page if more space is needed)

Other People Interviewed Date Time Res#

P-1:

P-2:

P-3:

P-4:

P-5:

P-6:

(Continue list on next page if more space is needed)

INTERVIEWS: SIGNIFICANT INFORMATION

Summarize any significant information gathered from these interviews.

Upon review of the fore-referenced testimonial evidence, the following was determined important to this investigation:

RECORDS REVIEW-Include review of assessments, care plans, progress notes, caregiver guides, etc.

Medical Records Reviewed Date Time Res #

MR-1:

MR-2:

MR-3:

Employee Personnel Records Date Time Res #

PR-1:

PR-2:

PR-3:

Chart Notes Reviewed Date Time Res #

CR-1:

CR-2:

CR-3:

Care Plan Notes Reviewed Date Time Res #

CP-1:

CP-2:

CP-3:

Employee Time Sheets Reviewed Date Time Res #

TS-1

TS-2:

TS-3:

Medical Orders Reviewed Date Time Res #

MO-1:

MO-2:

MO-3:

Other documents Reviewed Date Time Res #

O-1:

O-2:

O-3:

O-4

O-5

O-6

O-7

O-8

O-9

RECORDS REVIEW: SIGNIFICANT INFORMATION

Summarize any significant information gathered from review of medical records, care plans, personnel record, etc..

Upon review of documentation, the following was determined important to this investigation:

PHYSICAL EVIDENCE REVIEW

Describe Specific Piece of Evidence Date Time Res #

PE-1:

PE-2:

PE-3:

PE-4

PE-5

PE-6

PE-7

PE-8

PE-9

PE-10

PE-11

PE-12

PHYSICAL EVIDENCE: SIGNIFICANT INFORMATION

Summarize any significant information gathered from individual pieces of evidence including incident/accident report if available

RECREATE THE EVENT: SUMMARY

Using the information gathered, summarize what occurred, the order in which it occurred, and what evidence supports this re-creation of the event. In the narrative also identify and explain any gaps in the timeline, any contradictions with other evidence and any significant information gathered in the process of recreating the event.

STEP 5-CONCLUSION

The facts in this investigation: Support Do not support

The allegation of

The analysis of:

1. All the evidence (physical, documentary and testimonial), and
2. The recreation of the event has led this investigator to determine that the following evidence supports the conclusion of this investigation:

(Write a conclusion, answering the cardinal questions, who, what, when, where, why and how.)

Investigator Signature: _____

Date: _____ Time: _____

Idaho State Veterans Home, Pocatello

Investigation of Resident (fill in type of abuse)

Reporter:

Reporter Phone #:

Date/Time of Incident:

Date of Investigation:

Date called to Bureau of Facility Standards (208-364-1899):

Date of fax to Bureau of Facility Standards (208-364-1888):

Location of Incident:

Staff Involved:

Resident(s) Involved and SS#:

Description of Occurrence:

Background Information:

Investigation:

Injuries Incurred:

ISVH Corrective Action Plans to Prevent Repeat Incidents:

Social Worker Date

Director of Nursing Services Date

Josiah Dahlstrom, Administrator Date

Staff Interviews

Resident Interviews

In-Services Completed

RESIDENT TO RESIDENT ALTERCATION

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, or to the Administrator.

REASONABLE SUSPICION POSTING NOTICE

IF YOU HAVE REASONABLE SUSPICION THAT A CRIME HAS OCCURRED AGAINST A RESIDENT OR PERSON RECEIVING CARE AT THIS FACILITY, FEDERAL LAW REQUIRES THAT YOU REPORT YOUR SUSPICION DIRECTLY TO BOTH LAW ENFORCEMENT AND THE STATE SURVEY AGENCY

If you believe the crime involves serious bodily injury including criminal sexual abuse to the resident, you must report it immediately, but no later than 2 hours after forming the suspicion.

OR

If the crime does not appear to cause serious bodily injury to the resident you must report it within 24 hours after forming the suspicion.

WHO MUST REPORT

- Individuals who must comply with this law are: owner(s), operators, employees, managers, agents or contractors of this LTC facility. This law applies to the above individuals associated with nursing facilities, skilled nursing facilities, hospices that provide services in LTC facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

PENALTIES FOR NOT REPORTING

- If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to \$300,000 and possible exclusion from participation in any Federal health care program.

NO PENALTIES FOR REPORTING

- A LTC facility cannot punish or retaliate against you for lawfully reporting a crime under this law.

Examples of punishment or retaliation include: firing/discharge, demotion, threatening these actions, harassment, and denial of a promotion or any other employment-related benefit or any discrimination against an employee in the terms and conditions of employment. In addition, a facility may not file a complaint or a report against a nurse or other licensed individual or employee with the state professional disciplinary agencies because the individual lawfully reports the suspicion of a crime.

- Employees can file a complaint with the state survey agency against the facility if there is retaliation for reporting a reasonable suspicion of a crime to the appropriate authorities.

HOW DO I REPORT

- Individuals reporting suspicion of a crime must call, fax, or email both local law enforcement and the state survey agency.

- Multiple individuals can report a suspicion of a crime jointly and will be considered in compliance with the law.

However, an individual may report the suspicion separately if he/she elects to do so and the facility may not prevent an individual from reporting.

If you reasonable suspect that a crime has occurred against a resident receiving care at the ISVH-L, you must report your suspicion to the police and the State Survey Agency:

Bureau of Facility Standards Pocatello Police Department

Hotline: (208) 364-1899 (208) 746-0171

Facsimile: (208) 364-1888

To file a complaint because you believe you have been punished or retaliated against for reporting the suspicion of a crime, contact the Bureau of Facility

Standards at (208) 334-6626.

For additional details regarding you responsibilities and rights under the federal law, please see the ISVH-L Nursing Procedure concerning Reasonable Suspicion of a

Crime Against a Resident (Section XII).

XI MOOD & BEHAVIOR

MEDICATION REVIEW COMMITTEE

POLICY STATEMENT

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).

POLICY INTERPRETATION AND IMPLEMENTATION

The committee is comprised of the RN Manager, Assigned Social Worker, Pharmacist and MD.

Frequency, Location, Time and Place

1. Will meet quarterly
2. Meetings will occur on the unit reviewed
3. Social Work Services to coordinate time and date.
4. All residents prescribed psychotropic medication which includes anti- psychotic, antianxiety, anti-depressant and hypnotic medication or other medication for behavior will be reviewed at least quarterly.
5. Social Work Services will chair the meeting.

Quarterly Psychoactive Medication Review Form

1. Social Work Services will complete the assessment form with the information requested.
2. The information contained on the assessment will be reviewed by the committee.
3. Any additional information will be presented at the review meeting and documented.
4. The committee will make recommendations and those recommendations documented.
5. All attendees at the meeting will sign the attendance record.
6. Changes including MD orders, Care Plan Revisions will be made prior to the adjournment of the meeting.
7. Social Work Services will document a progress note in the Resident chart that the meeting took place and the quarterly assessment is located under assessments in the Residents medical file..

QUARTERLY MOOD/BEHAVIOR MEDICATION REVIEW

QUARTERLY MOOD/BEHAVIOR MEDICATION REVIEW

DATE: _____ RESIDENT: _____ DOA: _____

GDR Contraindicated? Yes d/t _____ NO _____

Relevant Diagnosis: Depression _____ Bipolar d/o _____ Dementia/agitated features _____

Dementia/paranoid features _____ Schizoaffective d/o _____ Other _____

Current M/B Medications/Date of Initiation:

Anti-anxiety: _____

Antidepressant: _____

Antipsychotic: _____

Mood Stabilizer: _____

Other: _____

Assessments: AIMS _____ BIMS _____ PHQ _____

Pain/Environmental Factors: _____

Behavioral Trend: _____

Attempted Dose Reduction & Outcome: _____

Committee Recommendations: _____

MD: _____ RNM: _____

Pharmacist: _____ SW: _____

DEMENTIA CARE & PSYCHOPHARMACOLOGICAL USE

POLICY STATEMENT

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.

POLICY INTERPRETATION AND IMPLEMENTATION

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:

Person-Centered Care

Quality Staff and Quantity of Staff

Thorough Evaluation of New or Worsening Behaviors

Individualized Approaches to Care

Critical Thinking Related to Antipsychotic Drug Use

Engagement of our Resident and/or Representative in Decision-Making

All residents are provided individualized care by:

Information obtained from a thorough Psychosocial History Assessment;

Information obtained from the Activity Assessment;

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

Prior/Present psychiatric/psychological/medical information;

Observation;

BIMS and PHQ 9 assessments;

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.;

And, any additional information that will assist staff in formulating a personalized plan of care.

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:

Recognition and Assessment: comprehensive psychosocial and medical information about the resident;

Cause identification and diagnosis: utilization of knowledge gained about the resident to identify causes of behavior and related symptoms;

Development of a comprehensive care plan: developing a well-defined problem with measurable objectives and individualized interventions;

Individualized approaches and treatment: implementation of the care plan interventions to address the needs of the resident through staff training and an interdisciplinary approach;

Monitoring, follow-up and oversight: the resident's progress toward defined goals and interventions are reviewed, monitored, and modified as needed;

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.

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.

The home is furthermore committed to the effective and appropriate use of psychopharmacological medications. By following the key principles and gathering information for individualized personcentered care, such medications are used 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.

The home monitors antipsychotic medications and all medications prescribed for mood and behavior by:

Evaluation of any resident who does not require PASRR screening and is admitted on an antipsychotic medication;

Following Psychotropic Medication Justification Tracking and Charting guidelines;

Mood/Behavior Medication Committee Meetings held quarterly;

Pharmacy review;

VA Medical Center Behavioral Health Services consultation;

Monitoring side effects on the Medication Administration Record;

Abnormal Movement Scale Assessment;

Following PRN Guideline Use;

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.

ANTIPSYCHOTIC DRUG USE CONSENT FORM

Informed Consent for Antipsychotic Drug Use

in Dementia Residents and Antipsychotic Use for Approved Diagnoses

Resident Full Name: _____

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 is in 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 whom 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 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 substantially prevents necessary physical care
- 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 safe guarding 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 characteristic(s) of the patients is not clear.

Your primary doctor or licensed care provider 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 known 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

RISKS VERSUS BENEFIT NOTIFICATION

RISK VERSUS BENEFIT OF THE USE OF CERTAIN MEDICATIONS

FOR DEMENTIA RESIDENTS & THEIR AGENTS

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

Medication/Current Dosage Medication Changes/Date

_____	_____
_____	_____
_____	_____
_____	_____

My signature indicates the following:

- I understand the information contained in the letter and have no further questions. _____ Initial
- I DO want to continue the use of antipsychotic medication. _____ Initial
- I DO NOT want to continue the use of antipsychotic medication. _____ Initial

Print Name and Decision-making authority:

Signature of resident/Decision-Maker Date

Signature of Health Care Professional Date

XII RESIDENT RIGHTS

POLICY STATEMENT

POLICY STATEMENT

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.

POLICY INTERPRETATION AND IMPLEMENTATION

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.

Staff is educated about resident rights and provided with a copy of resident rights through:

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.

All residents have the right to:

- Exercise his/her rights
- Be informed about what rights and responsibilities he/she has
- If he or she wishes, have facility manage their 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, letters, packages, etc.
- 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 team determines it is safe
- Refuse a transfer from a distinct part, within the institution

RESIDENT'S BILL OF RIGHTS

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 won't 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, exploitation, and misappropriation of funds.

7. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. 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 wellbeing.

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. Roommate

1. The resident has the right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents' consent to the arrangement.

O. 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.

P. Admission, Transfer and Discharge Rights

1. Transfer and discharge include movement of a resident to a placement out of the facility.

2. 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.

3. Documentation – When a facility discharges or transfers a resident, the primary physician must document in the resident's chart.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. The facility management maintains identical policies regarding transfer and discharge and service provision to all individuals regardless of the payment source.

11. 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.

Q. 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, verbal abuse or neglect, exploitation, 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.

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

3. Staff treatment of Residents

i. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse, exploitation, and misappropriation of resident property.

ii. The facility management must ensure that all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source, exploitation, 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.

R. 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

3. 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.

4. 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.

5. 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.

6. 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. 3/17

SEXUAL EXPRESSION OF RESIDENTS

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 decisions.

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 from 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, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (November 2017 Revision) F550 – Resident Rights. 42 C.F.R. §483.10.

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) F600 – Free from Abuse and Neglect. 42 C.F.R. §483.12.

XIII IDVS SUICIDE PREVENTION

POLICY AND PROCEDURE

The Division of Veterans Services is committed to promoting the health and safety of its residents, clients, employees, and any other person in the workplace. Consequently, this suicide prevention and reporting policy is intended to raise awareness and provide guidance to employees, supervisors, and managers in carrying out an appropriate response to suicidal behavior in the workplace.

Suicide is often preventable, especially in situations where agencies support intervention and provide the knowledge which allows an individual to intervene with a person at risk. The Division of Veterans Services will ensure that all persons in the workplace, and all clients of the Division, are aware of the resources available to appropriately respond when concerned about the suicide risk of oneself or a that of a resident, client, coworker, or any other person in the workplace, and that those experiencing suicidal behaviors understand that seeking help is encouraged and that help is available. It is essential that each Division Program establish a culture of seeking and obtaining help for suicidal behaviors among residents, clients, employees, and all others in the workplace. It is important to recognize any threat as a request for help. A threat to harm oneself is a real and imminent emergency. Because there is no way to know if the threat is serious or simply a cry for help, should a coworker, client, resident, intern, contract employee, volunteer or visitor threaten to harm themselves, employees must respond quickly and decisively to prevent a tragic outcome. Even if the person does not actually intend to harm themselves, threatening suicide can be a way of voicing hopeless feelings and the desire on the part of the person to end the pain they are feeling. Therefore, should a resident, client, coworker, or any other person in the workplace express suicidal intentions, or discuss suicidal thoughts and feeling, these threats shall be taken seriously and must be reported immediately to the appropriate personnel and/or authorities to keep the person safe and get them the help they need.

SECTION 1 – INTERVENTION PROCEDURES

The Division seeks to offer support and guidance should an employee express suicide ideation, show suicidal behavior, or encounters a resident, client, coworker, or other person in the workplace expressing suicide ideation or showing suicidal behavior. While it is impossible to anticipate every scenario, it is the Division's intent to strongly encourage employees to act in their best interest, and the best interest of their fellow workers, residents, and clients. The following actions are guides to that end:

1 A If You Are Considering Suicide

Thoughts of suicide are very frightening for both you and your family. If you have thoughts of

suicide, please seek help from experts or colleagues.

Immediate Warning Signs (for example):

- Thinking or talking about wanting to harm yourself.
- Looking for ways to commit suicide.
- Talking or writing about death.
- Feeling overwhelming emotions like rage, anger, or shame.
- Experiencing a serious triggering event like a death or other life-altering issue.

Seek immediate help:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

- Go to the emergency room.
- Call 911.
- Call or Text 1-208-398-4357 (Idaho Suicide Prevention Hotline- available 24 hours a day staffed by people trained to assess suicide risk).
- If a Veteran, call the Veterans Crisis Line and Military Crisis Line (1-800-273-8255 Press 1).
- Call the Employee Assistance Program (24/7) 1-877-427-2327

Other Warning Signs (for example):

- Acting recklessly or taking risks.
- Increasing your alcohol or drug use.
- Seeing no reason to live.
- Feeling hopeless or trapped.
- Having dramatic mood changes.
- Withdrawing from family, friends, and others.
- Feeling anxious or agitated.
- Retreating to bed to sleep most of the time.

You should consider:

(if calling from a state-owned landline phone, always

dial "9" for an outside line)

- Confiding in someone you trust (i.e., doctor, clergy, counselor, colleague, or mental health professional).
- Contact the Human Resource Office.
- Calling the Employee Assistance Program (24/7) 1-877-427-2327.
- Calling 211 (Can help find resources and referrals in Idaho).
- Calling or Texting 1-208-398-4357 (Idaho Suicide Prevention Hotline-available 24 hours a day staffed by people trained to assess suicide risk).
- If a Veteran, calling the Veterans Crisis Line and Military Crisis Line (1-800-273-8255 Press 1).

1 B Helping a Coworker, Contract Employee, Intern, Volunteer, or Visitor Who May Be Suicidal

As employees, you spend a great deal of time at work and have day-to-day contact with your coworkers and all others who are in the workplace. You may observe changes in others behavior and may see them at critical times in their life. Coworkers are often the first to notice that a fellow employee or peer is experiencing a crisis, suicidal behavior and/or suicide ideation.

If an employee has reason to believe a coworker is in danger of suicide, take him/her seriously until it is determined that there is no danger.

When approaching a person who you think may be at imminent risk for suicide, speak to him/her directly and compassionately. Show you care. Depending on your relationship with him or her, you might say:

- You seem to be in great pain; I know where we can get some help.
- I'm frightened/concerned about you based on (state what you saw or heard).
- Are you considering harming yourself? Are you thinking about suicide?
- Do you have access to weapons or things that can be used as weapons to harm yourself?
- What can I do for you; I want to get you the help you need.
- I want to help.
- You are not alone!

Take immediate and prompt action if the person is (for example):

- Expressing a desire to harm him/herself.
- Talking or writing about death or suicide.
- Looking for ways to commit suicide.
- Seeing no reason to live.
- Feeling hopeless.
- Displaying unusual anger, anxiety or agitation.
- Complaining about not sleeping or sleeping all the time.

Seek immediate help:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

- Stay calm and stay with the person (or make sure the person is in a private, secure place with another caring person) until you can find help.
- If it can be done safely, remove any objects that could be used in a suicide attempt.
- Call 911 (if coworker or other person has the means at hand to do self-harm or is out of control).
- Immediately report threat of self-harm, whether written or oral and from any source, to your supervisor.
- Supervisors shall immediately report such incidents to the Program Executive or Home Administrator, and to the Human Resource Office.
- The Program Executive and/or Human Resource staff will then determine the best course of action to include:
 - Assisting the employee/person with calling 1-208-398-4357 (Idaho Suicide Prevention Hotline- available 24 hours a day staffed by people trained to assess suicide risk).

- The Idaho Suicide Prevention Hotline Professional will then advise and provide guidance.
- Should the employee/person deny assistance with calling the Hotline, and instead choose to leave or attempt self-harm, call 911. Explain the situation, requesting for an officer to make a wellness check. Be prepared to furnish the person's full name, location and the person's contact number, if possible.
- Provide employee (for state employees only) with the information related to the Employee Assistance Program information - (24/7) 1-877-427-2327.
- The Program Executive shall report the incident to the Deputy Administrator and Division Administrator.

If you are concerned about the recent alarming behavior changes listed in the left box below, it is appropriate to have a private conversation with him/her. Again, depending on your relationship with this person, you might say:

- There seems to be something weighing you down; I'm willing to talk about it with you.
- You haven't been yourself lately; do you want to talk about it?
- I'm worried; you seem anxious/desperate/detached recently.
- Is there anything wrong that talking with a professional might help?

If you observe that a coworker/person may be (for example):

- Feeling hopeless.
- Acting recklessly or taking risks.
- Having dramatic mood changes.
- Withdrawing from family, friends, and others.
- Expressing rage or uncontrolled anger.
- Stating he/she feels like a burden to others or feels trapped.
- Displaying unusual anxiety or agitation.
- Complaining about not sleeping or sleeping all the

time.

Encourage the coworker/person to:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

- Confide in a professional person of trust (i.e., doctor, clergy, counselor, or mental health professional).
- Contact the Human Resource Office.
- Call the Employee Assistance Program (24/7) 1-877-427-2327 (benefit for state employees only).
- Call 211 (provides assistance in finding resources and referrals in Idaho).
- Call or Text 1-208-398-4357 (Idaho Suicide Prevention Hotline- available 24 hours a day staffed by people trained to assess suicide risk.

Notify your supervisor:

- Report all reasonable concerns to your supervisor.
- Supervisors shall report such incidents to the Program Executive or Home Administrator, and to the Human Resource Office.

1 C Helping a Resident of the Veterans Homes Who May Attempt Suicide

Suicide in long-term care patients is most often associated with depression. The level of depression that a long-term care patient can experience ranges from minor depression to major depression.

Depression can also develop in patients who were previously happy individuals due to the changes associated with going into a nursing home setting, changes in medical conditions, or other

environmental changes. Although all residents are properly assessed upon admission, monitored

and regularly reassessed per regulations thereafter, and care plans are developed for at-risk patients, it is essential for employees to recognize the signs of depression and immediately report

any change in condition to the appropriate personnel per the nursing procedure manual.

If an employee has reason to believe a resident is in danger of suicide, take him/her seriously until it is determined that there is no danger.

When approaching a resident who you think may be at imminent risk for suicide, speak to him/her directly and compassionately. Show you care. You might say:

- You seem to be in great pain; I know where we can get some help.
- I'm frightened/concerned about you based on (state what you saw or heard).
- Are you considering harming yourself? Are you thinking about suicide?
- What can I do for you; I want to get you the help you need.
- I want to help.
- You are not alone!

Take immediate and prompt action if the resident is (for example):

- Expressing a desire to harm him/herself.
- Talking or writing about death or suicide.
- Looking for ways to commit suicide.

Seek immediate help:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

- Stay calm and stay with the resident until help arrives.
- Pull the call-light for assistance.
- If it can be done safely, remove any objects that could be used in a suicide attempt.
- If the resident is in imminent danger, shout for assistance.
- Call 911 (if the resident has the means at hand to do self-harm or is out of control and you are unable to calm the resident down to transfer safely to the emergency room).
- Transfer the resident to the emergency room for proper evaluation if the resident was never in any imminent danger for self-harm and it can be done safely.
- Abide by the Nursing Procedures for such incidents.
- Immediately report threats/attempts of self-harm to the unit RN Manager, Director of Nursing, and the designated Social Worker.

- The Director of Nursing shall report such matters

to Home Administrator.

- The Home Administrator shall report the incident

to the Bureau of Facility Standards per

state regulations (Informational Letter 2014-4

Resident Abuse Reporting) and to the Deputy

Administrator and Division Administrator.

1 D Helping a Veteran Client or Veterans Family Member In-Person or Via Telephone

Who May Be Suicidal

According to the U.S. Department of Veterans Affairs, some studies have found that combat trauma is related to suicide. In this research, combat trauma survivors who were wounded more than once or put in the hospital for a wound had the highest suicide risk. This suggests suicide risk in Veterans may be affected by how intense and how often the combat trauma was. Suicide risk may be higher in trauma survivors because of the symptoms of post-traumatic stress (PTSD) or it may be due to other problems, like depression.

Research suggests that for Veterans with PTSD, the strongest link to both suicide attempts and thinking about suicide is guilt related to combat. Many Veterans have very disturbing thoughts and extreme guilt about actions taken during times of war. These thoughts can often overwhelm the Veteran and make it hard for him or her to deal with the intense feelings.

Veterans and Veteran family members may also enter into a state of depression and have suicidal thoughts following changes in life and financial status, such as receiving an unfavorable decision towards their Veterans Benefit Claim or the loss of a loved one.

If an employee has reason to believe a Veteran is in danger of suicide, take him/her seriously until it is determined that there is no danger.

When speaking to a Veteran/family who you think may be at imminent risk for suicide, speak to him/her directly and compassionately. Show you care. Depending on your relationship with him or her, you might say:

- You seem to be in great pain; I know where we can get some help.
- I'm frightened/concerned about you based on (state what you saw or heard).
- Are you considering harming yourself? Are you thinking about suicide?
- Do you have access to weapons or things that can be used as weapons to harm yourself?
- What can I do for you; I want to get you the help you need.
- I want to help.
- You are not alone!

Take immediate and prompt action if the

Veteran/family is (for example):

- Expressing a desire to harm him/herself.
- Talking or writing about death or suicide.
- Looking for ways to commit suicide.
- Seeing no reason to live.

Seek immediate help:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

In-Person:

- Stay calm and stay with the person (or make sure the person is in a private, secure place with another caring person) until you can find help.
- If it can be done safely, remove any objects that could be used in a suicide attempt.
- Call 911 (if Veteran or other person has the means at hand to do self-harm or is out of control).
- Immediately report threat of self-harm, whether written or oral and from any source, to the Veterans Service Officer or your supervisor.
- Supervisors shall immediately report such incidents to the Program Executive or Deputy Administrator.
- The Veterans Service Officer, Program Executive or Deputy Administrator, will then determine the best course of action to include:
 1. Assisting the Veteran/family with calling the Veterans Crisis Line and Military Crisis Line (1-800-273-8255 Press 1).
 2. Assisting the Veteran/family with calling 1-208-398-4357 (Idaho Suicide Prevention Hotline-available 24 hours a day staffed by people trained to assess suicide risk).
- The Veterans Crisis Line or Idaho Suicide

Prevention Hotline Professional will then advise and provide guidance.

- Should the Veterans/family deny assistance with calling the Crisis Line of Hotline, and instead choose to leave or attempt self-harm, call 911.

Explain the situation, requesting for an officer to make a wellness check. Be prepared to furnish the person's full name, location and the person's contact number, if possible.

- The Program Executive shall report the incident to the Deputy Administrator (if not previously involved) and Division Administrator.

Take immediate and prompt action if the Veteran/family is (for example):

- Expressing a desire to harm him/herself.
- Talking or writing about death or suicide.
- Looking for ways to commit suicide.
- Seeing no reason to live.

Seek immediate help:

(if calling from a state-owned landline phone, always dial "9" for an outside line)

Via Telephone:

- Stay calm and try to stay connected with the Veteran/family until you know help has arrived.
- Try to get the attention of a coworker and have them call 911 (if Veteran or other person has the means at hand to do self-harm or is out of control). Be prepared to furnish the person's full name, location and the person's contact number, if possible.
- Provide Veteran/family with the number for the Veterans Crisis Line and Military Crisis Line (1-800-273-8255 Press 1).

- Provide Veteran/family with the number for Idaho Suicide Prevention Hotline-available 24 hours a day staffed by people trained to assess suicide risk). 1-208-398-4357.
- Recommend that the Veterans make an appointment immediately with the VAMC. Each VA Medical Center has a Suicide Prevention Coordinator or team to offer Veterans the services they need.
- If unable to find a coworker to help or if the Veterans/family disconnect, call 911. Explain the situation, requesting for an officer to make a wellness check. Be prepared to furnish the person's full name, location and the person's contact number, if possible. After calling 911, call the VA Crisis Hotline or VAMC Suicide Prevention Coordinator and report the event.
- Immediately report incident to your Program Executive.
- Program Executive shall report such incidents to the Deputy Administrator and Division Administrator.

SECTION 2 – DO'S AND DON'TS OF SUICIDE PREVENTION

There are certain “do” and “don’t” behaviors that experts recommend using when either approaching someone who appears imminently suicidal or someone who may be considering suicide or is in a crisis. These “do”, and “don’t” actions include:

Do's

- Take him/her seriously and offer your full attention.
- Stay calm and in control of your own emotions, fears, or anger.
- Listen, Listen, Listen.
- Show compassion and concern.
- Speak carefully and slowly.

- Be direct.
- Be positive and reassuring.
- Remove the means of committing suicide (pills, knife, gun) ONLY if safe to do so.
- Build hope.

Don'ts

- Don't judge.
- Don't offer advice.
- Don't say you know how they feel.
- Don't interrupt.
- Don't agree to keep a secret.

SECTION 3 – SURVIVORS OF SUICIDE

For those who have lost a loved one or coworker to suicide getting back into a normal work routine can be a positive experience. Depending on the relationship with the deceased and the personality/vulnerability of the coworker, the person's workspace may also be a constant reminder. Some coworkers may feel a sense of responsibility or question if they could have/should have been able to intervene. The Employee Assistance Program (EAP) is available for state employees to work out these emotional responses to suicide. If a suicide occurs in the workplace or you are affected by someone who committed/attempted suicide, addressing the grief that follows is important. Often people will feel confused about how they can find support for themselves or provide support to a person who is touched by suicide. If several staff members are affected, consider a debriefing guided by an EAP counselor or consider encouraging individuals to seek personal help through the EAP.

Call the Employee Assistance Program (24/7) 1-877-427-2327.

SECTION 4 – EDUCATION AND OUTREACH

This policy and procedures will be distributed to all employees. Information on this policy and suicide awareness and intervention services will be part of the New Employee Orientation and included in the new employee orientation package.

All employees are expected to become familiar with this policy and procedures