INSERVICE: Nursing Guidelines Regarding Injury of Unknown Origin (IUO) on Night Shift (11:00 a.m. to 7:00 a.m.)

Audience: RN Supervisors

Purpose: The purpose of this inservice is to provide guidance and consistency for the RN Supervisor regarding notification of administrative staff and physicians in the process that is followed when an injury of unknown origin is discovered on the night shift (11:00 p.m. to 7:00 a.m.)

- IUO requires report 1910 be completed. Failure to report is grounds for progressive disciplinary action up to and including termination.
- RN Supervisor will assess the resident with an IUO and document in the medical record. A head to toe body audit will be completed on the shift that it is discovered and faxed with the report to Risk Management.
- IUO Notifications of the Administrative RN on call, Administrator on call and Physician on call must be made at the time of the discovery if after RN assessment, the RN deems the call is of an urgent nature such as medical condition or if the IUO resulted from abuse or neglect of the resident. If the RN assessment reveals that the IUO is minor and does not require immediate attention, the RN may make the decision based on his/her clinical judgment that the call may be placed at 5:30 a.m. to 6:00 a.m. THIS IS NOT DIRECTION OR AUTHORIZATION TO DELAY ANY CALL THAT THE RN DEEMS OF AN URGENT NATURE. THIS IS DIRECTION THAT THE RN SUPERVISOR ON DUTY IS TO WITHOUT EXCEPTION TO ASSESS IUOs. THIS IS DIRECTION THAT THE CLINICAL JUDGMENT OF THE RN BE DOCUMENTED IN THE RECORD.

DOCUMENTATION, REPORTING AND FOLLOW-UP POST CHOKING EPISODES OF AHC RESIDENTS

- THIS IS AN EMERGENCY SITUATION
- IMMEDIATELY FOLLOW CURRENT PRACTICE FOR OBSTRUCTED AIRWAY
- NOTIFY CHARGE NURSE & RN SUPERVISOR (SEND SOMEONE, DO NOT LEAVE THE RESIDENT)
- RN ASSESSMENT IN NURSES NOTES: AIRWAY, BREATH SOUNDS, O2 SAT, DESCRIPTION OF WHAT OCCURRED OR WAS REPORTED TO YOU, DETAILED DESCRIPTION OF INTERVENTIONS AND BY WHOM, VITAL SIGNS & OTHER PERTINENT INFORMATION
- NOTIFICATIONS: PHYSICIAN, FAMILY, & OTHERS AS REQUIRED BY REPORTING PROTOCOL
- I & A REPORT TO BE COMPLETED FOR ALL CHOKING EPISODES & FOLLOW I & A CHECKLIST.
- 1910 REPORT IS COMPLETED IF THE RESIDENT IS SENT TO THE EMERGENCY ROOM
- RESIDENT PLACED ON HOT RACK CHARTING & OBSERVATIONS TO BE CHARTED EACH SHIFT FOR 72 HOURS: O2 SAT, VITAL SIGNS
- PLACE RESIDENT ON PHYSICIAN LIST TO BE SEEN NEXT VISIT
- PHYSICIAN ORDERS AS INDICATED.
- NOTIFY SPEECH THERAPIST FOR CONSULT AT 860-0774. FAX ORDER TO REHAB DIRECTOR @ 860-0794.
- DIETARY STAFF TO BE NOTIFIED OF ANY CHANGE IN ORDERS

Quick Reference for Use of AED in Emergency

- AED is for use in victims who are pulseless and breathless, both witnessed and unwitnessed arrest.
- For AHC residents, determine the code status of resident. If the resident is "Blue Dot" or "Full Code", the AED is to be used as part of emergency response and the Code.
- CPR guidelines should be initiated and continued for victims immediately while AED is obtained and a 911 call placed.
- AEDs are set up on the crash cart at each nursing station and in Public Safety at AHC. For victims on campus other than the resident buildings, Dial 0 from house phone or (501) 860-0500 for the facility operator to notify Public Safety. State it is an emergency and the campus location that the AED is needed.
- Apply AED patches as indicated on the diagram with the AED. Do not place the patches directly over pacemaker, AICD site or medication patches. AED can be used in victims with a pacemaker or implanted defibrillator.
- Follow the AED voice instructions.
- The Code must be continued until emergency personnel arrive or a physician present stops the Code.

I/A CHECKLIST

COMPLETE I/A FORM

NOTIFY THE RN ON DUTY

NOTIFY THE MD
(if middle of night and **non emergency** can wait till next am)

NOTIFY THE FAMILY
(if middle of night and non emergency can wait till next am)

DOCUMENT IN THE CHART
(THE EVENT, body audit if needed) AND ALL NOTIFICATIONS WITH TIMES)

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

FAX TO SKIN OFFICE IF IT IS A SKIN RELATED ISSUE (860-0832)

UPDATE THE I/A LOG BOOK

PAIN ASSESSMENT (IF APPROPRIATE FOR I/A)

HOT RACK FOR 72 HOURS OR MORE IF NEEDED

DOCUMENT UNTIL THE INJURY IS COMPLETELY HEALED

NOTIFY MDSC OF EVENT FOR CP UPDATE

OBTAIN WITNESS STATEMENTS

MAKE A COPY FOR THE UNIT RN & MDSC

ALL SHIFTS MUST CHART THE HOT RACK CHARTS AND ALL I/A EVENTS

Revised April 2011

FALLS CHECKLIST

COMPLETE I/A FORM

COMPLETE POST FALL INVESTIGATION FORM

NOTIFY THE RN

NOTIFY THE MD

NOTIFY THE FAMILY

FAX I/A TO REHAB DIRECTOR (860-0794)

FAX TO RISK MANAGEMENT (860-0532)

DOCUMENTATION IN THE CHART
(Body audit on all falls, neuro checks if applicable, document until injury is completely healed/resolved)

UPDATE THE FALL RISK ASSESSMENT (MDSC Complete)
(MDS COORDINATORS UPDATE CARE PLAN)

UPDATE FALL LOG BOOK

PAIN ASSESSMENT

WITNESS STATEMENTS

HOT RACK FOR 72 HOURS OR MORE IF NEEDED

UPDATE 24 HOUR NURSING REPORT

IF RESIDENT REQUIRES OUTSIDE MEDICAL INTERVENTION COMPLETE 1910 PAPERWORK AND MAKE PROPER NOTIFICATIONS

Revised April 2011

SUSPECTED/ALLEGED VERBAL/PHYSICAL ABUSE/NEGLECT MISAPPROPRIATION OF PROPERTY

IMMEDIATE NOTIFICATION OF SUPERVISOR

NOTIFY RN ON DUTY

IF ALLEGED/SUSPECTED PERPATRATOR IS STAFF-REMOVE FROM DUTY IMMEDIATELY AND OBTAIN WRITTEN STATEMENT

ENSURE SAFETY OF RESIDENT (IF ALLEGED IS ANOTHER RESIDENT, SEPARATE AND PLACE 1:1)

COMPLETE FORM 1910 AND I/A FORM

NOTIFY PUBLIC SAFETY

NOTIFY MD

NOTIFY FAMILY

NOTIFY ADMINISTRATIOR (ON CALL)

NOTIFY THE DON/ADON

NOTIFY MDSC FOR CP UPDATE

ABUSE/NEGLECT—WTINESS STATEMENTS FROM **EVERY** WORKING NURSING STAFF ON UNIT (& OTHER EMPLOYEES IF WARRANTED)

COMPLETE BODY AUDIT IF APPLICABLE AND DOCUMENT IN NS NOTES/AUDIT BOOK

DOCUMENT NOTIFICATIONS AND INCIDENT IN NURSES NOTES AS REQUIRED

HOT RACK FOR 72 HOURS OR MORE IF NEEDED FOR **ABUSE**

COMPLETE MENTAL ANGUISH ASSESSMENT

WITH ABUSE/NEGLECT YOU MUST DOCUMENT EVERY 2 HOURS ANY "MENTAL ANGUISH" FOR 24 HOURS

(ex. Resident displays no s/s of distress or mental anguish from event on 4-1-05)
(ex. Resident is tearful and withdrawn. Encouraged to verbalize feelings and support with reassurance provided)

Revised April 2011

MEDICATION VARIANCES

EVALUATE THE RESIDENT (PROVIDING APPROPRIATE CARE)

NOTIFY THE RN ON DUTY

COMPLETE THE MEDICATION VARIANCE FORM

NOTIFY THE MD

NOTIFY THE FAMILY

NOTIFY THE DON/ADON

DOCUMENT IN THE NURSES NOTES

COMPLETE I/A

COMPLETE 1910 **IF** THERE IS A NEGATIVE RESPONSE AND/OR THE RESIDENT HAS TO BE SENT OUT TO THE HOSPITAL AND MAKE ALL PROPER NOTIFICATIONS

IF THE NARCOTIC COUNT IS OFF REFLECTING A MISSING PILL/S
OR
IF THERE IS A MEDICATION MISSING, YOU MUST COMPLETE A 1910 AND COMPLETE THAT PROCESS

ONLY AN RN CAN CORRECT A NARCOTIC BOOK COUNT. THE SPECIFIED ADON WILL COMPLETE THE CONTROL LOSS REPORT AND NOTIFY DEPARTMENT OF PHARMACY BOARD

PLACE RESIDENT ON HOTRACK

UPDATE 24 HOUR REPORT

Revised April 2011

ELOPEMENT FROM FACILITY REMAINING ON THE GROUNDS

ONCE RESIDENT IS LOCATED AND RETURNED TO UNIT—OBTAIN FULL BODY AUDIT

NOTIFY PUBLIC SAFETY OFFICE

NOTIFY MD

NOTIFY RN

NOTIFY DON/ADON

NOTIFY FAMILY

NOTIFY ADMINISTRATIOR ON CALL

COMPLETE I/A

PLACE ON HOTRACK

UPDATE ELOPMENT RISK ASSESSMENT

UPDATE 24 HOUR NURSING REPORT

OBTAIN WITNESS STATEMENTS FROM ALL STAFF ON DUTY (WHEN LAST TIME RESIDENT WAS SEEN)

COMPLETE DOCUMENTATION IN THE NURSES NOTES OF EVENT WITH TIMES

PLACE ON 1:1 SUPERVISION AND COMPLETE THE 15-MINUTE CHECK SHEET UNITL DISCONTINUED BY PHYSICIAN

**COMPLETE A 1910 IF INJURY OCCURS AND/OR THE RESIDENT REQUIRES OUTSIDE TREATMENT/HOSPITALIZATION

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

Revised April 2011

ELOPEMENT FROM THE FACILITY

NOTIFY PUBLIC SAFETY OFFICE & SWITCHBOARD IMMEDIATELY

NOTIFY DIRECTOR
(OBTAIN INFO TO INITIATE SEARCH PARTY)

NOTIFY ADMINISTRATOR ON CALL

NOTIFY DON/ADON

NOTIFY MD

NOTIFY RN

NOTIFY FAMILY

ONCE RESIDENT IS LOCATED AND RETURNED TO THE UNIT
(OBTAIN FULL BODY AUDIT, DOCUMENT NS NOTES & BODY AUDIT FORM)

COMPLETE I/A

COMPLETE 1910

PLACE ON HOTRACK

UPDATE ELOPMENT RISK ASSESSMENT

UPDATE 24 HOUR NURSING REPORT

OBTAIN WITNESS STATEMENTS FROM ALL STAFF ON DUTY
(WHEN LAST TIME RESIDENT WAS SEEN)

COMPLETE DOCUMENTATION IN THE NURSES NOTES OF EVENT
WITH TIMES

PLACE ON 1:1 SUPERVISION AND COMPLETE THE 15-MINUTE CHECK SHEET
UNITL DISCONTINUED BY PHYSICIAN

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

Revised April 2011

NURSING SUMMARIES

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be considered as an all-inclusive list

1. A nursing summary will be completed every (2) two weeks for each resident. The schedule should be created by room and bed number versus the resident's name. The resident should have a nursing summary scheduled for the day shift and the other one scheduled for the night shift.
    a. For example, Room 4A will be scheduled for the 5th of every month on the day shift and the 19th of every month on the evening shift.
2. The Unit RN Supervisor will develop a schedule to ensure all residents on the have a nursing summary completed. Educate all nurses regarding this assignment including documentation requirements, location of the nursing summary schedule, etc.
3. Nursing Summaries will be completed in narrative format in the nurse's notes. The nurse should identify the notation as a "NURSING SUMMARY"
4. A nursing summary should
    a. Provide a full assessment as to the residents current physical, social and mental status
    b. Address care plan problems and goals, etc.
5. The nursing summary should include the following: (This is not an all-inclusive list)
    a. **Mental Status**: Is the resident alert, oriented, confused, exhibit s/s of short of long term memory deficit, safety awareness, decision making skills, comatose, etc? Do not just list the descriptive word but provide a narrative notation to justify the use of these words. Also, include any interventions the staff utilizes to address these issues.
    b. **Emotional Status/Behaviors**: Is resident depressed? Anxious? Noisy? Easily upset? Withdrawn? Hostile? Resistant to care? Verbally or physically abusive? Socially inappropriate? Cooperative? Outgoing?
    c. **Hearing**: Does resident have any hearing deficit? Does resident utilize a hearing device? Does the resident refuse to wear the device? Does resident hear better on one side versus the other? Is hearing Adequate? Does staff adjust tone when communicating with the resident? Does staff utilize non-verbal techniques to enhance communication?
    d. **Speech**: Does resident have difficulty speaking? How does resident communicate needs? Is speech slurred? Does resident have difficulty completing thought processes/sentences?
    e. **Vision**: Does resident have any visual deficits? Is visions adequate with visual aide (glasses)? Is staff required to assist with care and utilization of visual appliances? Does resident have cataracts? Is resident blind?

f. **Bowel and bladder Function**: Is resident continent or incontinent of bowel? Bladder? Does resident use the toilet? Depends? Catheter? Ostomy? Impactions? Constipation? UTI's? What type of assistance is required? **EXAMPLE**: Resident is incontinent of bowel and bladder with inability to retrain as evidences by unaware of need to void or defecate due to dementia. Resident wears depends during the day and staff provides peri-care after each incontinent episode. Although resident has a history of constipation and receives Colace every night, he has had a bowel movement at least every 2-3 days during the past two weeks.
g. **Grooming/personal hygiene/ADL's:** What type of assistance does the resident require with each ADL task i.e., oral care, nail care, dressing, bathing, hair care.
h. **Ambulation/Mobility:** Is the resident ambulatory? Does the resident utilize a wheel chair? Is resident able to propel self in w/c? Does resident use a walker? Cane? Is resident's gait steady? Is the resident able to turn and reposition self in bed? Does resident require assistance with positioning? Does the resident participate at all with this task (i.e., can resident grab a hold of the side rail when turned to his/her side to maintain position for a few moments?) Does resident require assistance with transfers? One person? Two Person? Hoyer Lift?
i. **Eating Habits:** What type of diet does the resident receive? Does the resident feed self? Require assistance? What type of assistance? Tray set up? Verbal cues and prompts? Spoon-Feeding? Does resident tolerate diet? Voice complaints about diet/food: How is the resident's appetite? Is weight stable? Weight loss? Does resident receive supplements? Snacks?
j. **Vital Signs:** Always include a complete set of vital signs
k. **Restraints:** Discuss type of restraint used?
l. **Skin Assessment:** Does resident have impaired skin integrity? Is skin fragile? Does resident have history of skin tears? Bruises easily? Dry skin? What interventions do we utilize? Padded side rails? Lotion? Hydration? Etc. Does resident have any treatment orders?
m. **Medications:** Review physician orders for the past two weeks. Has the resident had any new orders for medications? Changes in medication: Discuss this in the narrative?
n. **Care Plan:** Discuss any care plan problems and interventions.

6. As part of the start-up routine, check the nursing summary schedule and review the nursing documentation in the residents medical record for the previous day assignments to ensure completion as scheduled
7. Look for areas of concern. Provide ongoing training regarding documentation requirements.

ARKANSAS HEALTH CENTER
NURSING SUMMARY

VITAL SIGNS:

B/P _____ PULSE_____ RESPIRATION_____ TEMPERATURE_____

MENTAL STATUS: (Check all that apply)

ORIENTED TO:
- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Environment
- ☐ Comatose

MENTAL STATUS:
- ☐ Alert
- ☐ Non-responsive
- ☐ Confused
- ☐ Forgetful
- ☐ Lethargic
- ☐ Unaware

DECISION MAKING SKILLS/SAFETY AWARENESS
- ☐ Able to make appropriate decisions
- ☐ Able to make simple decisions (yes/no or choose between 2 options)
- ☐ Poor decision making skills / rarely makes decisions
- ☐ Good safety awareness
- ☐ Poor safety awareness

EMOTIONAL/BEHAVIOR: (Check all that apply)

- ☐ Happy
- ☐ Sociable
- ☐ Cooperative
- ☐ Friendly
- ☐ Sad
- ☐ Withdrawn
- ☐ Noisy
- ☐ Depressed
- ☐ Resists Care
- ☐ Sexually Inappropriate
- ☐ Combative
- ☐ Wanders
- ☐ Anxious
- ☐ Agitated
- ☐ Abusive
- ☐ Socially Inappropriate
- ☐ Attention-seeking behaviors
- ☐ Delusional
- ☐ Comatose
- ☐

HEARING/VISION: (Check all that apply)

HEARING:
- ☐ Adequate
- ☐ Requires tone/volume adjustment
- ☐ Very Hard of Hearing
- ☐ Profound loss / deaf
- ☐ Unable to determine

HEARING DEVICE:
- ☐ None
- ☐ Hearing device
- ☐ Requires Assistance with hearing aid

VISION:
- ☐ Adequate
- ☐ Sees small print
- ☐ Sees large print
- ☐ Identify/tracks objects
- ☐ Unable to determine
- ☐ Legally Blind

VISUAL AID:
- ☐ None
- ☐ Glasses
- ☐ Prosthetic

SPEECH/COMMUNICATION: (Check all that apply)

SPEECH:
- ☐ Clear
- ☐ Slurred
- ☐ Aphasia

COMMUNICATION:
- ☐ Able to make needs known
- ☐ Not able to make needs known
- ☐ Verbally expresses self but has difficulty completing sentences
- ☐ Understands message
- ☐ Does not understand
- ☐ Uses Gestures
- ☐ Uses sounds/grunts/noise
- ☐ Communicates through writing
- ☐ Uses voice box / trach
- ☐ Communication Device

ADL FUNCTION: (Check all that apply)

AMBULATION:
- ☐ Ambulates
- ☐ Non-ambulatory (bed/chair bound)
- ☐ Able to ambulate w/ assistance
- ☐ Uses cane or walker
- ☐ Amputation

MOBILITY:
- ☐ Doesn't use mobility device
- ☐ Geri-chair / Wheelchair
- ☐ Able to propel self in chair
- ☐ Requires assistance
- ☐ Dependent

TRANSFER:
- ☐ Independent
- ☐ 1 person assist
- ☐ 2 person assist
- ☐ Lift
- ☐ Able to assist in transfer
- ☐ Dependent

POSITIONING IN BED:
- ☐ Independent
- ☐ Assist with turning
- ☐ Uses Bed-rails for turning
- ☐ Dependent

POSITIONING IN CHAIR:
- ☐ Independent
- ☐ Requires limited assist
- ☐ Dependent

BATHING: ☐ Shower ☐ Whirlpool ☐ Tub Bath
- ☐ Independent
- ☐ Set-up assist /Supervision
- ☐ Participates but requires staff assistance
- ☐ Dependent

DRESSING:
- ☐ Independent
- ☐ Set-up Assist/Supervision
- ☐ Limited assist
- ☐ Dependent

ORAL STATUS
- ☐ Own Teeth
- ☐ Partial / Bridge
- ☐ Edentulous
- ☐ Dentures
  - ☐ Uppers ☐ Lowers

ORAL HYGEINE:
- ☐ Independent
- ☐ Set-up/supervision
- ☐ Limited Assist
- ☐ Dependent

NAIL CARE:
- ☐ Independent
- ☐ Breaks easily
- ☐ PRN by staff
- ☐ Thick
- ☐ Diabetic Nail Care
- ☐ Podiatrist

GROOMING:
- ☐ Independent
- ☐ Set-up/Supervision
- ☐ Limited Assist
- ☐ Dependent

RESIDENT NAME:

FORM 1160-A1

BOWEL & BLADDER FUNCTION (Check all that apply)

BOWEL:
- ☐ Continent
- ☐ Incontinent with some control
- ☐ Incontinent:
- ☐ Ostomy

BLADDER:
- ☐ Continent
- ☐ Incontinent w/ some control
- ☐ Incontinent:
- ☐ Catheter _____

PROGRAMS:
- ☐ N/A
- ☐ Scheduled toileting
- ☐ Incontinent care PRN
- ☐ B&B Program

URINARY PRODUCTS:
- ☐ N/A
- ☐ Urinal/Bedpan
- ☐ Bed side commode
- ☐ Briefs / Depends

DIET/NUTRITIONAL STATUS: (Check all that apply)

EATING:
- ☐ Independently
- ☐ Set-up assist / Supervision
- ☐ Limited Assist
- ☐ Fed by staff
- ☐ Thickened Liquids
- ☐ Eats in Dining Room
- ☐ Eats in room

NUTRITIONAL STATUS:
- ☐ Good Appetite
- ☐ Fair Appetite
- ☐ Poor Appetite
- ☐ Tube Feeding
- ☐ Therapeutic Diet
- ☐ Mechanically Altered Diet
- ☐ Supplements / Snacks

WEIGHT: _____
- ☐ Stable
- ☐ Gain
- ☐ Loss

SLEEP PATTERN

SLEEP:
- ☐ Sleeps all night
- ☐ Takes Nap during day
- ☐ Awake most of night
- ☐

SKIN: (Check all that apply)

- ☐ No Breakdown
- ☐ Bruises
- ☐ Dry Skin
- ☐ Abrasions/skin tears
- ☐ Decubitus Ulcer
- ☐ Stasis Ulcer
- ☐ Fragile
- ☐ Turn & Re-position
- ☐ Incontinent PRN
- ☐ Pressure relieving cushion
- ☐ Pressure relieving mattress
- ☐ Lotion for dryness
- ☐ Supplement

Turgor ☐ Good ☐ Poor

CONTRACTURE/S: (Check all that apply)

☐ None

Hand	☐ Right	☐ Left	☐ Therapy Services
Arm	☐ Right	☐ Left	☐ ROM
Leg	☐ Right	☐ Left	☐ Hand-roll
Foot	☐ Right	☐ Left	☐ Splint
			☐

RESTRAINTS/POSITIONING/SAFETY DEVICES (Check all that apply)

- ☐ None
- ☐ Bed Alarm
- ☐ Chair Alarm
- ☐ Wander Alarm
- ☐ Low Bed
- ☐ Vail Bed
- ☐ Side Rails Up
- ☐ Side Rails Down
- ☐ Restraint Type: _____
- ☐ Positioning Devices: _____

NARRATIVE PROGRESS NOTE: (Provide a brief description of any changes in medications, new orders, lab results, new treatments, hospitalizations, referrals, etc occurring during the previous 2 weeks).

Name/Title: Date:

NURSING SUMMARY SCHEDULE

MONTH:_____ UNIT_____

1	2	3	4	5	6	7
ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #

8	9	10	11	12	13	14
ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #

15	16	17	18	19	20	21
ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #

22	23	24	25	26	27	28
ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #	ROOM #

REVISED APRIL 2011

SLEEP NOTES

1. Sleep notes are to be documented on according to the nursing summary schedule. (example, who ever is due to have a nursing summary on the 7a and 7p shift for that day, will be the sleep notes that will be completed)
2. The night nurse is responsible for completing the sleep notes.
3. any resident who is having problems during the night time hours with sleeping will be documented on.

DAILY UNIT SURVEY CHECKLIST

1. Check to see that all tube feeders rate of formula and flush matches the pump readings.

2. See if the feeding pumps and poles are clean.

3. Check for gloves in trash cans and empty cans if needed.

4. Check all shower/bathing rooms for cleanliness, thermometer, and egg timer.

5. Check the bathing equipment for cleanliness and see that they have chemicals in the pump sprayer for cleaning the equipment.

6. Ask the CNA's if they have the RIS (Resident Info Sheet) in their pocket.

7. Check all OXYGEN filters and clean if needed.

8. Check to see that all rooms with OXYGEN have NO SMOKING signs. Check date on O2 tubing. ALL EXTRA OXYGEN CONCENTRATORS MUST BE STORED ON WILLOW.

9. Check all microwaves and refrigerators for cleanliness.

10. Check crash cart for signatures.

11. Look for anything on top of AC/Heating units.

12. Monitor knocking on doors before entering a room.

13. Monitor privacy curtains being pulled during care.

14. Check call light placement.

15. Check all alarms on chairs, beds and doors to ensure they are turned on and operating properly.

16. Check temperature of washcloths on clean linen buggies.

17. Check usage of Peri-wash.

18. Check water pitchers for fresh ice and water, check dates on water pitchers, check for proper thickened liquids.

19. Remove extra linens for rooms

20. Check Foleys – positioned properly, privacy bag, thigh strap

21. Make sure draw sheets are applied correctly (Halved and tucked under mattress)

22. Empty trash cans if needed.
23. Make sure each room has gloves and hand sanitizer available
24. Make sure all doors are closed and locked that are suppose to be.

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DAILY UNIT SURVEY CHECKLIST

25. Check Dining rooms for cleanliness

26. Check employee break room refrigerators. All food and drink has to have the employee name and date on it. If over 3 days old needs to be thrown away. If no name and date, throw away!

27. Check fingernails (cannot have chipped nail polish) toenails, shaving, and oral care needs

28. Every refrigerator (residents included) has to have a temperature log.

29. All beds must be made and have a comforter/bedspread

30. Make sure staffing logs are posted

31. Check all closets & drawers to make sure all handles are present and drawers work properly.

32. Each resident has to have a picture posted outside their door with a red dot or blue dot on it.

33. Check Isolation rooms for proper set-up

34. Check privacy curtains for cleanliness. Call Hsk if needs to be washed.

35. Replace full Sharp's Containers

36. Check to see that all w/c's/geri-recliners are clean

37. Check all fans for cleanliness

38. Remind Housekeeping to deep clean all rooms when the resident is admitted to the hospital! Remove all equipment from the room (IV bags/poles/pumps, O2 concentrators, suction machines, etc). Make the bed after the mattress is washed.

39. All chemicals to be stored behind locked doors!

SURVEY READINESS TEAM DUTIES

DATE_____ AM_____PM_____

UNIT_____

WHEN THE UNITS RECEIVE THE WORD THAT LONG TERM CARE IS ON THE GROUNDS, THE FOLLOWING IS TO BE DONE IMMEDIATELY BY ALL DISCIPLINES AS OUTLINED. AFTER COLLECTION FAX TO Teena Campbell 860-0837.

ADMINISTRATIVE ASSISTANTS

1.	Make sure all of the dots are on the pictures by the door.	YES ____	NO____
2.	Make sure each room has gloves and hand sanitizer.	YES ____	NO____
3.	Be sure that all charting notebooks (ADL, Hydration, etc) closed and in the Nurses' Station or any HIPPA restricted items not open on top of nurses' counter or in Dining Room.	YES____	NO____

Problems Noted:

_____

_____

_____

ACTIVITY

1.	Make sure call lights are in reach.	YES ____	NO____
2.	Check for fresh ice and water.	YES ____	NO____
3.	Make sure the ACTIVITY SCHEDULE is happening.	YES ____	NO____
4.	Make sure each name is on the water pitcher with the date.	YES ____	NO____
5.	Check dates on juices.	YES ____	NO____
6.	Have diet list on hydration cart.	YES ____	NO____

Problems Noted:

_____

_____

_____

CLOTHING ROOM WORKERS

1.	Remove extra linen from the rooms.	YES ____	NO____
2.	Make sure there is nothing on the floors and no personal care items out in the open	YES ____	NO____
3.	Make sure call lights are in place.	YES ____	NO____
4.	Make sure that linens on beds are without holes or tears.	YES ____	NO____
5.		YES ____	NO____
6.		YES ____	NO____

Problems Noted:

_____

_____

_____

HOUSEKEEPING

1	Empty all trash cans and make sure liners are in all trash cans.	YES ____	NO____
2	Make sure all doors are closed and locked that are supposed to be closed and locked.	YES ____	NO____
3	Check privacy curtains to make sure all are in place.	YES ____	NO____
4	Check all bath rooms for cleanliness.	YES ____	NO____
5	Check lobby and halls for spills and cleanliness.	YES ____	NO____
6	Check for cans of chemicals under unlocked cabinets.	YES ____	NO____

Problems Noted:

_____

_____

_____

CNA

1.	Empty all laundry/trash bins in halls.	YES ____	NO____
2.	Empty all urinals and check for names on them.	YES ____	NO____
3.	Check all residents for cleanliness/dryness of clothing..	YES ____	NO____
4.	Check problem rooms on each unit thoroughly for odors, cleanliness and tidiness. (each unit needs to identify these rooms)	YES ____	NO____
5.	Check all nails (cleaned and trimmed) and men for shaving.	YES ____	NO____
6.		YES ____	NO____

Problems Noted:

_____

_____

_____

HAB REHAB

1.	Check Foleys for privacy bags and tubing for proper positioning and make sure not on floor.	YES ____	NO____
2.	Check that proper splints are on and on the right time schedule.	YES ____	NO____
3.	Make sure TED hose are in place where needed.	YES ____	NO____
4.	Check restraints for being applied properly.	YES ____	NO____
5.		YES ____	NO____
6.		YES ____	NO____

Problems Noted:

_____

SPEECH THERAPIST

1	**Check thickened liquids for right consistency and correct pictures for proper consistency on wall and water pitchers.**	**YES ____**	**NO____**
2	**GO TO OAK FIRST**	**YES ____**	**NO____**
3		**YES ____**	**NO____**
4		**YES ____**	**NO____**
5		**YES ____**	**NO____**
6		**YES ____**	**NO____**

Problems Noted:

LPN'S

1	**Check juices on Med Carts for readable dates.**	**YES ____**	**NO____**
2	**Check feeding pumps & Formula containers for same rates.**	**YES ____**	**NO____**
3	**Make sure the syringes and the formula bags have the current date on them.**	**YES ____**	**NO____**
4	**Check IV poles for cleanliness.**	**YES ____**	**NO____**
5	**Check rooms with Oxygen for "No Smoking signs".**	**YES ____**	**NO____**
		YES ____	**NO____**

Problems Noted:

4

LPN SUPERVISOR

1	Recheck entire unit and give directions where needed.	YES ____	NO____
2	Be prepared to make rounds with the Surveyors.	YES ____	NO____
3	Check bathing rooms.	YES ____	NO____
4	Check all beds to see if they are made.	YES ____	NO____
5	RN Supervisor should take one hall and the LPN Supervisor take the other and makes rounds.	YES ____	NO____
6	Staffing log posted	YES____	NO____
7	Check for cans of chemicals in areas unlocked.	YES ____	NO____
8	Ensure that C.N.A.'s have Resident Information Sheet on their person.	YES____	NO____
9	Complete RT list if not available	YES____	NO____

Problems Noted:

MAINTENANCE

1	Check for any mattress being stored on the units and remove if found.	YES ____	NO____
3	Check for extension cords.	YES ____	NO____
4		YES ____	NO____

5		YES ____	NO____
6		YES ____	NO____

Problems Noted:

_____

_____

_____

MDS COORDINATORS

1	Check supply rooms and treatment rooms for boxes on floors. Get boxes off floor if needed. Make sure all supplies are stored below 18" from ceiling.	YES ____	NO____
2	Report to RN/LPN Supervisor for additional instructions.	YES ____	NO____
3		YES ____	NO____
4		YES ____	NO____
5		YES ____	NO____
6		YES ____	NO____

Problems Noted:

_____

_____

_____

RESPIRATORY THERAPIST

1	Check water bottles on Humidifiers for current dates.	YES ____	NO____
2	Check dates on all oxygen tubing.	YES ____	NO____
3	Check oxygen concentrator filters.	YES ____	NO____
4	Check crash carts on each unit.	YES ____	NO____

5	Check Concentrator filters.	YES ___	NO___
6	Oxygen sign on doors.	YES ___	NO___

Problems Noted:

_____

_____

_____

6

RN SUPERVISOR

1	Recheck entire unit and give directions where needed.	YES ___	NO___
2	Be prepared to make rounds with the surveyors.	YES ___	NO___
3	Complete RT List if not availabel		
4	Make sure each bed is made.	YES ___	NO___
5	RN Supervisor should take one hall and the LPN Supervisor the other hall and make rounds.	YES ___	NO___
6	Check for cans of chemicals in areas unlocked.		
7	Check bathing rooms if LPN not here.	YES ___	NO___
8	Staffing log posted.	YES ___	NO___
9	Ensure that C.N.A.'s have Resident Information Sheet on their person.	YES___	NO___

Problems Noted:

_____

_____

_____

SKIN TEAM

1	Check residents for proper positioning.	YES ___	NO___
2		YES ___	NO___
3		YES ___	NO___

4		YES ____	NO____
5		YES ____	NO____
6		YES ____	NO____

Problems Noted:

_____

_____

_____

7

SOCIAL WORKERS

1	**Check A/C & Overbed lights for items on them.**	YES ____	NO____
2	**Check overbed tables for cleanliness.**	YES ____	NO____
3		YES ____	NO____
4		YES ____	NO____
5		YES ____	NO____
6		YES ____	NO____

Problems Noted:

_____

_____

_____

INFECTION CONTROL

1	**Check all Isolation Rooms (occupied and unoccupied).**	YES ____	NO____
2	**Check all Biohazard Rooms.**	YES ____	NO____
		YES ____	NO____

Problems Noted:

_____

_____

_____

		YES ____	NO____
		YES ____	NO____

Problems Noted:

ABBREVIATED STATE LICENSURE SURVEY

Entrance Conference Check Sheet

1. Do you have any private agency or contract employees working in your facility- including PT, OT, ST. Need copies of all TB's only. (Melinda will need to provide this)
2. Please provide a list of all employees in alphabetical order and their positions. (HR will need to provide this)
3. Please provide in-services and dates since the last abbreviated state licensure survey. (Staff Development)
4. Please provide state and national (FBI) Criminal Background records for employees. (Public Safety)
5. Please provide TB skin test cards on all employees. (Jacque Credit RN) List of all WHO administers the TB test and copy of documentation from health office?
6. COPIES of daily staffing logs with daily census provided for the previous two week pay period. (Staffing)
7. Please fill out nursing License Form on AHC and Agency staff. LPN's and RN's only. (Staffing)
8. Please provide CNA certificates for review on AHC and Agency staff. (Staffing)
9. Please provide a list of employees hired in the past four months with their positions. (HR)
10. Please provide COPIES of generator test loads, maintenance logs (since last abbreviated survey) and generator's annual inspection. (Maintenance Department)

Reminders:

- Staffing logs have to be legible for the surveyors to read
- Staffing logs have to be posted in designated area immediately after shift begins
- Staff cannot sign in and out at the same time on the staffing logs.
- 1st thing they will check is the ER boxes for expired drugs and the correct number of items
- They will check to see that Dr. Sudd has signed the ER list in the past year
- They will look for current licenses posted in the med room for Ken Lancaster, Consultant Pharmacist
- They will make environmental rounds
- They will ask for copies of the staffing logs for the previous 2 weeks
- If they find problems with staffing logs, they will ask for 3 months time sheets to audit
- They will ask for discharges, admissions, and transfers out of the facility in the last 4 months

PREVIOUS DEFICIENCIES:

- Cokes on the clean linen cart
- Staffing logs not posted in a timely manner
- ER drugs expired
- ER box had been opened and not reordered
- Chemicals left out in open in unlocked cabinet
- There were "NO SMOKING" signs posted on rooms with O2 equipment present
- Over bed tables with rough edges.

This is mainly a paperwork compliance survey, but they do make rounds on the units. They look at all the licenses, ensure all TB tests are current, in-services are up to date, etc. We need to make sure all TB tests are up to date the first of April and all licenses are given to Paige on time.

ITEMS REQUESTED WITH IN ONE HOUR OF SURVEYOR ENTRANCE TO FACILITY

1. List of residents with room numbers
2. RN and LPN schedules
3. Management staff locations
4. Resident rights packet
5. Meal times and menus
6. Med pass times
7. Admissions past month
8. Transfers/discharges in last 3 months
9. Copy of facility layout
10. Admission agreement packet
11. Abuse prevention policy and procedures
12. Unusual occurrence log/follow up
13. Activity calendar
14. List of residents under age 55
15. Residents using non-oral language or the non-dominant language
16. Roster sample matrix (HCFA 802)
17. Resident census and condition report (672)

SURVEY READINESS BINDER
ITEMS REQUESTED WITH IN ONE HOUR FACILITY

Survey type:_____ Entrance date:_____ Exit date:_____
SURVEY TEAM:_____

DOCUMENTS	RESPONSIBLE PARTY
1. List of residents with room numbers	
2. A copy of the actual working schedules for RN's and LPN's for the time period requested	
3. List of facility Management personnel and their locations	
4. A copy of written information that is provided to residents regarding their rights	
5. Meal service times by unit and dining locations & copies of all menus, including therapeutic menus that will be served during the survey	
6. Medication pass times	
7. List of Admissions during the past month	
8. List of residents Transferred or discharged during the past 3 months with destinations	
9. Copy of facility layout	
10. Copy of facility Admission agreement packet	
11. Copy of Policy and procedure regarding investigation & reporting of alleged neglect and abuse	
12. Evidence that the facility monitors accidents and other incidents, has a system in place to prevent or minimize further accidents	
13. Current resident activity schedule or calendar	
14. List of residents who are 55 y/o and under	
15. List of residents who communicate with non-oral communication devices, sign language or a non-dominant language of the facility	
16. Roster Sample Matrix (HCFA 802)	

SURVEY READINESS BINDER
ITEMS REQUESTED WITHIN 24 HOURS

OCUMENTS	RESPONSIBLE PARTY
1. A completed Long Term Care Facility Application for Medicare and Medicaid (HCFA-671)	
2. A resident census and conditions of resident (HCFA 672)	
3. Ownership document (HCFA 1513 or HCFA 855)	
4. A list of Medicare residents who requested demand bills in last 6 months	

SURVEY READINESS BINDER
ADDITIONAL ITEMS THAT MAY BE REQUESTED

DOCUMENTS	RESPONSIBLE PARTY
1. In-services for all depts. For calendar year since last survey	
2. Copy of CLIA permit/waiver	
3. Nurse Aide Training Program documentation	
4. Time sheets (last 2 weeks as worked)	
5. Pet Policy	
6. Orientation documentation for pool or agency personnel	
7. Resident Funds accounting records	
8. Copy of administrator license	
9. Copy of DON license	
10. Method for checking for staff current licensure	
11. Staff hired in last 4 months	

QUESTIONS ASKED OF ADMINISTRATOR UPON ENTRANCE

	QUESTION	RESPONSE
F457	1. Any variances for more than 4 residents per room?	
F458	2. Any variances for less square footage per room than required?	
F459	3. Do all resident's rooms have access to an exit corridor?	
F461	4. Is there at least one outside window in each resident room?	
F461	5. Are there any resident rooms below ground level?	
F466	6. What procedures are in place to ensure water availability if normal water supply is lost?	
	7. Are there any special features of facility's care or treatment programs, organization and resident case mix? Example: Special care units?	

SPECIFIC DOCUMENTATION REQUESTS DURING SURVEY

DOCUMENT	RESPONSIBLE PARTY

REQUIRED STATE INSERVICES

TOPIC	DATE
4 dates/quarterly separated AR 304.3-Use of fire-fighting equipment-90% employees (Quarterly)	* * * *
Evacuation of patients (Quarterly)	* * * *
Procedures to follow in case of fire or explosion (quarterly)	* * * *
(Semi-annually) Disaster Drills-Including Tornado Drills	* *
Fire Drills (Quarterly)	* * * *
AR 306 Abuse/Neglect (Orientation-Annually)	*
AR 327 Dentist-Oral care (Annually)	*
AR 518 Rehab Services (Orientation & Annually)	*

*=date

PHARMACY INFORMATION TAGS F322 & F323
OLTC PHARMACY SURVERYOR
JOHN TIPTON

- **Read your MAR's** – if it does not make any sense to you then it is probably written wrong. *Orders like : Lanoxin hold if 60...* Anyone writing orders must have knowledge of how to write drug orders. The doctor or the nurse must know how the drug is made. I.E., you CANNOT write an order for APAP 650mg- because APAP is not made in that strength, it is made in 325mg.
- **Medications crushed**- the pudding or the apple sauce must be placed in the cup first before the medication, because if medications are left in the corners of the cup, it will be an error since the correct dosage was not administered
- **Medications ordered to be administered with food**- There is a 1-2 hour window to administer meds, before the stomach is empty. If you give crackers or a scoop of pudding when you are giving meds, to replace a meal, it will be sited because crackers are not a meal and you have to give the resident the entire cup of pudding for it to be considered as a meal. If the nurse starts her med pass early and the resident does not consume enough of the meal, therefore causing abdominal pain, it will be an error. 4oz of supplement may be considered food if the order reads to be given with food
- **AC medications**- if the med is given immediately before the meal and not the minimum of 30 minutes, it will be sited as an error because the medication was not given enough time in the stomach to be effective

PHARMACY INFORMATION TAGS F322 & F323
OLTC PHARMACY SURVERYOR
JOHN TIPTON

*PRESENTATION: F322 & F323 PHARMACY TAGS

- **MVI vs MVI with iron**-if you have an order for MVI and give MVI with iron and the resident have a fecal impaction (a significant event) will result in an I.J. (Immediate Jeopardy) Resident need to be monitored for constipation
- **Sinemet 25/100 vs Sinemet 25/100 CR**- is a delayed release and if the order does not clearly state CR is to be given, but that is the dose on it will be a medication error
- **Depakote vs Depakote ER**-is also a delayed release and if the order does not clearly state ER is to be given, but that is the dose on hand, it will be a medication error regardless of what the pharmacy send you (the error will be on the facility)- John has seen numerous errors with Sinemet and Depakote. Calcium with D is another big error that is being seen. Calcium written in one area and the D in another.
- **Insulin errors**- use of syringes-bubble in syringe will be considered an error. Medication can't be OVER NO UNDER the line-it must be even with the line of the dosage being administered.
- **Insulin**-must be dated with the date removed from the refrigerator because if you puncture the bottle 2 days after removal from the refrigerator you only have 26 days left, not your usual 28 days.
- **Tube feeding**-all flush orders must have a minimum of 30cc of flush before and after meds. If a resident has 10 medication you do not have to give them 1 at a time, unless it contraindicates.
- We need to review our policy when it says "check for placement with air and gastric residual contents" because we are collapsing/flatten the tubes-causing the resident to be hospitalized for tube placement for frequently. If you just turned the pump off from running in the tube feeding no matter if it is dislodged you will get residual.
- **Dilantin liquid vs Dilantin Infatabs-**With Dilantin liquid, the pump has to be turned off for 1 hour before and after the administration. Then you have to calculate the calories that were missed during the time the pump was off and replace it per MD orders. With Dilantin Infatabs do not require the pump to be turned off
- **Omissions upon readmission-** changes are not being carried over to the computer where the medication has to be hand written in every month. Sends up a red flag because it only takes one month for someone to miss putting it back on the MAR causing the medication to be omitted. However, the nurses are still giving the medication because it remains in the drawer, it will be written as a medication error and depending on the medication and the amount of times it occurred it could result in a significant error

LONG TERM CARE
F-TAG SUMMARY

F150	Defines SNF/NF	F247	Notification of room/roommate change
F151	Resident Rights	F248	Activities (facility responsibilities)
F152	Incompetent/Legal Surrogate	F249	Qualification of activity leader
F153	Access to records	F250	Social Service
F154	Informed in language understood	F251	Social Worker qualification
F155	Refusal of treatment	F252	Environmental
F156	Notification requirements • Accessibility of physician • Ombudsmen, State Representative	F253	Housekeeping
F157	Notification of change in service	F254	Clean beds/linens
F158	Right to manage financial affairs	F255	Private closet space
F159	Facility responsibility-Resident funds	F256	Adequate lighting
F160	Death-conveyance of personal funds	F257	Comfortable/safe temperature
F161	Assurance of financial security	F258	Sound levels
F162	Limits of charges to resident funds	F271	Admission orders
F163	Right to choose personal physician	F272	Comprehensive assessments
F164	Privacy and Confidentiality	F273	Comprehensive assessments (cont.)
F165	Right to grievance	F274	Change of condition assessments
F166	Facility responsibility to resolve grievances	F275	Annual assessment (366 days)
F167	Examine most recent survey	F276	Quarterly assessment
F168	Receiving information from client advocates	F278	Accuracy of assessment
F169	Right to work/not work	F279	Comprehensive care plans
F170	Send and receive mail	F280	Time allowance for care planning
F171	Access to postage, stationary, writing tools	F281	Professional standard of quality
F172	Access and visitation rights-Ombudsmen	F282	Care given according to plan
F173	Access to records- Ombudsmen	F283	Discharge summary
F174	Right to access Telephone	F284	Post-discharge plan of care
F175	Rights of married couples	F285	Preadmission screening for MI/MR
F176	Self-administration of medications	F287	Automated data processing required
F177	Refusal of transfer	F309	Quality of care/ ADL's
		F310	Diminishing ADL ability
F201	Transfer/discharge requirements	F311	Maintenance/Restorative programs
F202	Documentation	F312	Dependence of ADL care
F203	Notice before transfer	F313	Vision/Hearing
F204	Orientation for transfer/discharge	F314	Pressure sores
F205	Bed-hold policy and readmission	F315	Urinary Catheters
F206	Permitting resident return (exceeds)	F316	Incontinence (bladder)
F207	Equal access to quality care	F317	Preventing decreased range of motion
F208	Assurance of payment (facility not allowed)	F318	Limited ROM- preventing decline
F221	Restraints- Physical	F319	Mental/psychosocial impaired treatment
F222	Restraints-Chemical	F320	Preventing mental/psychosocial difficulty
F223	Abuse	F321	Naso-gastric tubes
F224	Mistreatment, Neglect, Misappropriation	F322	Gastrostomy feedings
F225	Hiring limitation with criminal/abuse history	F323	Environmental accident hazards
F226	Development/Implement Policies and Procedures	F324	Supervision to prevent accidents
F240	Quality of life	F325	Nutritional status
F241	Dignity	F326	Therapeutic diet/nutritional problems
F242	Right to self-determination and participation	F327	Hydration
F243	Right to participate in resident and/or family groups	F328	Special needs (IV, trach, etc.)
F244	Facility responsibility to family and/or resident groups	F329	Unnecessary medication

F245	Participation in other activities	F330	Antipsychotic medication use
F246	Accommodation of needs	F331	Antipsychotic dose reductions
F332	Medication error rate (<5%)	F462	Toileting facilities
F333	Resident free of significant med. errors	F463	Call system
		F464	Dining and resident activities
F353	Sufficient staffing	F465	Dining furnishings and space
F354	R.N./ Licensed nurse	F466	Water supply
F355	Waiver of inadequate staff	F467	Adequate ventilation
		F468	Handrails in corridors
F360	Dietary services	F469	Pest control program
F361	Staffing dietician		
F362	Staffing dietary service	F490	Administration
F363	Menu/Nutritional adequacy	F491	Licensure
F364	Food preparation	F492	Compliance with professional standard
F365	Individual preparation (needs)	F493	Governing body (training of nurse aide)
F366	Substitution menu (resident refuses meal)	F494	Limits of work-time for nurse aides
F367	Therapeutic diets	F495	Nurse aide competency
F368	Frequency of meals	F496	Registry verification- nurse aides
F369	Assistive devices	F497	Regular in-service training for nurse aide (12 hours/year)
F370	Sanitation dietary	F498	Proficiency of nurse aides
F371	Sanitation dietary (cont.)	F499	Staff qualifications (Licensed/temporary agency)
F372	Disposal of garbage/refuse		
F388	Physician required visits	F500	Use of outside resources
F389	Physician available-Emergency care	F501	Medical director
F390	Performance of physician tasks	F502	Laboratory services
		F503	Laboratory requirements
F406	Specialized rehabilitation	F504	Lab ordered/ Not ordered by MD
F407	Qualifications- Rehab services	F505	Notification of MD with lab results
F411	Skilled nursing facility	F506	Transportation of residents
F412	Facility responsibility-Dental care	F507	Filing results in clinical records
F425	Pharmacy services	F508	Radiology and diagnostic services
F426	Pharmaceutical procedures	F509	Facility requirement obtain services from a provider or supplier
F427	Pharmacist consultant	F510	Provide/obtain radiology services ordered
F428	Drug regimen review	F511	Notification of MD with radiology results
F429	Consulting pharmacist responsibilities	F512	Assist with transfer to and from service
F430	Pharmacist report must be acted upon	F513	Filing radiology results in medical record
F431	Labeling of drugs/biologicals	F514	Clinical records
F432	Storage of drugs/biologicals	F515	Retention of medical records
		F516	Safe guard of medical records
F441	Infection control	F517	Disaster/Emergency preparedness
F442	Preventing spread of infection	F518	Training employees- emergency procedures
F443	Preventing spread (employee to resident)	F519	Transfer agreement with acute care facility
F444	Hand-washing	F520	Quality assessment/assurance requirement
F445	Linens	F521	QA required to meet quarterly
F454	Physical environment safety		
F455	Emergency power		
F456	Equipment in safe operating condition		
F457	Room size (max. 4 residents)		
F458	Room measurements		
F459	Direct access to exit corridor		
F460	Visual privacy		
F461	One window to outside or atrium		

F152 Resid[illegible]judged Incompetent
F153 Acce[illegible]ords
F154 Informed of Health Status
F155 Refuse Treatment
F156 Informed Medicaid Services
F157 Notification of change
F158 Protection of resident funds
F159 Manage resident funds
F160 Conveyance of funds upon death
F161 Assurance of financial security
F162 Limit of personal funds
F163 Choose of physician
F164 Privacy/confidentiality of records
F165 Voice grievances
F166 Grievances
F167 Survey results
F168 Agencies acting as Advocates
F169 Work-refusal, agreement
F170 Mail-unopened and delivery
F171 Access to Stationary
F172 Access & visitation rights
F173 Ombudsman access to records
F174 Privacy during telephone calls
F175 Married Couples share room
F176 Self-Administration of Drugs
F177 Refusal of Certain Transfer

483.12 -ADMISSION TRANSFER & DISCHARGE RIGHTS
F201 Transfer and Discharge
F202 Documentation by MD-Transfer
F203 Notice before Transfer
F204 Orientation for Transfer/Discharge
F205 Bed hold Policy and Readmission
F206 Return to the Facility
F207 Equal access to Quality Care
F208 Admissions Policy

483.13 -RESIDENT BEHAVIOR AND FACILITY PRACTICES
F221 Physical Restraints
F222 Chemical Restraints
F223 Free of Abuse
F224 Abuse (Staff Tx)
F225 Not employ ind. Guilty of abuse
F226 Abuse Policies

483.15-QUALITY OF LIFE
F240 Quality of Life
F241 Dignity
F242 Self-Determination/participation
F243 Participate in resident/family group
F244 Facility listen to group

[illegible]ccommodation of needs
F247 Notice of room change
248 Activities
F249 Qualifications of Activity Director
F250 Social Services
F251 Full time Social Worker
F252 Safe, clean, homelike environment
F253 Housekeeping and Maintenance
F254 Linens in good condition
F255 Private closet space
F256 Lighting Levels
F257 Comfortable temperature
F258 Comfortable sound levels

483.20-RESIDENT ASSESSMENT
F271 Admission Orders
F272 Comprehensive Assessment
F273 Frequency of assessments
F274 Significant change assessment
F275 Every 12 months
F276 Quarterly review
F277 Coordination of PASAAR
F278 Accuracy, RN signs
F279 Comprehensive care plan
F280 Care plan in 7 days
F281 Services meet professional standards
F282 Services by qualified persons
F283 Discharge summary
F284 Post d/c plan of care
F285 MI/MR PASARR

483.25 -QUALITY OF CARE
F309 Highest Practicable Care
F310 ADL diminished capacity
F311 Appropriate TX and services
F312 ADL dependent residents
F313 Vision and hearing
F314 Pressure Sores
F315 Indwelling catheters
F316 Prevent UTI/Bladder function
F317 ROM not diminished
F318 ROM Tx and services
F319 Mental and Psychosocial Function
F320 No dev. Of Mental Problems
F321 NG Tube
F322 Prevent aspiration
F323 Accident hazards
F324 Supervision Prevent Accidents
F325 Nutritional parameters
F326 Therapeutic Diet
F327 Hydration
F328 Special needs/Trach/Respiratory
F329 Unnecessary Drugs

F[illegible] Dose reduction
Medication Error 5% or greater
Significant medication error

483.30 -NURSING SERVICES
F353 Sufficient staff/Nursing
F354 RN 7 days
F355 Waiver

483.35-DIETARY SERVICES
F360 Dietary Services
F361 Qualified Dietician
F362 Sufficient staff/Dietary
F363 Menus meet nutritional needs
F364 Food palatable, temperature
F365 Food meets individual needs
F366 Substitutes offered
F367 Therapeutic Diets
F368 Frequency of meals
F369 Assistive devices
F370 Food sources
F371 Store/prepare/distribute food
F372 Dispose of garbage

483.40 -PHYSICIAN SERVICES
F385 MD Services/supervision
F386 Physician visits
F387 Frequency of MD visits
F388 Visits by MD exception
F389 Emergency Availability
F390 MD delegation of tasks

483.45 -SPECIALIZED REHAB
F406 Specialized Rehab Services
F407 Qualifications

483.55-DENTAL SERVICES
F411 SNF Obtain Dental Services
F412 NF Obtain Dental Services

483.60-PHARMACY SERVICES
F425 Pharmacy Services
F426 Pharmacy Procedures
F427 Licensed Pharmacist
F428 Drug Regimen Review
F429 Report Irregularities
F430 Reports acted upon
F431 Labeling of Drugs
F432 Storage of Drugs

483.65-INFECTION CONTROL
F441 Infection Control Program
F442 Prevent Spread of Infection
F443 Spread by Employees

F445 Handle Linens

483.7[illegible] -PHYSICAL ENVIRONMENT
F454 Physical Environment
F455 Emergency Power/Life Supp.
F456 Equipment Maintenance
F457 No more than 4 residents
F458 Room Square Footage
F459 Access to Corridor
F460 Full visual privacy
F461 Outside window/grade level
F4621 Toilet facilities
F463 Resident Call System
F464 Dining and activities rooms
F465 Other Env. Conditions
F466 Water Supply
F467 Outside Ventilation
F468 Handrails
F469 Pest Control

483.75-ADMINISTRATION
F490 Administration
F491 Facility must be licensed
F492 Compliance with laws
F493 Governing Body
F494 NA Competent/Training
F495 CNA Competent
F496 Registry Verification
F497 In-services
F498 Proficiency of Nurse Aides
F499 Staff Qualifications
F500 Use of Outside Resources
F501 Medical Director
F502 Lab Services
F503 Lab meets requirements/certified
F504 MD order Labs
F505 MD Notified
F506 Transport to Lab
F507 File Lab Report
F508 Obtain Radiology
F509 Service Meets Regulations
F510 Radiology when ordered
F511 Notify MD of findings
F512 Transport to Radiology
F513 File Reports
F514 Clinical Records
F515 Retention of Records
F516 Safeguard Records
F517 Emergency Plan
F518 Unannounced Drill
F519 Transfer Agreement
F520 QA Committee
F521 QA Quarterly
F522 Ownership Disclosure

THIS IS NOT AN OLC APPROVED ITEM

Weight Change

Usual weigh - actual weight X 100
Usual Weight = % of wt change

Significant Weight Change

5% in 1 month
7.5% in 3 months
10% in 6 months

Temperatures

Resident Water: = or < 120F
Air: 71F to 81F
Serving line: 140F (hot)
41F (cold)
Leftovers reheat to 165F
Freezer: 0 F
Refrigerator: 41F
Dishwasher: 140F wash
180F rinse.

Medication Pass

1. I need to see the bottle, box, card or whatever container the medication comes from, long enough to write it down.
2. Tell me anything scheduled now, that you are giving later or omitting at this time for any reason, otherwise I must assume you forgot to give it.
3. If you give any over the counter medication or any medication from a bottle, I need to see the medication in the cap before you place it in the medication cup.
4. I want to see multiple routes of administration – eye drops, inhalers, etc…not just PO medications.
5. During the time I am with you, please use clear plastic medication cups.

Closed Chart Review

1. Is there a discharge summary?
2. When was the resident discharged?
3. To where, was the resident discharged?
4. Was the family notified?
5. Was the physician notified?
6. Other notifications required?
7. Were their belongings picked up? When and by whom?
8. What happened to their medications?
9. Was follow up care arranged, if needed? (i.e. Home Health, Meals on Wheels, Physician appointments, etc)

Baseline Fluid Needs

1. Body weight (lbs) (divided by) 2.2 = weight in kilograms

2. Weight in kilograms x 30cc = _____ cc/day (Daily Fluid Needs)

Resident Sample Selection

Resident Census	Phase 1/ Phase 2	Comp Reviews*	Focused Reviews*	Closed Rec Reviews	Res/Family Interviews	W,H,P Group **
1 - 4	All / 0	2	2	0	1 / 1	All
5 - 10	3 / 2	2	2	1	1 / 1	2
11 - 20	5 / 3	2	5	1	2 / 2	3
21 - 40	6 / 4	2	7	1	3 / 2	3
41 - 44	7 / 4	2	8	1	3 / 2	4
45 - 48	7 / 5	2	9	1	3 / 2	4
49 - 52	8 / 5	3	9	1	4 / 2	4
53 - 56	8 / 6	3	9	2	4 / 2	4
57 - 75	9 / 6	4	9	2	4 / 2	5
76 - 80	10 / 6	4	9	3	4 / 2	5
81 - 85	10 / 7	4	10	3	4 / 2	5
86 - 90	11 / 7	4	11	3	4 / 2	6
91 - 95	11 / 8	4	12	3	4 / 2	6
96 - 100	12 / 8	5	12	3	5 / 2	6
101 - 105	13 / 8	5	13	3	5 / 2	7
106 - 110	13 / 9	5	14	3	5 / 2	7
111 - 115	14 / 9	5	15	3	5 / 2	7
116 - 160	14 / 10	5	16	3	5 / 2	7
161 - 166	15 / 10	5	17	3	5 / 2	8
167 - 173	16 / 10	5	18	3	5 / 2	8
174 - 180	16 / 11	5	19	3	5 / 2	8
181 - 186	17 / 11	5	20	3	5 / 2	9
187 - 193	17 / 12	5	21	3	5 / 2	9
194 - 299	18 / 12	5	22	3	5 / 2	9
300 - 400	18 / 12	5	22	3	6 / 3	9
401 -	18 / 12	5	22	3	7 / 3	9

* Comprehensive reviews plus focused reviews plus closed record reviews added together equals the total sample size (Phase 1 plus Phase 2).
** For any survey in which there are identified concerns in the areas of (W) unintended weight loss, (H) hydration, and/or (P) pressure sores, this is the minimum total of residents who must be selected for the Phase 1 sample to represent any or all of these conditions.

OFF SITE PREP

Oscar3 – choose concerns from facility history.
Oscar4 – Choose concerns from profile that are out of line with state, region and national.
Oscar40 Choose concerns from substantiated complaints in the past year.
QI's – Choose flagged, 90% and above 75% & above
Complaints – list any you are working

***

Highlight
#11 Fecal Impaction
#15 Dehydration
#24b-Low Risk Pressure Sores
QI's >75%
<-Get #s from Table

Pre-select
1 resident for each Sentinel Event WHP's required
Residents with multiple concerns

J	K	L
G	H	I
D	E	F
A	B	C

Isolated | Pattern | Widespread

- **Immediate Jeopardy to resident health or safety**
- **Actual harm that is not Immediate Jeopardy**
- **No actual harm with potential for more than minimal harm that is not Immediate Jeopardy**
- **No actual harm with potential for minimal harm.**

Isolated-One or a very limited number of residents are affected
Pattern – More than a very limited number of residents are affected or same resident affected by repeated occurrences.
Widespread – Pervasive in the facility or represents systemic failure and the potential to affect large portion or all the facility's residents.

ased on observation, record review and interview the facility failed to (provide, ensure, complete, maintain, etc) for # (resident #s) of # case mix residents who (received, required, etc.) (What the facility iled to provide for the resident). This failed practice had the potential to affect # of # residents in the facility, according to the (Source of information - Resident Census and Conditions Report dated ____. DON, Administrator, etc on [what date and time], etc). The findings are:

. Diagnoses, MDS Information a. Observations b. Record review information c. Any conducted interviews d. Policies and Procedures e. Manufacturer's Guidelines f. Industry Standard or Scientific Based Documentation

THIS IS NOT AN APPROVED ITEM

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F326 cont.	Weight/diet/Nutrition Make sure families are notified of significant weight losses	Suggested parameters for evaluating significance of unplanned and undesired weight loss are: INTERVAL / SIGNIFICANT LOSS / SEVERE LOSS 1 month / 5% / Greater than 5% 3 months / 7.5% / Greater than 7.5% 6 months / 10% / Greater than 10% The following formula determines percentage of loss: % of body weight loss = (usual weight - actual weight) / (usual weight) x 100 In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food? **Suggested laboratory values are:** Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion) Plasma Transferrin >60 yr.: 180 380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.) Hemoglobin / Males: 14-17 g/dl / Females: 12-15 g/dl Hematocrit / Males: 41 - 53 / Females: 36 - 46 Potassium / 3.5 - 5.0 mEq/L Magnesium / 1.3 - 2.0 mEg/L

REFERENCE NUMBERS

DO YOU HAVE QUESTIONS AND/OR ISSUES WITH THE FOLLOWING?

*RESIDENT RIGHTS

*QUALITY OF CARE

*FOOD QUALITY

*MEDICAID ISSUES/MEDICARE ISSUES

*ABOUT THE OMBUDSMAN PROGRAM

*ADULT PROTECTIVE SERVICES

*FILING A COMPLAINT

THE FOLLOWING HOTLINE NUMBERS ARE AVAILABLE TO ASSIT YOU:

*OLTC-1-800-582-4887 (IN PULASKI COUNTY 682-8425)

*MEDICAID-1-800-482-5431

*MEDICARE- 1-800-633-4227

*ARKANSAS LTC OMBUDSMAN PROGRAM- 1-800-482-6359 OR 501-372-5300

*TO REPORT ELDER ABUSE DOMESTIC/COMMUNITY-1-800-332-4443

*CRIMES AGAINST CHILDREN-1-800-482-5964

UPDATED JULY 2010

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79	F80	F81
Dressing	F82	F83	F84
Transferring	F85	F86	F87
Toilet Use	F88	F89	F90
Eating	F91	F92	F93

A. Bowel/Bladder Status

F94____ With indwelling or external catheter

F95 Of total number of residents with catheters, ____ were present on admission.

F96____ Occasionally or frequently incontinent of bladder

F97____ Occasionally or frequently incontinent of bowel

F98____ On individually written bladder training program

F99____ On individually written bowel training program

B. Mobility

F100____ Bedfast all or most of time

F101____ In chair all or most of time

F102____ Independently ambulatory

F103____ Ambulation with assistance or assistive device

F104____ Physically restrained

F105 Of total number of residents restrained,____ were admitted with orders for restraints.

F106____ With contractures

F107 Of total number of residents with contractures, ____ had contractures on admission.

C. Mental Status

F108____ With mental retardation

F109____ With documented signs and symptoms of depression

F110____ With documented psychiatric diagnosis (exclude dementias and depression)

F111____ Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type

F112____ With behavioral symptoms

F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program ____.

F114____ Receiving health rehabilitative services for MI/MR

D. Skin Integrity

F115____ With pressure sores (exclude Stage I)

F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission?____.

F117____ Receiving preventive skin care

F118____ With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119____ Receiving hospice care benefit

F120____ Receiving radiation therapy

F121____ Receiving chemotherapy

F122____ Receiving dialysis

F123____ Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion

F124____ Receiving respiratory treatment

F125____ Receiving tracheostomy care

F126____ Receiving ostomy care

F127____ Receiving suctioning

F128____ Receiving injections (exclude vitamin B12 injections)

F129____ Receiving tube feedings

F130____ Receiving mechanically altered diets including pureed and all chopped food (not only meat)

F131____ Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)

F132____ Assistive devices while eating

F. Medications

F133____ Receiving any psychoactive medication

F134____ Receiving antipsychotic medications

F135____ Receiving antianxiety medications

F136____ Receiving antidepressant medications

F137____ Receiving hypnotic medications

F138____ Receiving antibiotics

F139____ On pain management program

G. Other

F140____ With unplanned significant weight loss/gain

F141____ Who do not communicate in the dominant language of the facility (include those who use sign language)

F142____ Who use non-oral communication devices

F143____ With advance directives

F144____ Received influenza immunization

F145____ Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date

TO BE COMPLETED BY SURVEY TEAM

F146	Was ombudsman office notified prior to survey?	Yes ☐	No ☐
F147	Was ombudsman present during any portion of the survey?	Yes ☐	No ☐
F148	Medication error rate ____%		

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

GENERAL INSTRUCTIONS
THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is not a federal requirement for automation of the 672 form. The facility may continue to complete the 672 with manual methods. The facility may use the MDS data to start the 672 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the 672 to represent current resident status according to the definitions of the 672. Since the census is designed to be a representation of the facility during the survey, it does not directly correspond to the MDS in every item.

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds). For the purpose of this form "residents" means residents in certified beds regardless of payor source.

Following the definition of each field, the related MDS 2.0 codes and instructions will be noted within square brackets ([ ]).

Where coding refers to the admission assessment, use the first assessment done after the most recent admission or readmission event.

Complete each item by specifying the number of residents characterized by each category. If no residents fall into a category enter a "0".

INSTRUCTIONS AND DEFINITIONS

Provider No. - Enter the facility's assigned provider number. Leave blank for initial certifications.

Block F75 - Enter the number of facility residents, whose primary payer is Medicare. [code manually]

Block F76 - Enter the number of facility residents, whose primary payer is Medicaid. [code manually]

Block F77 - Enter the number of facility residents, whose primary payer is neither Medicare nor Medicaid. [code manually]

Block F78 - Enter the number of total residents for whom a bed is maintained, on the day the survey begins, including those temporarily away in a hospital or on leave. [Total residents in nursing facility or on bedhold]

ADLS (F79 – F93)
To determine resident status, unless otherwise noted, consider the resident's condition for the 7 days prior to the survey. [Horizontal totals must equal the number in F78; Manually re-code all "8" responses.]

Bathing (F79 – F81)
The process of bathing the body (excluding back and shampooing hair). This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. [F79: G2A = 0; F80: G2A = 1, 2, 3; F81: G2A = 4]

Many facilities routinely provide "setup" assistance to all residents such as drawing water for a tub bath or laying out bathing materials. If this is the case and the resident requires no other assistance, count the resident as independent.

Dressing (F82 – F84)
How the resident puts on, fastens, and takes off all items of street clothing, including donning or removing prostheses (e.g., braces and artificial limbs). [F82: G1Ag = 0; F83: G1Ag = 1, 2, 3; F84: G1Ag = 4]

Many facilities routinely set out clothes for all residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance with donning a brace, elastic stocking, a prosthesis and so on, securing fasteners, or putting a garment on, count the resident as needing the assistance of 1 or 2 staff.

Transferring (F85 – F87)
How the resident moves between surfaces, such as to and from the bed, chair, wheelchair or to and from a standing position. (EXCLUDE transfers to and from the bath or toilet). [F85: G1Ab = 0; F86: GlAb = 1, 2, 3; F87: GlAb = 4]

Many facilities routinely provide "setup" assistance to all residents, such as handing the equipment (e.g., sliding board) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use (F88 – F90)
How the resident uses the toilet room (or bedpan, bedside commode, or urinal). How resident transfers on and off toilet, cleans self after elimination, changes sanitary napkins, ostomy, external catheters, and adjusts clothing prior to and after using toilet. If all that is done for the resident is to open a package (e.g., a clean sanitary pad), count the resident as independent. [F88: GlAi = 0; F89: G1Ai = 1, 2, 3; F90: G1Ai = 4]

Eating (F91 – F93)
How resident eats and drinks regardless of skill. Many facilities routinely provide "setup" activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the extent of assistance, count this resident as independent. [F91: G1Ah = 0; F92: G1Ah = 1, 2, 3; F93: G1Ah = 4]

A. BOWEL/BLADDER STATUS (F94 – F99)

F94 - With an indwelling or an external catheter
The number of residents whose urinary bladder is constantly drained by a catheter (e.g., a Foley catheter, a suprapubic catheter) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., a Texas catheter). [H3c or d = check]

F95 - Of the total number of residents with catheters
The number of residents who had a catheter present on admission. For a resident readmitted from a hospital with a catheter, count this resident as admitted with a catheter. [H3c or d = check and A8a = 1 or A8b = 1 or 5]

F96 - Occasionally or frequently incontinent of bladder
The number of residents who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. [Hlb = 2, 3 or 4 and H3c and d are not = check]

F97 - Occasionally or frequently incontinent of bowel
The number of residents who have a loss of bowel control two or more times per week. [H1a = 2, 3 or 4]

F98 - On individually written bladder training program
The number of residents with a detailed plan of care to assist the resident to gain and maintain bladder control (e.g., pelvic floor exercises). Count all residents on training programs including those who are incontinent. [H3b = check]

F99 - On individually written bowel training program
The number of residents with a detailed plan of care to assist the resident to gain and maintain bowel control (e.g., use of diet, fluids, and regular schedule for bowel movements). Count all residents on training programs including those who are incontinent. [code manually]

B. MOBILITY (F100 – F107)

[Total for F100 – F103 should = F78; Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.]

F100 - Bedfast all or most of time The number of residents who were in bed or recliner 22 hours or more per day in the past 7 days. Includes bedfast with bathroom privileges. [G6a = check and G5d is not = check]

F101 - In chair all or most of time The number of residents who depend on a chair for mobility. Includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. [G5d = check]

F102 - Independently ambulatory The number of residents who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. [G1Ac = 0 and GlAd = 0 and G5a is not = check]

F103 - Ambulation with assistance or assistive devices The number of residents who required oversight, cueing, physical assistance or who used a cane, walker, crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. [G1Ac or d = 1, 2 or 3 or G5a = check]

F104 - Physically restrained The number of residents whose freedom of movement and/or normal access to his/her body is restricted by any manual method or physical or mechanical device, material or equipment that is attached or adjacent to his/her body and cannot be easily removed by the resident. [Any P4c, d or e = 1 or 2]

F105 - Of total number of restrained residents, number admitted or readmitted with an order for restraint. [Code manually when criteria for F104 is met and P4c, d or e = 1 or 2 and A8a = 1 or A8b = 1 or 5]

F106 - With contractures The number of residents that have a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc. Includes loss of range of motion in fingers, wrists, elbows, shoulders, hips, knees and ankles. [Any G4Aa, b, c, d, e or f = 1 or 2]

F107 - Of total of residents with contractures, the number who had a contracture(s) on admission. [Code when criteria for F106 is met on admission or readmission assessment and A8a = 1 or A8b = 1 or 5.]

C. MENTAL STATUS (F108 – F114)

F108 - With mental retardation Identify the total number of residents in all of the categories of developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. [Any AB10b, c, e or f = check]

F109 - With documented signs and symptoms of depression The total number of residents with documented signs and symptoms of depression as defined by MDS (Mood and Behavior Section). [I1ee = check or E1a, e, l or m > 0]

F110 - With documented psychiatric diagnosis (exclude dementias and depression) The number of residents with primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, and atypical psychosis). [I1dd, ff, or gg = check. Code manually for other psychiatric diagnoses listed here]

F111 - Dementia: Multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type The number of residents with a primary or secondary diagnosis of dementia or organic mental syndrome including multi-infarct, senile type, Alzheimer's type, or other than Alzheimer's type. [I1q or u = check]

F112 - With behavioral symptoms The number of residents with one or more of the following symptoms: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resistive to care. (See MDS Section (Mood and Behavioral Patterns)). [Any E4Aa, b, c, d or e = 1, 2 or 3]

F113 - Of the total number with behavioral symptoms, the number receiving a behavior management program. The number of residents with behavior symptoms who are receiving an individualized care plan/program designed to address behavioral symptoms (as listed above). [Manually code when criteria for F112 is met and P2a = check and P2c or d = check]

F114 - Receiving health rehabilitative services for MI/MR The number of residents for whom the facility is providing health rehabilitative services for MI/MR as defined at 483.45(a). [Use item for Residents who meet F108 or F110, then code manually]

D. SKIN INTEGRITY (F115 – F118)

F115 - With pressure sores The number of residents with ischemic ulcerations and/or necrosis of tissues overlying a bony prominence (exclude Stage I). [Any M1b, c or d > 0 or M2a > 1 Code for first assessment after latest admission or re-admission]

F116 - Of the total number of residents with pressure sores excluding Stage I, the number who had pressure sores on admission or who were readmitted with a new pressure sore (exclude Stage I). [Code when criteria for field 115 are met and A8a = 1 or A8b = 1 or 5.]

F117 - Receiving preventive skin care The number of residents receiving non-routine skin care provided according to a physician's order, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.) [Any M5a, b, c, d, e, f, g, h, or i = check]

Fl18 - With rashes Enter the number of residents who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., but not limited to antifungals, cortisteroids, emollients, diphenydramines or scabicidals, etc.) [M4d = check]

E. SPECIAL CARE (F119 – F132)

F119 - Receiving hospice care Number of residents who have elected or are currently receiving the hospice benefit. [P1ao = check]

F120 - Receiving radiation therapy The number of residents who are under a treatment plan involving radiation therapy. [P1ah = check]

F121 - Receiving chemotherapy The number of residents under a specific treatment plan involving chemotherapy. [P1aa = check]

F122 - Receiving dialysis The number of residents receiving hemodialysis or peritoneal dialysis either within the facility or offsite. [P1ab = check]

F123 - Receiving intravenous therapy, IV nutritional feedings and/or blood transfusion The number of residents receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. [K5a = check or P1ac = check or P1ak check]

F124 - Receiving respiratory treatment The number of residents receiving treatment by the use of respirators/ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheotomy care or respiratory suctioning. [P1ag = check or P1al = check or P1bd.A > 0]

F125 - Receiving tracheotomy care The number of residents receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/ coverings for the stoma. [P1aj = check]

F126 - Receiving ostomy care The number of residents receiving care for a colostomy, ileostomy, uretrostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheotomy. [P1af= check]

F127 - Receiving suctioning The number of residents that require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the mouth, nasal passage, or tracheotomy stoma. [P1ai = check]

F128 - Receiving injections The number of residents that have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) [Review residents for whom 03 = 1, 2, 3, 4, 5, 6 or 7. Omit from count any resident whose only injection currently is B12.]

F129 - Receiving tube feeding The number of residents who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). [K5b = check]

F130 - Receiving mechanically altered diets The number of residents receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). [K5c = check]

F131 - Receiving rehabilitative services The number of residents receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist. (Exclude health rehab. for MI/MR.) [P1baA or P1bbA or P1bcA > 0]

F132 - Assistive devices with eating The number of residents who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). [K5g = check]

F. MEDICATIONS (F133 – F139)

F133 - Receiving psychoactive drugs The number of residents that receive drugs classified as antidepressants, antianxiety, sedative and hypnotics, and antipsychotics. [Any O4a, b, c or d = 1, 2, 3, 4, 5, 6 or 7].

Use the following lists to assist you in determining the number of residents receiving psychoactive drugs. These lists are not meant to be all inclusive; therefore, a resident receiving a psychoactive drug not on this list, should be counted under F133 and any other drug category that applies - F134, F135, F136, and/or F137.

F134 - Receiving antipsychotic medications
[O4a = 1, 2, 3, 4, 5, 6 or 7]
Clorazil (Clozapine)
Haldol (Haloperidol)
Haldol Deconate (Haloperiodal Deconate)
Inapsine (Droperidol)
Loxitane (Loxapine)
Mellaril (Thioridazine)
Moban (Molindone)
Navane (Theothixene)
Olazapine (Zyprexa)
Orap (Pimozide)
Prolixin, Deconoate (Fluphenazine Deconate)
Prolixin, Permitil (Fluphenazine)
Quetiapine (Seroquel)
Risperdal (Risperidone)
Serentil (Mesoridazine)
Sparine (Promazine)
Stelazine (Trifluoperazine)
Taractan (Chlorprothixene)
Thorazine (Chlorpromazine)
Tindel (Acetophenazine)
Trilafon (Perphenazine)

F135 - Receiving antianxiety medications
[O4b = 1, 2, 3, 4, 5, 6 or 7]
Ativan (Lorazepam)
Centrax (Prazepam)
Klonopin (Clonazepam)
Librium (Chlordiazepoxide)
Paxipam (Halazepam)
Serax (Oxazepam)
Valium (Diazepam)
Vistaril, Atarax (Hydroxyzine)
Xanax (Alprazolam)

F136 - Receiving antidepressant medications
[O4c = 1, 2, 3, 4, 5, 6, 7]
Asendin (Amoxapine)
Aventlyl, Pamelor (Nortriptyline)
Bupropion (Wellbutrin)
Desyrel (Trazodone)
Effexor (Venlafaxine)
Elavil (Amtriptyline)
Lithonate, Lithane (Lithium)
Ludiomil (Maprotiline)
Marplan (Isocarboxazid)
Nardil (Phenelzine)
Nefazodone (Serzone)
Norpramin (Desipramine)
Parnate (Tranylcypromine)
Paroxetine (Paxil)
Prozac (Fluoxetine)
Sertraline (Zoloft)
Sinequan (Doxepin)
Tofranil (Imipramine)
Vivactil (Protriptyline)

F137 - Receiving hypnotic medications
[O4d = 1, 2, 3, 4, 5, 6 or 7]
Dalmane (Flurazepam)
Estazolam (ProSom)
Halcion (Triazolam)
Quazepam (Doral)
Restoril (Temazepam)
Zolpidem (Ambien)

F138 - Receiving antibiotics The number of residents receiving sulfonamides, antibiotics, etc., either for prophylaxis or treatment. [Code manually].

F139 - On a pain management program The number of residents with a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with alternative approaches (e.g., massages, heat, etc.). [Code manually when any J3a, b, c, d, e, f, g, h, i or j = check]

G. OTHER RESIDENT CHARACTERISTICS (F140 – F146)

F140 - With unplanned or significant weight loss/gain The number of residents who have experienced gain or loss of 5% in one month or 10% over six months. [K3a or K3b = 1 and K5h is not = check]

F141 - Who do not communicate in the dominant language at the facility The number of residents who only express themselves in a language not dominant at the facility (e.g., this would include residents who speak only Spanish, but the majority of staff that care for the residents speak only English). [code manually]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F142 - Who use non-oral communication devices (e.g., picture board, computers, sign-language). [Any C3b, c, d, e,or f = check]

F143 - Who have advanced directives (living will/ durable power of attorney) The number of residents who have advanced directives, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated.
[Any A10a, b, c, f, g, or h = check]

F144 - Received influenza immunization The number of residents known to have received the influenza immunization within the last 12 months. [code manually]

F145 - Received pneumococcal vaccine The number of residents known to have received the pneumococcal vaccine. [code manually]

F146 - Ombudsman notice - LEAVE BLANK
This will be completed by survey team. Indicate yes or no whether Ombudsman office was notified prior to survey.

F147 - LEAVE BLANK This will be completed by the survey team. Indicate whether Ombudsman was present at any time during the survey, 1 (yes) or 2 (no).

F148 - Medication error rate - LEAVE BLANK
This will be completed by the survey team.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B	C	D
	Tag Number	Services Provided			Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
		1	2	3			
Administration	F33						
Physician Services	F34						
Medical Director	F35						
Other Physician	F36						
Physician Extender	F37						
Nursing Services	F38						
RN Director of Nurses	F39						
Nurses with Admin. Duties	F40						
Registered Nurses	F41						
Licensed Practical/ Licensed Vocational Nurses	F42						
Certified Nurse Aides	F43						
Nurse Aides in Training	F44						
Medication Aides/Technicians	F45						
Pharmacists	F46						
Dietary Services	F47						
Dietitian	F48						
Food Service Workers	F49						
Therapeutic Services	F50						
Occupational Therapists	F51						
Occupational Therapy Assistants	F52						
Occupational Therapy Aides	F53						
Physical Therapists	F54						
Physical Therapists Assistants	F55						
Physical Therapy Aides	F56						
Speech/Language Pathologist	F57						
Therapeutic Recreation Specialist	F58						
Qualified Activities Professional	F59						
Other Activities Staff	F60						
Qualified Social Workers	F61						
Other Social Services	F62						
Dentists	F63						
Podiatrists	F64						
Mental Health Services	F65						
Vocational Services	F66						
Clinical Laboratory Services	F67						
Diagnostic X-ray Services	F68						
Administration & Storage of Blood	F69						
Housekeeping Services	F70						
Other	F71						

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ARKANSAS HEALTH CENTER
UNIT RN & LPN SUPERVISOR
DAILY START UP ROUTINE

PURPOSE: The purpose of unit observation rounds, documentation audits and the start up routine is to identify a pattern of concerns or problems. If a pattern is noted, then a breakdown in a system exists. At this point, investigate the problem / pattern / concern to determine interventions / solutions / approaches that will assist in elimination or correcting the problem.

There are three distinct components that make up this Quality Assessment routine

PART ONE: Creating the Target List
PART TWO: Unit / Resident Observation Rounds
PART THREE: Documentation Audit

PART ONE: CREATING A TARGET LIST

In order to create a target list, you will need to review, at a minimum the 24-hour nursing shift report, I & A reports, Hot Rack Charting list and any telephone orders written since last review. Once you have accomplished this task, a target group of residents should be identified.

A. 24-hour nursing shift report: identify residents with a change of condition, concerns, etc. and place the residents name on the list.
B. I & A Report: Every resident with an incident / accident report should be added to the target list
C. Telephone Orders: Review telephone orders and add the name of each resident requiring follow up to the list

PART TWO: UNIT / RESIDENT OBSERVATION ROUNDS

Note: **NEVER** delegate this task. You may assign other key personnel to assist in conducing these rounds but it is imperative that the RN Supervisor & LPN Supervisor conducts daily rounds to monitor the day-to-day function of the unit.

Resident / Unit observation rounds consist of conducting thorough rounds throughout the unit. Every resident on the target list will be seen during these rounds. As you are making rounds, look for patterns of problems. This may indicate a breakdown in the current system. Items requiring correction should be addressed immediately or as soon as possible. Remember writing a concern regarding observation rounds is useless unless correction and follow-up is also completed.

PART THREE: DOCUMENTATION AUDIT

Review the following components of documentation for compliance. Please note, that this may not be an all-inclusive list and only serves as a guideline.

RN SUPERVISOR/DESIGNEE AUDIT RESPONSIBILTIES:

1. Telephone Orders
2. Hot Rack List
3. Medication Ordering and Receiving Book
4. Controlled Substance Book
5. Incident and Accident Reports/ Fall logs
6. Skin Assessments
7. Nursing Summaries / Sleep notes
8. Meal Consumption Records
9. Behavior Documentation
10. Family or resident complaints / concerns

LPN SUPERVISOR AUDIT RESPONSIBILITIES:

1. Medication Administration Record
2. Treatment Administration Record
3. Glucometer Log
4. Refrigerator Temperature Log
5. ADL Flow sheets
6. Bath Schedules and completion
7. Security System Documentation on MAR
8. Restraint Documentation
9. Vital Signs
10. Weights
11. Intake and Output on MAR and I/O sheet
12. Snack consumption

ARKANSAS HEALTH CENTER
RN/DESIGNEE START UP ROUTINE
DATE: _____

Initial when item Reviewed	Documentation Audit Items to be Reviewed / Audited	Comments: Record any negative findings or items requiring follow up
	Telephone Orders	
	Hot Rack Charting	
	Medication Ordering / Receiving Log	
	Controlled Substance Book	
	Incident and Accident Reports/ Fall logs	
	Skin Assessments	
	Nursing Summaries / Sleep Notes	
	Meal Consumption Records	
	Behavior Documentation	
	Family or resident complaints/concerns	

ARKANSAS HEALTH CENTER
LPN START UP ROUTINE

DATE:_____

Initial when item Reviewed	Documentation Audit Items to be Reviewed / Audited	Comments: Record any negative findings or items requiring follow up
	Medication Administration Record	
	Treatment Administration Record	
	Glucometer Log	
	Refrigerator Temperature Log	
	ADL Flow Sheets	
	Bath Schedules and completion	
	Security System Documentation on MAR	
	Restraint Documentation	
	Vital Signs	
	Weights	
	Intake / Output on MAR and I/O sheet	
	Snack Consumption	

ARKANSAS HEALTH CENTER: RN START UP ROUTINE: TARGET LIST

DATE:_____

KEY CODE:

1. I / A report
2. Change of condition
3. Hot Rack List
4. Telephone Order
5. Behaviors
6. New Admit/Transfer
7. Med Variance
8. Other

Room #	Resident Name	Reason for target list: Use key code with brief explanation	After review of all documentation record any negative findings with follow up/corrections	Was the MD and family notified? Is it charted?

ARKANSAS HEALTH CENTER: LPN START UP ROUTINE: TARGET LIST

DATE:_____

KEY CODE:

4. I / A report
5. Change of condition
6. Hot Rack List
4. Telephone Order
5. Behaviors
6. New Admit/Transfer
7. Med Variance
8. Other

Room #	Resident Name	Reason for target list: Use key code with brief explanation	After review of all documentation record any negative findings with follow up/corrections	Was the MD and family notified? Is it charted?

TELEPHONE ORDER AUDIT

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list.

1. All orders shall be written on telephone orders
2. The RN unit supervisor will retrieve all telephone orders from the designated locations as part of the start up routine. The RN will review the order for accuracy and place the original telephone order in the physician's folder (or designated location) for the physician to review and sign. After the physician has reviewed and signed the order, the Administrative Assistant will file the telephone order, in reverse chronological order, in the resident's medical record.

3. The RN unit supervisor will keep the pink carbon copy
    a. Conduct a Telephone order audit- negative findings will require a telephone order check list to be completed
    b. Input orders into the computer
    c. Provide the MDSC with necessary information so the care plan can be updated
    d. Upon completion of these things, the pink copy may be destroyed.

4. A telephone order audit MUST be completed for each and every telephone order written that is not completed accurately. Please refer to the Telephone order audit checklist to ensure all components of the audit process has been completed.

5. Complete the telephone order audit ensuring all items on the checklist has been reviewed. If for whatever reason, the order is not accurately completed, address any concerns immediately and keep the order until it has been completed/ corrected.

6. **If a nurse fails to accurately write a telephone order after to T.O. audit checklist has been completed 2 times with them, then disciplinary actions will be taken next.

HOT RACK DOCUMENTATION SYSTEM

The purpose of the Hot Rack Charting System is to ensure resident's experiencing changes in condition will receive consistent assessments and accurate documentation at a minimum of every shift until the condition is resolved and or until the resident is stable.

1. Any resident experiencing a change in condition will be listed on the "Hot Rack Charting Form" located in a three-ring binder at each nurses station
2. The "Hot Rack Charting Form" will be reviewed by the licensed nurses on each shift and follow up assessment and documentation will be completed in the resident's medical record
3. The Unit RN supervisor will review the Hot Rack Charting list as part of the routine start up to ensure appropriate assessment, notification and documentation has been completed and recorded in the resident's medical record.
4. Any areas of concern must be addressed IMMEDIATLEY.

MEDICATION ORDERING AND RECEIVING BOOK

NOTE: The facility is held responsible and accountable for every single medication ordered, received, administered, wasted, destroyed, sent home, or sent to DHS Pharmacy Division for destruction. It is imperative that:

1. **All medications ordered and received are recorded in the medication ordering and receiving book**
2. **All medications administered are recorded on the MAR**
3. **All medications, wasted are recorded on MAR/ Controlled Substance book**
4. **All medications destroyed are recorded in the medication destruction log.**
5. **All medications sent home (discharged with resident) are recorded in the resident's medical record**
6. **All controlled substances sent to DHS Pharmacy Division for destruction are recorded on the Drug Surrendered form.**

1. The Medication Ordering and Receiving book will be reviewed during the start up routine as part of the telephone order audit.
2. All telephone orders are reviewed for new medications changes in medication, discontinuation of a medication, transfer of a resident, etc.
3. The pharmacy must be notified of all medication orders as well as transfers, discharges, hospitalizations, etc. The procedure for completing this notification this notification is to fax a copy of the order to the pharmacy, obtain a fax confirmation and attach to the order and file the order in the medication ordering and receiving book. Upon receipt of the medication, the nurse is required to note the date and time receiving the medication as well as the quantity received on the appropriate order form.
4. The Unit RN supervisor will review the medication ordering and receiving book to ensure the medication was ordered and received.
5. Any order not recorded as received will be addressed immediately. First, check to see if the medication was actually received and placed in the medication cart but not recorded on the appropriate form as being received. If medication is present, make a note on the form indicating medication was received and address with responsible nurse. If the medication was not received, notify the pharmacy immediately by phone.
6. Compare the medication received (including the label) to the physician's order to ensure the label and medication matches the order. Address and correct any discrepancies immediately.

CONTROLLED SUBSTANCE LOG

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. All controlled substances should be recorded on the front hard cover or "Page Index". This creates a tracking system so that in the event a page is missing from the controlled substance book; we will be able to identify the medication and resident the medication was prescribed. It is the responsibility of the nurse who entered the controlled substance into the log to transcribe this information to the Page Index. This should be reviewed as part of the start up routine and any areas of concern addressed immediately.
2. Nurses are required to sign the controlled substance log to verify the count is correct. Each shift, the on-coming nurse and the off-going nurse count the controlled substances and sign the log to signify the count is correct. Both nurses MUST look at the book count as well as the drug count and the back of the blister pack to ensure accuracy and no tampering. There can be no blanks. Review the signature page as part of the start up routine and address any areas of concern immediately.
3. On a random basis conduct a controlled substance count with the nurse. Does the nurse know how to count correctly? Does the nurse verbalize the name of the resident, name and strength of drug and quantity? Does the nurse check the back of the blister pack to ensure medications have not been taped? Does the nurse review the page AND verify the count by looking at the blister pack?
4. All controlled substances are to be stored behind double locks. Is the narcotic box locked? Is the medication cart kept locked when out of sight of the nurse? Is the narcotic book kept secured?
5. The controlled substance log is to be carried with the nurse on the medication cart at all times during medication pass. The controlled substance count MUST be accurate At ALL TIMES!!!! Is the nurse signing the medication out of the controlled substance log immediately upon removing the medication from the blister pack? Randomly audit this by checking the controlled substance book while the nurse is on medication pass. Address any concerns immediately.
6. Randomly review pages of the controlled substance book as part of the start up routine. Is the correct prescription number written on the page? If the order says give (1) every four hours---are the nurses signing out only one pill and at least four hours apart? If the order says, "give (1) bid"---had the medication been administered and signed out twice each day or where there any omitted does? Address any areas of concern immediately.
7. The controlled substance count cannot be corrected with out authorization from the DON/Designee. In the event the count is off the DON/Designee must be notified.

INCIDENT & ACCIDENT REPORTS / LOGS & FALL LOGS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. Review the policy on incident and accident reporting
2. Review all incident and accident reports as part of the start up routine
3. Enter the appropriate information on the unit I/A log and place the copy of the report with your notations in the I/A notebook. If you complete this as part of the start up routine, you will not have to spend a great deal of time trying to get your report together.
4. For almost every I/A report made, the resident's care plan will need to be updated. Be sure to communicate with the MDSC.
5. Review the I/A report with a critical or investigative eye. What happened? Why? What could be done to prevent this from happening again? Is all pertinent information pertaining to the incident documented on the I/A report? IF not address concerns with responsible person immediately.
    a. Did the resident have a fall? If yes, record the appropriate information on the fall log. Refer the resident to PT for a screen. Update Fall Risk Assessment after each fall. Update resident's care plan after each fall. Conduct an in-depth assessment to determine the cause for the falls (ie. Check blood sugar, orthostatic hypotension, change in condition, side effects of medication, infections, dehydration, incontinence, . environmental factors, etc)
    b. If the I/A report is in regards to skin breakdown, tear, abrasion, etc, has an order for a treatment been obtained? Has the care plan been updated to address the skin concern? Was the skin team notified?

6. Was the resident placed on the Hot Rack Charting list for follow-up documentation?
7. Review the resident's medical record. Are the facts clearly recorded in the notation? Was notification completed per policy and documented? Review the Time lines to ensure prompt documentation and notifications.
8. If the I/A was behavior related, was a BR completed?

WEEKLY SKIN ASSESSMENTS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be considered an all-inclusive list.

1. Develop a schedule for weekly skin assessments and educate all nurses as to when assessments are to be completed
2. As part of the start up routine review the documentation of skin assessments for the previous day to ensure assessments are completed as assigned. Address any areas of concerns immediately
3. Identify residents with an identified skin concern and check to ensure the MD and family have been notified and a treatment order obtained if indicated
4. Compare all skin assessment documentation to the current MD order for treatment. Every site identified should have a separate/specific treatment order
5. Resident's identified with a skin concern must have a detailed description as to location, stage, size, depth, odor, drainage, treatment in process, effectiveness, etc
6. Skin concerns regarding dry skin, skin tears, etc also require a notation regarding location, size, treatment, etc along with Treatment orders
7. Complete Braden score as indicated regarding at risk resident's

NURSING SUMMARIES / SLEEP NOTES

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be considered an all-inclusive list.

1. A nursing summary will be completed every 2 weeks for each resident. The schedule should be created by room and bed number versus the resident's name. The resident should have a nursing summary scheduled for the day shift and the other one schedule for the evening shift.
2. Sleep notes will be completed by the night shift using the schedule for the nursing summary for days and nights. Sleep notes will also be completed nightly if a resident is on a hypnotic medication.
3. The unit RN supervisor will develop a schedule to ensure all residents on the unit have a nursing summary and sleep note completed. Educate all nurses regarding this assignment including documentation requirements, location of the nursing summary/sleep note schedule, etc
4. Nursing Summaries will be completed in narrative format on the nursing summary form.
5. Sleep notes will be completed in narrative format in the nurses notes identifying the notation as "Sleep Note"
6. A nursing summary should
    a. A. Provide a full assessment as to the residents current physical, social and mental status
    b. Address care plan problems and goals
7. The nursing summary should include the following (this is not an all-inclusive list)
    a. Mental Status- Is the resident alert, oriented, confused, exhibit s/s short or long term memory deficit, safety awareness, decision making skills, comatose, etc? Do not just list the descriptive word but provide a narrative notation to justify the use of these words. Also include any interventions the staff utilized to address the issues.
    b. Emotional Status/Behaviors-Is resident depressed? Anxious? Noisy? Easily upset? Withdrawn? Hostile? Resistive to care? Verbally or physically abusive? Socially inappropriate? Cooperative, etc
    c. Hearing-Does resident have any deficit? Is a hearing device utilized: Des resident refuse to wear the device? Does resident hear better on one side versus the other? Is hearing adequate? Does staff adjust voice tone when communicating with resident? Does staff use non-verbal techniques to communicate?
    d. Speech-Does resident have difficulty speaking? How does resident communicate needs? Speech slurred? Difficulty completing thought processes?
    e. Vision- Does resident have any visual deficits? Do glasses correct vision? Is staff required to assist with application of glasses? Cataracts? Blind?

f. Bowel and Bladder Function- Is resident continent or incontinent of bladder? Bowel? Does resident use toilet? Pull ups, depends? Catheter? Ostomy? Impactions? Constipation? UTI? What type of assistance is required?
g. Grooming/personal hygiene/ADL's-What type of assistance does the resident require with each ADL task? Oral care, nail care, dressing bathing, feeding?
h. Ambulation/mobility- Is the resident ambulatory? Is a w/c utilized? Can they self propel? Does resident use a cane or walker? Is gait steady? Can they turn and reposition self in bed? Need assistance with repositioning? Can resident assist with task? Require assistance with transfer? One person? Two people? Hoyer?
i. Eating Habits- What type of diet is received? Can they feed self? Require assistance: What type? Set up, verbal cue? Spoon Fed? Tolerate diet? Voice complaints about diet/food? How is appetite? Is weight stable? Any loss? Receive supplements: Snacks?
j. Vital signs-always include a complete set of VS with summary
k. Restraints- Discuss type used
l. Skin assessment- Does resident have impaired skin integrity? Fragile? history of tears? Bruises? Dry skin? What interventions do we use? Padded rails? Lotion? Hydration? Any treatment orders?
m. Medications-review MD orders for past 2 weeks. Any new orders? Changes?
n. Care plan-discuss cp problems and interventions

8. As part of the start up routine, check the nursing summary schedule and review the nursing documentation in the resident's medical record for the previous day assignment to ensure completion as scheduled.
9. Look for areas of concern. Provide ongoing training regarding documentation requirements.

BEHAVIOR REPORTS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. Review all behaviors, I/A's as part of the start up routine
2. Provide the Social worker the appropriate information to be updated on the BR form.
3. Place a copy of BR for the SW and MD to review
4. Update the care plan as needed with behaviors
5. Review the behavior report with an investigative eye. What happened? Why? What could be done to prevent this from happening again?
6. Did the behavior require an I/A to be completed? If so were they placed on the Hot Rack Chart?

FAMILY OR RESIDENT COMPLAINTS / CONCERNS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. Monitor the complaint book daily for any written concerns/complaints
2. Provide the social worker with a copy
3. Notify DON, ADON with findings and what Plan of correction will be
4. Follow up with a written Plan of correction
5. Be sure to get with person making complaint/concern as to your POC.

GLUCOMETER LOG

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. Refer to the recommendation of the manufacturer. A copy of the manufacturer's recommendation should be kept in the Glucometer log notebook.
2. A glucometer log will be maintained for each glucometer in the facility. Each glucometer must have a separate log and should have the serial number / model number noted on the form.
3. Glucometers are to be checked/tested every day and the appropriate information is to be recorded on the glucometer log. This has been assigned to the night shift (11-7 or 7p-7a) LPN.
4. The glucometer log will be reviewed as part of the start up routine. Areas of concern MUST be addressed immediately.

TEMPERATURE LOG

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

A temperature log will be kept for **each medication refrigerator in the facility.** The night shift nurse (11-7, 7p-7a) will be responsible for ensuring this is completed on a daily basis. As part of the start up routine, the temperature log will be reviewed for areas of concern such as skips in documentation or temperature recordings deviating from the acceptable range of 36-46 degrees. Areas of concern must be addressed immediately.

**Note- all resident refrigerators must have a daily log maintained as well as the medication refrigerators.'

MEDICATION ADMINISTRATION RECORD
MAR

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list. The Medication Administration Record should be reviewed each day as part of the start up routine.

1. Monitor for skips in documentation. Never fill in blanks. Address compliance problems with the responsible individual. Look for patterns of concern and address immediately.
2. Monitor all hand-written (transcribed) orders on the MAR as part of the telephone order audit to ensure accuracy
3. Review orders especially hand-written orders, to ensure all components have been included in the order i.e., name of medication, strength, dosage, form, route, frequency, diagnosis, special directions, stop dates, etc.
4. Monitor for any orders that may require physician clarification
5. Monitor for nurses signature on the MAR
6. Monitor for nurses initials and corresponding documentation on the back of the MAR every time a PRN medication is administered. Documentation on the back of the MAR must include the name of the medication given, dosage, reason for administration, results or effectiveness, nurses signature, date administered and time administered. IF the PRN medication is for a controlled substance, a notation must also be made in the nurse's notes.
7. Monitor for notations on the MAR or back of the MAR such as "Unable to find medication or medication unavailable" This must be addressed immediately. Pharmacy services are available 24 hours per day and we, as nurses are responsible and held accountable for ensuring medications are available to administer as ordered by the physician.
8. Monitor for adherence to facility policy regarding medication administration times. A MD order must be obtained to administer medication at a time different than the facility's medication administration schedule. In the event a physician orders a medication to be given at a different time this MUST be reflected in the actual order. **NOTE: medications administered at times other than the time ordered by the physician and or based on the facility's medication administration schedule constitute a medication error.**
9. Conduct random audits to ensure availability of medications
10. Monitor for patterns"
    a. If resident is refusing medication: has the MD been notified? Family? Can we d/c the med?
    b. IF resident is spitting out medication, has MD been notified? Do we need to change to another medication that can be crushed?
    c. Is a resident requesting a PRN medication frequently? Has the MD been notified? Does this order need to be changed to a scheduled administration time?

d. If a resident has an order for a duragesic patch, is there documentation on the back of the MAR stating where the patch was applied? How the patch was removed and destroyed along with 2 nurses signature?

PLEASE NOTE:
The facility is held responsible and accountable for every single medication

1. Administered
2. Ordered
3. Received
4. Destroyed
5. Wasted
6. Discharged with a resident
7. Returned to pharmacy
8. Sent to Dept of Health-Pharmacy division for destruction

********Therefore, it is imperative that nurses are held responsible and accountable for completing and maintaining accurate records. **********

1. All medications administered are recorded on the MAR as evidenced by the the nurses initials
2. All medications ordered and received are recorded in the Medication ordering and receiving book
3. 'All controlled substances administered are recorded immediately in the controlled substance book upon removal from the locked CS box and initialed as administered on the MAR
4. All medications wasted are properly documented in the appropriate location
5. All medications destroyed are recorded in the Medication Destruction Log
6. All medications discharged with a resident are documented in the medical record
7. All controlled substances sent to DHS Pharmacy Division are recorded on the Drug Surrendered form

TREATMENT ADMINISTRATION RECORD
(TAR)

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

The Treatment Administration Record (TAR) should be reviewed as part of the start up routine.

1. Monitor for skips in documentation. Never fill in blanks. Address compliance problems with the responsible individual
2. Review each order with special emphasis on any hand-written orders to ensure accuracy. Treatment orders should include the following:
    a. Are we cleansing the site? With what?
    b. Location
    c. Name of ointment/solution/topical and strength (if applicable)
    d. Type of dressing to use
    e. Frequency to administer treatment
    f. Stop date

Example: Cleanse skin tear to LLE with soap and water, Apply triple antibiotic ointment and cover with Mepore Q shift until healed.

3. If a PRN treatment is administered, review the back of the TAR for appropriate documentation
4. Monitor for treatment supply availability
5. Compare all skin assessment documentation and incident and accident reports to the current physicians order/ treatment administration record. Unless a physician declines to treat a skin concern (which would be documented in the nurses notes) every reported skin condition or site should have a specific treatment order. Also EVERY site must have a separate order.

Example: If the resident has an incident and accident report for a skin tear written on 06-28-05, the resident must also have an order to treat the area written on the same date and transcribed to the TAR.

6. Monitor orders transcribed (hand-written) on the TAR to the telephone order and physician's orders form to ensure accuracy. This should be completed as part of the telephone order audit during the start up routine.
7. Review the TAR for any PRN orders which have not been utilized in the past 90 days. May we discontinue the order?

ADL NURSING CARE RECORD

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. ADL documentation is to be completed every shift by the certified nursing assistant. However, the charge nurse is responsible for ensuring documentation is completed as assigned
2. Review the ADL documentation as part of the start up routine
3. Monitor for skips. Address areas of concern with the appropriate shift or responsible person
4. Monitor for patterns of concerns.

Example:

   a. Documentation of no bowel movements for 3 days or more. If this has been recorded on the ADL record, is the nurse aware? Have we assessed the resident? Have we initiated treatment? Has the physician been informed? Family?
   b. Is there a pattern of skips?
   c. Are showers/ baths being recorded? Is the resident refusing? When was the last time the resident bathed? IF resident is refusing baths/ showers, is this addressed in the residents care plan?
   d. Review the percentage of meal consumption? How is the resident eating? Does resident consume less than 50% of meals? Is resident at risk for losing weight? Has the resident lost weight?
   e. Are we providing oral care at least twice a day? Is this documented?

RESTRAINT DOCUMENTATION

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. As part of the Start up routine, review the documentation for restraint utilization
2. Monitor for skips. Never fill in blanks. Address negative concerns immediately
3. Review new orders for restraints to ensure the order is written correctly and include all components of a restraint order. Is there a signed informed consent for the use of the specific restraint in the resident's medical record? If not, is there documentation that a verbal consent was obtained by phone and the written consent form is or has been mailed? Has a pre-restraining assessment been completed? Has the restraint been addressed in the care plan? Has the resident been referred to PT or OT for a screening / eval?
4. Is documentation regarding the checking and releasing of restraints present?
5. Do nurses address restraint use when documenting nursing summaries?
6. Does staff know which residents has/have an order for a restraint? Does staff know what type of restraint the resident requires? What about staff borrowed from other units or agency staff? Is there a list available indicating name of resident, type of restraint to use, and when to use the restraint?
7. Conduct observation rounds as part of the start up routine and compare the physician ordered restraint to what type of restraint is being utilized. Address areas of concern immediately. During observation rounds, monitor to ensure restraints are applied correctly? If any areas of concern are present, address immediately. If a pattern is present, conduct in-service training (request assistance from PT) for the staff to educate them on the proper application of restraints. Be sure to document this.

VITAL SIGNS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. The Unit RN/LPN supervisor will develop and post a schedule for completing weekly vital signs.
2. Educate staff regarding this assignment
3. As part of the routine start up, the Unit RN supervisor will review the vital sign records to ensure this assignment has been completed as assigned. If the RN schedules all weekly Vital Signs to be completed every Monday on 3-11 shift, then on Tuesday morning during the start up routine, the RN will review the vital sign record to ensure completion. Address areas of concern immediately.
4. A complete set of Vital signs must be documented at a minimum of every 7 days
5. Vital signs should be recorded along with the date they were obtained
6. Monitor to ensure each resident has a vital sign record
7. Monitor for skips. Never fill in blanks. Address areas of concern immediately.

SUPPLEMENT/SNACK DOCUMENTATION

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. All therapeutic snacks/supplements must be administered in a timely manner. A supplement is just as important as a medication. It is important for the nurse to document the administration of the supplement and to include the amount of consumption on the TAR.
2. Review orders for supplements to ensure the order is written completely and accurately. The order should include the supplement to administer, how much and how often.

   Example: Ensure (1) can PO BID at 1000 & 1400
3. The nurse must record the amount the resident consumed. Remember, if the order says on e can, and the resident only consumed half of the can, the nurse needs to record 50% instead of just initiating the box which would indicate that the resident received the entire can as ordered.

   The order should look like:

Ensure (1) can PO BID at 1000 & 1400---------1000—TC %------100 1400---TC %------50

Review documentation as part of the start up routine. Address any areas of concerns such as skips, etc

If the resident has a pattern of refusing the supplement, notify the physician and see if the order can be discontinued.

INTAKE AND OUTPUT RECORD

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

An intake /output record should be utilized for every resident who has an order for strict I & O; catheter; IV; feeding tube; etc. The Intake and or output should be recorded on the MAR at the end of each shift. The 3-11 shift should add the amounts from all three shifts and document the 24 hour total.
If this is a 12-hour unit, the 7p-7a shifts will add the amounts from both shifts and document the 24-hour total.

As part of the start up routine, review the MAR for Intake and Outputs.

1. Look for skips. Never fill in blanks. Address negative concerns
2. Is there a discrepancy between the physician's order and the amount recorded on the MAR? For example, if a resident has an order for Jevity at 100 cc per hour, we would expect the 24-hour total to be 2400cc. If there is a difference in the amount recorded, is documentation available to justify the reason.
3. Review all physician orders and all new telephone orders to ensure resident with orders for catheter, tube feeding, IV's, etc have an Input and or Output record.

WEIGHTS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. Weights must be documented at a minimum of every 30 days.
2. If possible the same scale should be used to weigh the resident. If for whatever reason, the same scale is not being utilized, documentation should reflect what scale was utilized to obtain the residents weight
3. Educate staff on the proper procedure for weighing residents
4. Weights should be recorded along with the actual day they were obtained.
5. Any resident with a 5-pound weight variance must be re-weighed within 24 hours.
6. Every resident with a significant weight variance:
    a. Should be placed on weekly weights until the weight is stable.
    b. Should receive an assessment to determine the cause of the weight loss/gain. Conduct a chart audit to determine percentage of meal consumption, talk with staff to determine if resident is having difficulty swallowing, refusing to eat, etc. Are there any other changes in the residents condition? Is resident lethargic, more confused? Does the resident require more assistance with meals? Does the resident exhibit signs or symptoms of infection, impaction, dehydration, depression, etc?
    c. Should be referred to dietary for consultation
    d. Should be referred to the physician. The physician should review the medication regimen to determine possible adverse side effects
    e. Does the resident need a feeding/swallowing evaluation? Should resident be referred to OT, PT or ST?
    f. Should have a care plan addressing poor appetite/weight loss or gain/etc. It is very important that a care plan be developed addressing the weight concern.
7. Monitors to ensure monthly weights are completed as assigned. Review the entire list of weights and identify any areas of concern. Address the areas immediately.
8. Forward a copy of the completed weights to dietary.
9. As part of the start up routine, review the monthly weights on a monthly basis and weekly weights on a weekly basis.

SECURITY SYSTEM DOCUMENTATION

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1. Every resident with a security alarm bracelet, should be checked each shift to ensure placement of the alarm. This information should be recorded on the MAR/TAR each shift.
2. The security alarm bracelet will be tested weekly and as needed. This information will be recorded on the MAR/TAR
3. Residents with a security alarm bracelet will be monitored closely during fire drills or any time the alarm system is malfunctioning.
4. Residents with a security alarm will be supervised at all times when off the unit.
5. Review the MAR/TAR for documentation of alarm placement and checks.
6. Conduct random observation rounds to identify placement of the alarm bracelet.

24 HOUR NURSING REPORT

NOTE: The 24-hour nursing report should be used as a tool to communicate between shifts and key personnel. The report assists in ensuring continuity of care for residents and ensures staff awareness of changes in condition.

1. The 24-hour nursing report should always include the following information.
    a. New orders
    b. Medication changes
    c. Change in condition
    d. Appointments
    e. I/A's
    f. PRN meds administered
    g. New admits/transfers/discharges/deaths, out on pass
    h. Behaviors
    i. Family request
    j. Residents on antibiotics
    k. Residents with a skin condition—i.e., new pressure sore or skin tear or excoriation

2. This is not an all-inclusive list. Any information deemed pertinent in providing continuity in care must be reported to the oncoming nurse and accessible to the unit RN supervisor and thus should be included on the 24 hour nursing report.
3. The 24-hour nursing report should not be utilized to criticize or complain about fellow works
4. The 24-hour nursing report will be kept for 72 hours and then destroyed.
5. As part of the routine start up procedure, the Unit RN supervisor will review the 24-hour nursing report for the past 24 hours or since the last time he or she reviewed the reports (ie on Mondays, go back and review the reports for Friday, Saturday and Sunday.) Reports over 72 hours old will be removed and destroyed.
6. Create a priority list/ target list of residents based on the information recorded on the 24-hour nursing report. Review the Hot Rack Charting List to ensure the resident has been placed on the list. Review the resident's medical record to ensure documentation is present. Has all parties been notified of changes (ie, physician, family, etc) Look at the times of documentation to ensure nurses are addressing concerns and notifications in a timely manner.

MEDICATION REFRIGERATOR/CART/ROOM/ ER BOX

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

1) MEDICATION REFRIGERATOR:
The medication refrigerator should be checked at a minimum on a weekly basis for the following items.

a. All fluid and food containers should be covered, dated, and stored above all medications
b. Medications of like forms should be stored together and separated from medications of different forms. Example: store oral meds together, suppositories together, vials for injections together and so for the, but DO NOT store oral medications with suppositories, etc.
c. Vials such as insulin should be dated when opened
d. Check expiation dates for all items and remove any expired items
e. Ensure specimens such as urine specimens are not stored with medications
f. All items should be stored in the appropriate container or placed in a bag and labeled as to contents.
g. All items must be identified as belonging to either a specific resident or to stock
h. Monitor manufactures instructions and or MD orders for proper storing of medications. Example: Vitamin B injections should be stored at room temperature due to the risk for the medication to crystallize
i. Is the refrigerator clean and odor free?

2) MEDICATION CART
The medication cart should be checked at a minimum on a weekly basis for the following items:

A. Is the pill crusher clean
B. Are containers of fluids and food properly covered and dated?
C. Are all medications identified as belonging either to a resident or stock?
D. Do the sharps container need replaced? Are the needles disposed of without being recapped?
E. Check expiration dates for OTC medications and all PRN medication blister packs
F. Are liquid bottles free of sticky residue?

G. Look at medications not packaged in a blister pack such as eye drops, inhaler, eardrops, and liquid PO medications. Look at the date the medication was dispensed by the pharmacy? Look at the quantity dispensed by the pharmacy? Look at the amount remaining in the container? Does the amount remaining in the container appear correct based on the dispensing date and MD order for administration?

TREATMENT CART AND SUPPLIES

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded an all-inclusive list.

On a weekly basis the treatment cart and supplies should be checked for the following:

1. Is the treatment cart clean?
2. Is the treatment cart stocked with needed supplies
3. Are any supplies in the cart expired or are no longer being used? If so remove these items
4. Are all labeled with either residents name or as belonging to "Stock"
5. Are items stored correctly? Either in the original container or placed in a bag and labeled?
6. Are there treatments with resident's names that is still a current order, but not being used correctly?
7. Address any areas of concerns immediately.

CODE STATUS

BLUE DOT--- **Full Code**. If

you find a resident who is a blue dot without vital signs, then you need to immediately initiate CPR and call 911. Continue CPR until the paramedics arrive unless a physician stops the code.

EVERYTHING must be done for a full code blue dot status.

Medical Director: _____

Director of Nursing: Teresa Campbell RN

Director: _____

Date: 4/2/11

Revised April 2011

CODE STATUS

RED DOT--- Do Not Resuscitate (DNR)

If you find a resident who is a DNR without vital signs, then you DO NOT initiate CPR.

HOWEVER, if you find a resident who is a DNR with vital signs but they are "making a turn for the worse" or "crashing", you need to ACT IMMEDITAELY and call 911 to transfer them out of the facility. If while waiting on the paramedics to arrive, the resident loses vital signs, you WILL NOT initiate/perform CPR.

If the resident has an established comfort care activated DNR (and the addendum has been signed by 2 physicians) then the resident/family may choose to not seek any further treatment or treatment outside the facility.

Medical Director: _____

Director of Nursing: _____

Director: _____

Date: _____

Revised April 2011

Quick Reference for Use of AED in Emergency

- AED is for use in victims who are pulseless and breathless, both witnessed and unwitnessed arrest.
- For AHC residents, determine the code status of resident. If the resident is "Blue Dot" or "Full Code", the AED is to be used as part of emergency response and the Code.
- CPR guidelines should be initiated and continued for victims immediately while AED is obtained and a 911 call placed.
- AEDs are set up on the crash cart at each nursing station and in Public Safety at AHC. For victims on campus other than the resident buildings, Dial 0 from house phone or (501) 860-0500 for the facility operator to notify Public Safety. State it is an emergency and the campus location that the AED is needed.
- Apply AED patches as indicated on the diagram with the AED. Do not place the patches directly over pacemaker, AICD site or medication patches. AED can be used in victims with a pacemaker or implanted defibrillator.
- Follow the AED voice instructions.
- The Code must be continued until emergency personnel arrive or a physician present stops the Code.

Policy Type	Subject of Policy	Policy No.
Nursing	Comfort Care	NS 907

1. PURPOSE. It is the purpose of this policy to provide supportive care for residents during the last stage of life by enabling them to participate in interactions of their choice, in a supportive environment, with the assistance of compassionate caregivers.

2. SCOPE. All Nursing Staff.

3. POLICY.
   A. Treatments and interventions focus on comfort and supportive measures that improve or maintain quality of life to the greatest extent.

   B. All available resources are used to provide optimal care that meets resident and family needs.

   C. Resident and family participate in developing the plan of care where appropriate.

   D. Service is provided to all residents in need of last stage support.

   E. There must be a physician's order in the chart for comfort care.

   F. An Advanced Directive should be signed by resident or responsible person.

4. PROCEDURE.
   A. Comfort care is goal directed through planning, implementation, and evaluation by the interdisciplinary team of caregivers.

   B. Disciplines represented in the team include medicine, nursing, pharmacy, dietary, social work, recreation, and pastoral care.

   C. Nursing coordinates the plan of care and collaborates closely with other disciplines as needed.

   D. Emphasis is placed on management of physical and psychological needs of resident and psychosocial needs of family.

   E. All treatments and interventions are representative of current standards of care.

   F. The team strives to offer a therapeutic environment that offers a sense of security, hospitality, participation, strength, and peace for residents and family members. Families are encouraged to participate in resident care and may remain with the resident when appropriate.

5. DEATH:
   Death will be as peaceful and pain-free as possible. Staff provides bereavement for the family.

ARKANSAS HEALTH CENTER
NURSING HOME

ADDENDUM TO PATIENT DECLARATION REGARDING LIFE-SUSTAINING TREATMENT ("LIVING WILL")

The Attending Physician has conferred with the consulting physician and both agree that _____ is terminally ill, and/or is either unconscious or unable to communicate.

The Patient's Declaration regarding life-sustaining treatment becomes operative with the signatures of both the attending physician and the consulting physician.

_____	_____	_____
Attending Physician (Print)	Signature	Date
_____	_____	_____
Consulting Physician (Print)	Signature	Date

Policy Type	Subject of Policy	Policy No.
Administrative	Advance Directive	AP 404

1. PURPOSE. The purpose of this policy is to establish guidelines for the use of the Arkansas Health Center (AHC) in accordance with state and federal laws and regulations and to comply with the requirements of established guidelines.

2. SCOPE. This policy is applicable to all residents of Arkansas Health Center.

3. POLICY. The Arkansas Health Center will inform all residents verbally and in writing of their right to make their own health care decisions, including the right to accept or refuse medical treatment.

4. The AHC will give all residents the opportunity upon admission to execute an advance directive, but will in no way require an individual to execute an advance directive.

   This facility will not discriminate against an individual based on whether or not they have executed an advance directive. The resident has the right to reaffirm, change, or revoke an advance directive at any time and in any manner. If the Administration of this facility or the attending physician objects to a resident's advance directive on moral grounds, all reasonable steps will be made to transfer the resident to another care provider.

   As part of New Employee Orientation, all nursing personnel will receive training on this policy and the meaning of the code system.

   All agency/temporary personnel will read and sign that they understand the meaning of this policy prior to being assigned to resident care.

5. PROCEDURES.

   A. All new admissions and existing residents will be informed of their right to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute an advance directive. The unit social worker will initiate this action and keep on hand materials to assist the resident or the resident's health care proxy in making health care declaration decisions. This material will include, but not be limited to, health care declaration forms, copies of Act 713 of 1987, "Arkansas Rights of the Terminally Ill Act or Permanently Unconscious Act" and other appropriate materials and brochures.

   B. The social worker will document in the resident's record whether or not an advance directive has been executed and the terms of the advance directive. A competent resident has the right to change an advance directive at any time and in any manner. The Social Worker will review the Advance Directive on an annual basis, and/or when there is a significant change of condition.

   C. The unit physician will be made aware of all residents who have executed advance directives and the terms of the directive.

D. Residents' medical record is to be marked with a colored dot: RED is to indicate a Do Not Resuscitate (DNR) status; and a BLUE dot indicates FULL-CODE status. Additionally, the correct dot is to be placed on the resident's picture that is on the wall, on the MARS and TARS, and on the pictures outside the door. Should a resident be moved to another room his/her picture, name, and the correct dot are also moved.

E. When the attending physician, in consultation with another physician, has determined the resident to be in a terminal condition, or in a permanently unconscious state, and is no longer able to make decisions regarding administration of life-sustaining treatment, the attending physician will direct the resident's treatment in accordance with the advance health care declaration.

F. Admitting hospitals will be advised as to whether or not an AHC resident has executed an advance directive, and if so, a copy of the advance directive will accompany the resident to the hospital.

G. As established by Arkansas law, In the case of minors and adults for whom there has not been a previously executed valid Advance Directive and who are no longer able to make health care decisions, another person acting on their behalf may execute a declaration.

_____ _____

Facility Director
Arkansas Health Center

Date

Declarant's signature

Signed this _____ day of _____ (Month), _____ (Year) by _____ (Declarant's signature)

_____ (Declarant's name (Print)) _____ (Street address) _____ (City, State, Zip Code)

Witnesses' signatures

The Declarant signed this writing voluntarily in my presence.

1.

_____ (First witnesses' name) _____ (Signature) _____ (Date)

_____ (Street address) _____ (City & State) _____ (Zip Code)

2.

_____ (Second witnesses' name) _____ (Signature) _____ (Date)

_____ (Street address) _____ (City & State) _____ (Zip Code)

Procedure	Mark each procedure: Check either DON'T DO or DO	
Kidney dialysis	☐ DON'T DO	☐ DO
Surgery	☐ DON'T DO	☐ DO
Other:	☐ DON'T DO	☐ DO

OTHER DIRECTIONS

☐	YES	☐	NO	It is my specific directive that nutrition may be withheld after consultation with my attending physician.

☐	YES	☐	NO	It is my specific directive that hydration may be withheld after consultation with my attending physician.

III. DURABLE POWER OF ATTORNEY FOR HEALTH CARE – APPOINTMENT OF AN AGENT (OPTIONAL)

3. I hereby appoint the person named below as my agent to make any necessary health care decisions on my behalf if I am unable to make my own health care decisions for any reason. This appointment specifically authorizes the appointed person to make decisions to withhold or withdraw life-sustaining or life-saving treatment, CPR, hydration, and nutrition. If my stated wishes are ambiguous or unclear or don't cover a particular circumstance or condition, THEN AND IN THAT EVENT my agent may interpret my stated wishes for me and direct my health care providers to act accordingly. Health care providers who act in accordance with my agent's directions will be held harmless, and no tort liability will attach thereto.

4. I direct that should I become permanently unconscious, or should I have an incurable or irreversible illness that will cause my death within a relatively short period of time and I am unable to make decisions regarding my medical treatment, or should I be unable to make medical treatment decisions for myself for any reason whatsoever, then and in that event, and subject to the provisions set forth in the paragraph above, I appoint the person named below as my Health care Proxy to decide my medical treatment, including whether life-sustaining treatment should be withheld or withdrawn. Health care providers who act in accordance with my agent's directions will be held harmless, and no tort liability will attach thereto. This special and limited power of attorney shall specifically survive any period of disability that I may have in the future.

Agent's name & contact information

Agent's name (Print)	Street address	City, State, Zip Code
Phone number(s)	Email address	Relationship to Declarant

I execute this document in accordance with the formalities required by ACA §§ 20-17-201, et seq (Arkansas Rights of the Terminally Ill or Permanently Unconscious Act) and ACA § 20-13-104 (Durable Power of Attorney for Health Care Act) and pursuant to my constitutional liberty right to refuse unwanted medical treatment. I understand the impact and potential consequences of this document, and my decisions are fully informed.

Declarant's Initials: _____ Date: _____

MY HEALTH CARE WISHES

I, _____ the Declarant, am at least eighteen (18) years of age, of sound mind, and competent to make my own health care decisions. I hereby declare and specifically express my wishes concerning my medical care and treatment as clearly and convincingly as I am able. I hereby revoke any prior declarations or statements that are inconsistent with this Declaration.

I make this declaration in accordance with my constitutional right to direct my own health care, including the termination of life-saving or life-sustaining treatment, as recognized by the United States Supreme Court in Cruzan v. Director, MDH, 497 U.S. 261 (1990).

I. GENERAL INSTRUCTIONS REGARDING CPR

1. If I am found unconscious, without a pulse, respirations, or both, I direct that health care providers react in accordance with the directive checked off immediately below, regardless of whether I have a terminal condition or have been declared to have a terminal or fatal condition, and which stands alone and apart from directives made in Section 2 below. [CHECK ONE BOX BELOW]

☐ **DO NOT** PERFORM CPR ON ME. TERMINATE CPR ON ME IF BEGUN BY MISTAKE

If health care providers begin CPR by mistake, I authorize and direct them to stop CPR once they realize the mistake. Healthcare providers who act in accordance with this direction will be held harmless, and no tort liability will attach, even if they begin CPR by mistake, whatever the outcome.

☐ PERFORM CPR ON ME.

Healthcare providers who act in accordance with this direction will be held harmless, and no tort liability will attach, whatever the outcome.

II. ADVANCE DIRECTIVE / LIVING WILL DECLARATION (OPTIONAL)

2. If I should have a fatal condition (excluding normal aging) including injury, disease or illness that is incurable or irreversible that will cause death within a relatively short period of time, **and** I am no longer able to make decisions regarding my medical treatment, **OR** if I should become permanently unconscious, I direct my attending physician to withhold or withdraw treatment that is not necessary to my comfort or to alleviate pain and that only prolongs the process of dying or extends the period of unconscious existence. In these circumstances I specifically request my health care providers to honor my wishes as I have checked them below. If any procedures marked "Don't Do" are inadvertently or mistakenly begun, they are to be terminated and thereafter withheld, without tort liability to the health care providers.

FOR EACH PROCEDURE, CHECK EITHER "DON'T DO" OR "DO"

Procedure	Mark each procedure: Check either DON'T DO or DO			
CPR (Cardiopulmonary resuscitation)	☐	DON'T DO	☐	DO
Artificial breathing machine (respirator or ventilator)	☐	DON'T DO	☐	DO
Transfer to a medical/surgical hospital	☐	DON'T DO	☐	DO
Blood transfusion	☐	DON'T DO	☐	DO
Antibiotics	☐	DON'T DO	☐	DO
Medications that aren't for comfort or pain relief	☐	DON'T DO	☐	DO

Witnesses' signatures

The Declarant signed this writing voluntarily in my presence.

1.

First witnesses' name _____ Signature _____ Date _____

Street Address _____ City & State _____ Zip Code _____

2.

Second witnesses' name _____ Signature _____ Date _____

Street Address _____ City & State _____ Zip Code _____

Procedure	Directives: Check either DON'T DO or DO	
Kidney dialysis	☐ DON'T DO	☐ DO
Surgery	☐ DON'T DO	☐ DO
Other:	☐ DON'T DO	☐ DO

☐ YES ☐ NO Nutrition may be withheld after consultation with the Person's attending physician.

☐ YES ☐ NO Hydration may be withheld after consultation with the Person's attending physician.

OTHER DIRECTIONS

If the Person is found unconscious, without a pulse, respirations, or both, I direct that health care providers react in accordance with the directive checked off immediately below. These instructions apply at all times, regardless of whether the person has a terminal condition or has been declared to have a terminal condition. [CHECK ONLY ONE BOX BELOW]

☐ **DO NOT PERFORM CPR. TERMINATE CPR IF BEGUN BY MISTAKE.**

If health care providers begin CPR by mistake, I authorize and direct them to stop CPR once they realize the mistake. Healthcare providers who act in accordance with this direction will be held harmless, and no tort liability will attach, even if CPR was begun by mistake, regardless of outcome.

☐ **PERFORM CPR**

Healthcare providers who act in accordance with this direction will be held harmless, and no liability will attach, regardless of outcome.

I execute this document in accordance with the formalities required by ACA §§ 20-17-201, *et seq.* (Arkansas Rights of the Terminally Ill or Permanently Unconscious Act). I understand the impact and potential consequences of this document, and my decisions are fully informed.

Declarant's signature

Signed this _____ day of _____ Month _____ Year by _____ Declarant's Name (Print)

_____ Declarant's Signature

_____ Street Address

_____ City, State, Zip Code

(____) _____ - _____ Phone Number

(____) _____ - _____ Cell Phone / Pager

_____ E-mail address

Declarant's Initials: _____ Date: _____

HEALTH CARE DIRECTIVES ON BEHALF OF ANOTHER PERSON, PER ACA § 20-17-214

This Declaration is made on behalf of the Person named immediately below ("Person"). The Person is a minor or an adult for whom: a) a valid declaration does not exist; b) a health care proxy has not been designated; and c) who, in the opinion of the attending physician, is no longer able to make health care decisions.

Person's name (Print) _____ Address (Street, City, State, Zip) _____ Age _____

I, _____ the Declarant, have checked below the category into which I fall. I am the first of the following individuals or category of individuals who exist and who was available for consultation. My authority to execute this Declaration is based on § 20-17-214 of the Arkansas Code Annotated. I am: [CHECK ONE BOX BELOW]

- ☐ A legal guardian of the Person
- ☐ A parent of the Person. The Person is unmarried and under the age of eighteen (18)
- ☐ The Person's spouse
- ☐ The Person's adult child, and spokesman or spokeswoman for a majority of the Person's adult children if there is more than one (1) adult child participating
- ☐ A parent of the Person. The Person is over the age of eighteen (18)
- ☐ The Person's adult sibling, and spokesman or spokeswoman for the majority of the Person's adult siblings if there is more than one (1) adult sibling participating
- ☐ One who stands in loco parentis to the Person
- ☐ The spokesman or spokeswoman for a majority of the Person's adult heirs at law who are participating

ADVANCE DIRECTIVE FOR ANOTHER PERSON

1. If the Person should have an incurable for irreversible condition that will cause death within a relatively short time, or if the Person becomes permanently unconscious, I direct the Person's attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment, including life-sustaining medical treatment that only prolongs the process of dying or extends the period of unconscious existence, and is not necessary for the Person's comfort or to alleviate pain. In these circumstances, I specifically request the Person's health care providers to honor the directives I have checked below on the Person's behalf.

   If any procedures marked "DON'T DO" are inadvertently or mistakenly begun, they are to be terminated and thereafter withheld, and no tort liability will attach to the health care providers, regardless of outcome. [CHECK "DON'T DO" OR "DO" FOR EACH PROCEDURE]

Procedure	Directives: Check either DON'T DO or DO	
CPR (Cardiopulmonary resuscitation)	☐ DON'T DO	☐ DO
Artificial breathing machine (respirator or ventilator)	☐ DON'T DO	☐ DO
Transfer to a medical/surgical hospital	☐ DON'T DO	☐ DO
Blood transfusion	☐ DON'T DO	☐ DO
Antibiotics	☐ DON'T DO	☐ DO
Medications that are *not* for comfort or pain relief	☐ DON'T DO	☐ DO

Declarant's Initials: _____ Date: _____

NO CPR

HOWEVER

Send To HOSPITAL When Indicated

The **REST** of the

Advance Directive is Not in Effect

at the Arkansas Health Center *Until*
the ADDENDUM is attached with signatures of both
the attending physician and a consulting physician

If Resident goes Inpatient,
Status will then be determined by
Hospital treating physician
in consultation with
the resident / health care proxy

FULL CODE

Resident does not meet medical criteria
for Advance Directive to be operative
at the Arkansas Health Center at this time.

If Resident goes Inpatient,
Status will then be determined by
Hospital treating physician

This Advance Directive is
Not in Effect

When a Resident:

does have an advanced directive
but **does want CPR** at this time,
and is a "BLUE DOT",

Then we will put the advance directives that are ***not operative*** in a plastic sleeve with the attached note in front of it.

When in the physician's judgment the person "has a condition .....death in a relatively short period of time, and no longer able to make decisions,
OR.....Permanently unconscious....",
AND 2 doctors sign that form,
THEN the "Full Code" page will be taken from the chart and replaced with the 2 doctor's signed form and the resident will be "Red Dot"

If the resident / family, have completed the form that they NEVER want CPR, We would not use the "Full Code" page. They are a "Red Dot" in this situation even though the full Advance Directive is not operative.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administration	Cardio-Pulmonary Resuscitation	AP 215

1. PURPOSE. It is the purpose of this policy to ensure the safety of the residents and staff of Arkansas Health Center (AHC) during cardio-pulmonary emergencies and provide guidelines for proper implementation of Cardio-Pulmonary Resuscitation (CPR).

2. SCOPE. All staff of Arkansas Health Center.

3. POLICY. It is the policy of AHC to ensure that all staff are trained in Cardio-Pulmonary Resuscitation (CPR), and that they maintain current certification, so that in cardio-pulmonary emergency techniques are utilized by certified individuals to persons in physical distress.

4. DEFINITION.

   A. Cardio-pulmonary Resuscitation (CPR) – Action taken to ventilate and establish circulation on an individual with an absence of respirations and pulse.

   B. Automated External Defibrillator (AED) – A portable electronic device that diagnosis and treats potentially life threatening cardiac arrhythmias in a patient by application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm.

   B. Do Not Resuscitate (DNR) – Identifies that staff is to stop medical treatment and is not to initiate cardio-pulmonary resuscitation in the event of cardiac arrest.

   C. Advanced Directive – A signed document that gives directions to care givers regarding the desire of the resident concerning the withholding or withdrawal of treatment that is not necessary for comfort, alleviates pain, and only prolongs the process of dying or extends the period of unconscious existence.

   D. "Red Dot/Blue Dot" – A red dot on a resident's chart indicates he/she is not to be resuscitated if they are without pulse or blood pressure. A blue dot is a full- code status on a resident's chart and means the person will be resuscitated if they are found without blood pressure or pulse or if they arrest during their evaluation or transfer process.

   E. American Heart Association is the accreditation entity that sets the standards for persons at AHC providing CPR as well as trains persons to certified CPR instructors.

5. TRAINING.

   A. A certified instructor using the American Heart Association standards will teach CPR training.

   B. Upon completion of a course, the Staff Development Department will submit a training roster to a designated official training center for official record keeping. CPR cards will be provided from the official training center to Staff Development for trainees. Staff Development will retain a copy of the roster within the Department; will provide the trainee with their CPR card and a copy of the card will be submitted to the employee's formal personnel file.

C. The AHC Staff Development Department will provide certification update training to all employees on an annual basis and re-certification training every two years.

D. All new employees of AHC will receive CPR training as part of their New Employee Orientation.

6. PROCEDURE.

A. CPR using the AED will be performed according to the guidelines established in Appendix A.

B. CPR will be initiated on residents without pulse or respiration except for those designated as Do Not Resuscitate (DNR).

C. In the event a resident appears to be in serious physical distress, AHC will arrange immediate transfer of the resident to the emergency room by calling 911. Staff appointed to call 911 will also contact the Physician and family or responsible party.

D. When the resident presents with serious physical distress which is the direct result of an act of negligence or intentional misconduct on the part of another person, AHC will arrange for immediate transfer to the emergency room regardless of the individuals' advance directives.

E. Once begun, CPR must be continued until advanced life-support systems are available and operable. CPR may be discontinued only when the victim responds, or the Physician orders CPR to be discontinued.

7. DOCUMENTATION.

A. Nursing shall document in the Nurses' Notes the date, time, condition of the resident, and any other pertinent information such as vital signs or absence of vital signs. The documentation should further reveal if the resident was transferred to the emergency room, and the notification (date/time) of the Physician and family.

B. The care plan shall be updated as needed.

_____ _____

AHC Director Date

NEWEST CPR

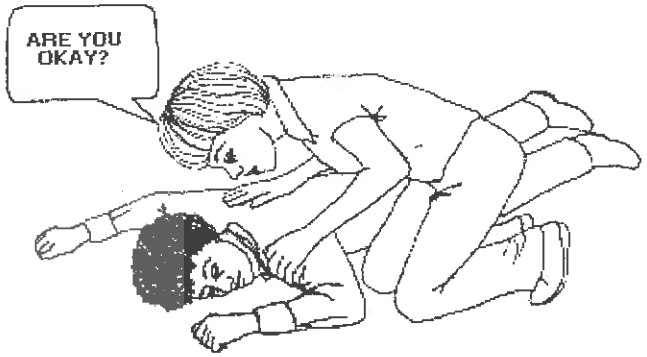
REGULATIONS

THAT BEGAN

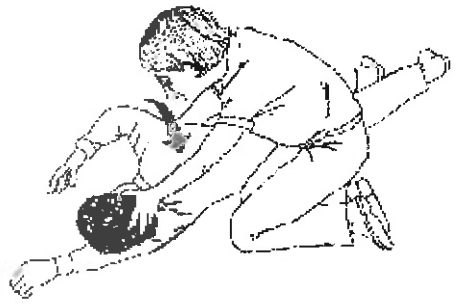
APRIL 1, 2011

The CPR procedures should be learned and practiced on a training mannequin under the guidance of a certified AHA BLS CPR Instructor. The step by step procedure for cardiopulmonary resuscitation is as follows:

- **Establish unresponsiveness.** Gently shake the victim's shoulder and shout, "Are you OK?" The individual's response or lack of response will indicate to the rescuer if the victim is just sleeping or unconscious (Figure 3-1).



- **Call for help.** ***CALL 911 or the operator at 860-0500 and have them call 911*** Help will be needed either to assist in performing CPR or to call for medical help.
- **Position the victim.** If the victim is found in a crumpled up position and/or face down, the rescuer must roll the victim over; this is done while calling for help; ***You may instruct a co-worker to call 911 immediately.*** (Figure 3-2)

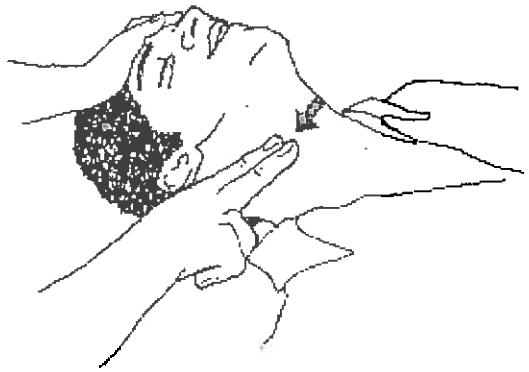


- When rolling the victim over, take care that improper handling does not further complicate broken bones. Roll the victim as a unit so that the head, shoulders, and torso move simultaneously with no twisting.
- Kneel beside the victim, a few inches to the side.
- The arm nearest the rescuer should be raised above the victim's head.

- The rescuer's hand closest to the victim's head should be placed on the victim's head and neck to prevent them from twisting.
- The rescuer should use the other hand to grasp under the victim's arm furthest from rescuer. This will be the point at which the rescuer exerts the pull in rolling the body over.
- Pull carefully under the arm, and the hips and torso will follow the shoulders with minimal twisting.
- Be sure to watch the neck and keep it in line with the rest of the body.
- The victim should now be flat on his/her back.

-Circulation. Check for pulse. Check the victim's pulse to determine whether external cardiac compressions are necessary.

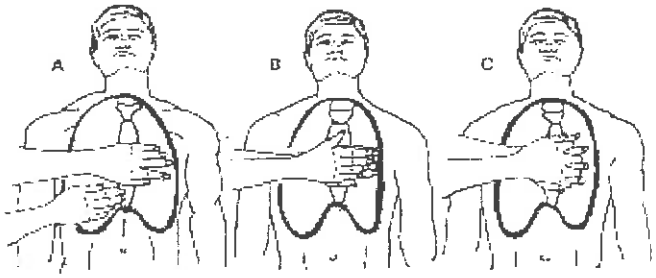
- Maintain an open airway position by holding the forehead of the victim.
- Place your fingertips on the victim's windpipe and then slide them towards you until you reach the groove of the neck. Press gently on this area (carotid artery) (Figure 3-5).
- Check the victim's carotid pulse for at least five to ten seconds but no more than ten seconds.



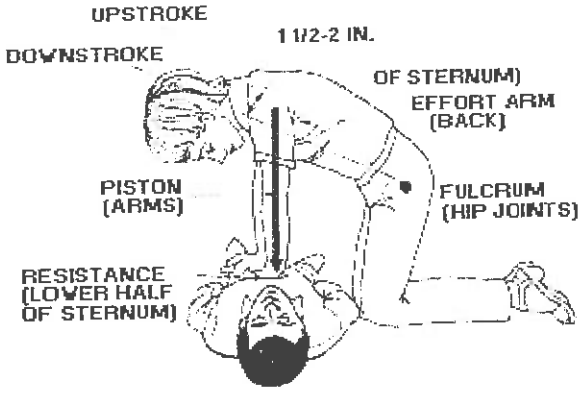
- If a pulse is present, continue administering artificial ventilation once every 5 seconds or 12 times a minute. If not, make arrangements to send for trained medical assistance and begin CPR.

Perform cardiac compressions.

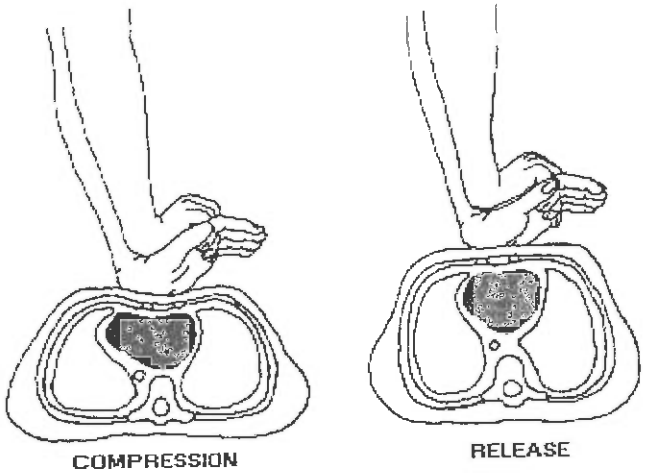
- Place the victim in a horizontal position on a hard, flat surface.
- Locate the victim's nipples and place your hands on top of the sternum directly in line with the nipples.
- Keep the fingers off the chest, by either extending or interlocking them (B and C of Figure 3-7).



- Keep the elbows in a straight and locked position.
- Position your shoulders directly over the hands so that pressure is exerted straight downward (Figure 3-8).



- Exert enough downward pressure to depress the sternum of an adult 1 1/2 to 2 inches.
- Each compression should squeeze the heart between the sternum and spine to pump blood through the body.
- Totally release pressure in order to allow the heart to refill completely with blood.
- Keep the heel of your hand in contact with the victim's chest at all times (Figure 3-9).
- Make compressions down and up in a smooth manner.
- Compressions should be "Hard and Fast"

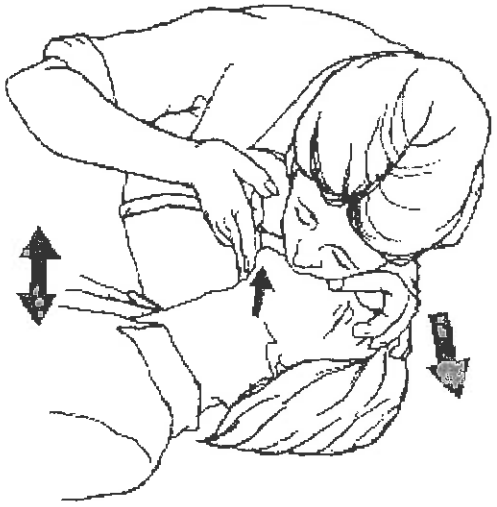


- Perform 30 cardiac compressions at a rate of 100 per minute, counting "one and, two and, three and,.....thirty".
- Use the head-tilt/chin-lift maneuver and give two full breaths (artificial ventilation).
- Repeat cycle five times (30 compressions and 2 ventilations).
- After the fifth cycle, recheck the carotid pulse in the neck for a heartbeat (5 to 10 seconds).
- If breathing and heartbeat are absent, resume CPR (30 compressions and 2 ventilations).
- Stop and check for heartbeat every few minutes thereafter.
- Never interrupt CPR for more than 10 seconds.

- **-Airway. Open the airway.**
- Use the head-tilt/chin-lift maneuver to open airway. (This maneuver is not recommended for a victim with possible neck or spinal injuries use the jaw-thrust maneuver.)

-Breathing. Establish breathlessness. After opening the airway establish breathlessness.

- Provide artificial ventilation.
  - If the victim is not breathing give two full breaths by mouth-to-mouth, mouth-to-nose, or mouth-to-stoma ventilation (Figure 3-4).



- Allow for lung deflation between each of the two ventilation's.

Two Rescuers

All of the above was for the single rescuer; below we will show you Two Rescuer CPR.

Two Rescuer CPR is done pretty much the same way "except" When performing with two; one is at the head giving breaths and the other one on one side of the chest doing compressions.
Now all compressions and breaths are done the same as taught above.
There is no difference; the person at the chest will give 30 compressions then the other person will give two breath this is also done in a rotation of five cycles total of 200 compressions or 100 per minute. (This is approximately 2 minutes of CPR)
Next step once a cycle is done you need to check for a pulse, this is done the same way as taught above, and change places to avoid exhaustion. The exchange should take less than 10 seconds.

REMEMBER: IF you have two-people then one person should do CPR while the other person calls 911.

If no pulse continue CPR.

OLDER REGULATIONS

OF CPR PROCEDURES

THAT ARE STILL

ACCEPTABLE

AND

CURRENTLY BEING

PRACTICED UNTIL ALL

STAFF HAVE BEEN

INSERVICED

ARKANSAS HEALTH CENTER

A. PROCEDURE.

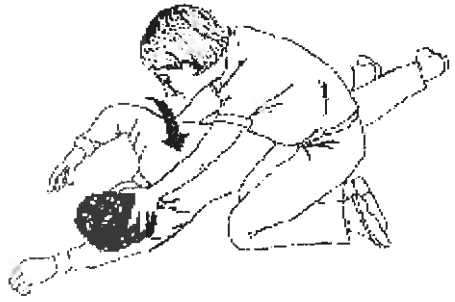
I. The CPR procedures should be learned and practiced on a training mannequin under the guidance of a qualified instructor. The step by step procedure for cardiopulmonary resuscitation is as follows:

A. Establish unresponsiveness. Gently shake the victim's shoulder and shout, "Are you OK?" The individual's response or lack of response will indicate to the rescuer if the victim is just sleeping or unconscious (Figure 3-1).

-

B. **Call for help.** ***CALL 911 or the operator at 860-0500 and have them call 911*** Help will be needed either to assist in performing CPR or to call for medical help.

C. **Position the victim.** If the victim is found in a crumpled up position and/or face down, the rescuer must roll the victim over; this is done while calling for help; ***you may instruct a co-worker to call 911 immediately.*** (Figure 3-2)



-

- When rolling the victim over, take care that improper handling does not further complicate broken bones. Roll the victim as a unit so that the head, shoulders, and torso move simultaneously with no twisting.
- Kneel beside the victim, a few inches to the side.
- The arm nearest the rescuer should be raised above the victim's head.
- The rescuer's hand closest to the victim's head should be placed on the victim's head and neck to prevent them from twisting.
- The rescuer should use the other hand to grasp under the victim's arm furthest from rescuer. This will be the point at which the rescuer exerts the pull in rolling the body over.
- Pull carefully under the arm, and the hips and torso will follow the shoulders with minimal twisting.
- Be sure to watch the neck and keep it in line with the rest of the body.
- The victim should now be flat on his/her back.

D. **CPR Procedures for Single Rescuer:**

A-Airway. Open the airway. The most common cause of airway obstruction in an unconscious victim is the tongue.

Use the head-tilt/chin-lift maneuver to open airway. (This maneuver is not recommended for a victim with possible neck or spinal injuries).

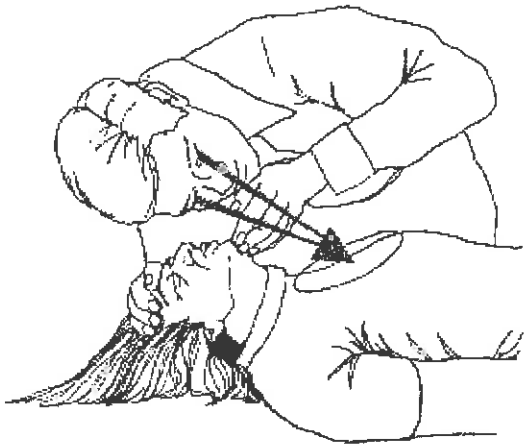
When opening the airway, check the neck for stomas and make sure this airway is not obstructed.

If a person is choking or appears to have an obstructed airway, perform the procedures outlined in section II. titled A and B under Emergency Procedures for Choking.

B-Breathing. Establish breathlessness. After opening the airway establish breathlessness.

- Turn your head toward the victim's feet with your cheek close over the victim's mouth or stoma(5 to 10 seconds).

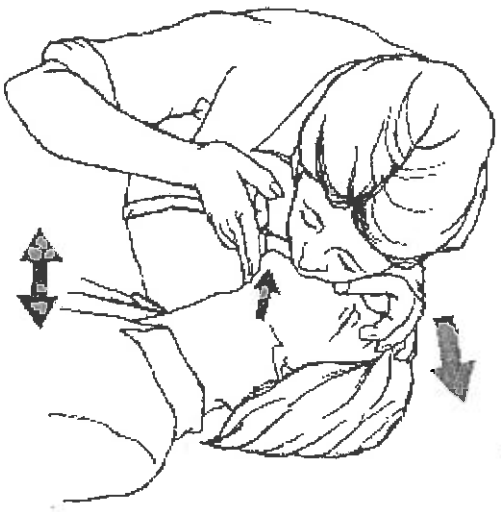
- **Look** for a rise and fall in the victim's chest
- **Listen** for air exchange at the mouth and nose or stoma.
- **Feel** for the flow of air (Figure 3-3).



Sometimes opening and maintaining an open airway is all that is necessary to restore breathing.

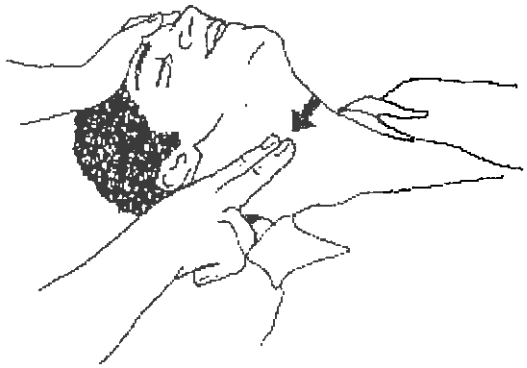
Provide artificial ventilation.

- If the victim is not breathing give two full breaths by mouth-to-mouth, mouth-to-nose, or mouth-to-stoma ventilation (Figure 3-4). Allow for lung deflation between each of the two ventilations.



C-Circulation. Check for pulse. Check the victim's pulse to determine whether external cardiac compressions are necessary.

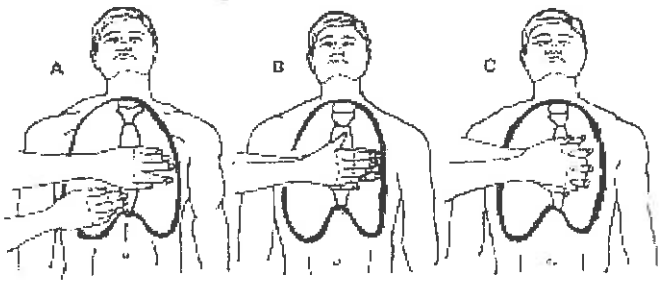
- Maintain an open airway position by holding the forehead of the victim.
- Place your fingertips on the victim's windpipe and then slide them towards you until you reach the groove of the neck. Press gently on this area (carotid artery) (Figure 3-5).
- Check the victim's carotid pulse for at least five to ten seconds but no more than ten seconds.



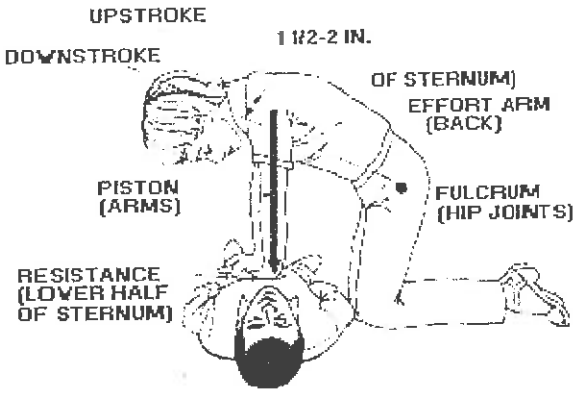
- If a pulse is present, continue administering artificial ventilation once every 5 seconds or 12 times a minute. If not, make arrangements to send for trained medical assistance and begin CPR.

Perform cardiac compressions.

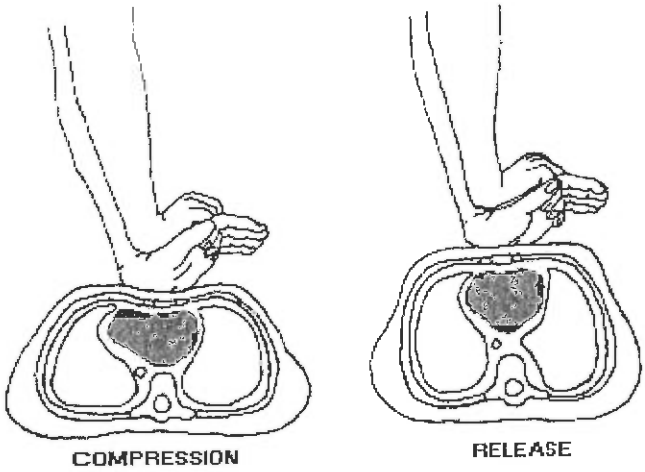
- Place the victim in a horizontal position on a hard, flat surface.
- Locate the victim's nipples and place your hands on top of the sternum directly in line with the nipples.
- Keep the fingers off the chest, by either extending or interlocking them (B and C of Figure 3-7).



- Keep the elbows in a straight and locked position.
- Position your shoulders directly over the hands so that pressure is exerted straight downward (Figure 3-8).



- Exert enough downward pressure to depress the sternum of an adult 1 1/2 to 2 inches.
- Each compression should squeeze the heart between the sternum and spine to pump blood through the body.
- Totally release pressure in order to allow the heart to refill completely with blood.
- Keep the heel of your hand in contact with the victim's chest at all times (Figure 3-9).
- Make compressions down and up in a smooth manner.
- Compressions should be "Hard and Fast"



- Perform 30 cardiac compressions at a rate of 100 per minute, counting "one and, two and, three and...thirty".
- Use the head-tilt/chin-lift maneuver and give two full breaths (artificial ventilation).
- Repeat cycle five times (30 compressions and 2 ventilations).
- After the fifth cycle, recheck the carotid pulse in the neck for a heartbeat (5 to 10 seconds).
- If breathing and heartbeat are absent, resume CPR (30 compressions and 2 ventilations).
- Stop and check for heartbeat every few minutes thereafter.
- Never interrupt CPR for more than 10 seconds.

E. Two Rescuers

1. All of the above was for the single rescuer; below we will show you Two Rescuer CPR.

2. Two Rescuer CPR is done pretty much the same way "except" When performing with two; one is at the head giving breaths and the other one on one side of the chest doing compressions.

3. Now all compressions and breaths are done the same as taught above. There is no difference; the person at the chest will give 30 compressions then the other person will give two breath this is also done in a rotation of five cycles total of 200 compressions or 100 per minute. (This is approximately 2 minutes of CPR)

4. Next step once a cycle is done you need to check for a pulse, this is done the same way as taught above, and change places to avoid exhaustion. The exchange should take less than 10 seconds.

REMEMBER: IF you have two-people then one person should do CPR while the other person calls 911.

If no pulse continue CPR.

II. Emergency Procedures for Choking

A. Adults: Conscious Victim

1. Choking is indicated by the Universal Distress Signal (hands clutching the throat).

2. If the victim can speak, cough or breathe, do not interfere.

If the victim cannot speak, cough or breathe, give abdominal thrusts (the Heimlich maneuver).

Reach around the victim's waist. Position one clenched fist above navel and below rib cage. Grasp fist with other hand. Pull the clenched fist sharply and directly backward and upward under the rib cage 6 to 10 times quickly.

In case of extreme obesity or late pregnancy, give chest thrusts. Stand behind victim. Place thumb of left fist against middle of breastbone, not below it. Grab fist with right hand. Squeeze chest 4

3. Continue uninterrupted until the obstruction is relieved or advanced life support is available. In either case, a physician should examine the victim as soon as possible.

B. If Victim Becomes Unconscious

1. Help the victim to the floor and position victim on back with their arms by their side.

2. Shout for "Help". Call 9-1-1 or the local emergency number.

3. Look into the victim's mouth to see if you can see a foreign object. If you see the object, perform a finger sweep to try to remove the foreign body.

4. Perform rescue breathing. If unsuccessful, begin chest compressions as performed in CPR.

5. Continue uninterrupted until obstruction is removed or advanced life support is available. When successful, have the victim examined by a physician as soon as possible.

6. After obstruction is removed, begin the ABC's of CPR, if necessary.

⚠ Warning!

- Use the AED Plus unit only as described in this manual. Improper use of the device can cause death or injury.
- DO NOT use or place the AED Plus unit in service until you have read the AED Plus Operator's and Administrator's Guides.
- DO NOT use or place the AED Plus unit in service if the unit's status indicator window (located on the left side of the handle) displays a red "X".
- DO NOT use or place the AED Plus unit in service if the unit emits a beeping tone. Connect the
- electrode cable to the AED Plus unit after installing batteries.
- Keep the electrode cable connected to the AED Plus unit at all times. This device should
- only be used by properly trained individuals.
- Only use electrodes labeled "Infant/Child" on children less than 8 years old or weighing less than 55 lbs (25 kg). Use CPR -D padz if patient is older than 8 years or weighs more than 55 lbs (25 kg).
- Always stand clear of patient when delivering treatment. Defibrillation energy delivered to the patient may be conducted through the patient's body and cause a lethal shock to those touching the patient.
- DO NOT touch the electrode surfaces, the patient, or any conductive material touching the patient during ECG analysis or defibrillation.
- Move patient away from electrically conductive surfaces prior to use of equipment. DO NOT use the
- unit near or within puddles of water.
- Keep the patient as motionless as possible during ECG analysis.
- DO NOT use the unit near flammable agents, such as gasoline, oxygen-rich atmospheres, or flammable anesthetics.
- Avoid radio frequency interference from high-power sources that might cause the defibrillator to interpret cardiac rhythms incorrectly by turning off cell phones and 2-way radios.
- Disconnect non-defibrillation protected electronic devices or equipment from patient before defibrillation.
- Dry victim's chest, if wet, before attaching electrodes.
- Apply freshly opened and undamaged electrodes, within the electrode expiration date, to clean and dry skin to minimize burning.
- DO NOT place electrodes directly over the patient's implanted pacemaker. Pacemaker stimuli may degrade the accuracy of ECG rhythm analyses or the pacemaker may be damaged by defibrillator discharges.
- Check labeling inside the ZOLL AED Plus cover before using the cover as a Passive Airway Support

System (PASS) device to ensure it is intended for this use.

- DO NOT use the Passive Airway Support System (PASS) if there is a suspected head or neck injury. Place the patient on a firm surface before performing CPR.
- DO NOT recharge, disassemble, or dispose of batteries in fire. Batteries may explode if mistreated.
- DO NOT use or stack the AED PLUS unit with other equipment. If the unit is used or stacked with other equipment, verify proper operation prior to use.

⚠ Caution!

- DO NOT disassemble the unit. A shock hazard exists. Refer all servicing to qualified personnel.
- Use only commercially available type 123A lithium manganese dioxide batteries. Discard batteries properly after removal from unit. Use only batteries from recommended manufacturers. See the AED Plus Administrator's Guide (P/N 9650-0301-01) for a list of recommended battery manufacturers.
- If the device is stored outside the recommended environmental conditions, the electrode pads and/or batteries may be damaged or their useful life reduced.
- The CPR-D Padz Electrode can be connected to other ZOLL defibrillators with Multifunction Cables. Defibrillation can be administered when connected to other ZOLL defibrillators.The CPR function does not operate with any device other than the AED Plus defibrillator.

Important!

This symbol indicates that an AED Plus unit is equipped for treating adult and pediatric patients. An AED Plus unit without this symbol is not equipped to treat pediatric patients and will NOT work with pedi•padz II ™ pediatric electrodes. To upgrade an AED Plus unit for use with ZOLL pedi•padz II pediatric electrodes, contact ZOLL Medical Corporation or an authorized ZOLL distributor for information on the ZOLL AED Plus Pediatric Upgrade Kit.

Set-up and Check-out Procedure:

1. Insert 10 new batteries into AED Plus unit.
2. Connect electrode cable to AED Plus unit and pack sealed electrodes inside unit cover. Close cover.
3. Turn unit on and wait for "Unit OK" audio message. Verify that unit issues appropriate "Adult Pads" or "Pediatric Pads" audio message.
4. Turn unit off.
5. Wait 2 minutes. Verify that green check symbol (✓) appears in status indicator window (located on left side of handle) and that unit does not emit a beeping tone.
6. Place AED Plus unit in service.
7. Check AED Plus unit periodically to ensure that green check symbol (✓) appears in status indicator window.

Battery Replacement

Replace batteries before expiration date or if unit prompts. Use only type 123A lithium manganese dioxide batteries from recommended manufacturers.

Remove all batteries from battery compartment and discard before installing any new batteries.

- Insert 10 new batteries into battery well. Do not use old batteries. Press button in battery well only after installation of new batteries.

Cleaning

- Clean and disinfect unit with soft, damp cloth using 90% isopropyl alcohol or soap and water, or chlorine bleach (30 ml/liter water). Do not immerse any part of the unit in water.
- Do not use ketones (MEK, acetone, etc.).
- Avoid using abrasives (e.g., paper towels) on the LCD display, if so equipped.
- Do not sterilize the unit.

TROUBLE SHOOTING

Problem	Recommended Action
Self-test failed.	Manually test by pressing and holding the ON/OFF button for more than 5 seconds. If unit fails test again, remove from service.
"Change batteries" prompt.	Replace all batteries at the same time.
Red "X" in Status Indicator window OR beeping noise when unit is OFF.	Perform manual test. Check to see if cable is attached properly to unit. Replace batteries. If unit still does not operate correctly, remove from service.
Red "X" in Status Indicator window when unit is ON.	Power cycle the unit. If Red "X" is still present in Status Indicator

Policy Type	Subject of Policy	Policy No.
Administration	Cardio-Pulmonary Resuscitation/AED	AP 215
	Appendix A	

Video Content
Dr. Cooper Dental Video

- The purpose of this video is to give insight and instruction to deliver the best oral care to our patients
- The most common problem is decay of the gum line. This is a hard to reach area.
- Gums decay naturally through our life.
- The roots are softer than enamel so they can decay faster.
- Gingivitis- a condition in when the gum becomes red and swollen. It can bleed easily and is inflamed. If not cleaned, gingivitis can become an infection, if that infection continues, it can erode your gums and bone, and teeth can fall out.
- Techniques for brushing
    - Aim bristles between the tooth and gum at a 45° angle
    - Brush in circles, not up and down or side to side
    - Start with the upper outside- make sure to get up in the cheek and make short circles on each tooth
    - Upper inside- same as the outside. Use a circular motion.
    - Lower outside- same technique.
    - Lower inside- same technique.
    - Finally brush the biting surfaces- in a back and forth motion

- A lot of our patients do not want to floss and it is difficult to do this on them
- For those who can use these techniques:
    - Use 1 ft. to 1.5 ft. of floss
    - On the 3rd finger, use your thumb and index finger to manipulate
    - When inserting the floss, do not jam it into the teeth- use a back and forth motion gently until you hear a "pop"
    - Hug the tooth behind the floss and use an up and down motion 3-4 x's then move to the tooth in front and use and up and down motion 3-4 x's
    - To remove the floss, use a back and forth motion gently until you hear a "pop"
    - Continue this with every tooth

- For those patients who will not let you brush their teeth we use toothettes.
- These are only used when the patient is not brushing.
- To use the toothette:
    - Place it in a solution of ½ hydrogen peroxide and ½ mint flavor mouthwash
    - These things are little sponges
    - Get it wet, tap it off and push it on the teeth like you were brushing
    - Make sure to put it between the tooth and gum

- Demonstration on brushing
    - If the patient is in a chair tilt their head back and have them open their mouth
    - Use gloves
    - *instructor shows a demonstration of brushing techniques*

- Demonstration on flossing
- Dentures and Partials
- Once a day for at least 5 min. you should take the denture or partial out of the patient's mouth and let their gums get some air.
- If a denture is left in for long periods of time, you can get a bad infection
- Patients should not sleep with dentures in, but some insist on doing so
- Another option you can use to get the 5 min. break for the denture wearer is when they are bathing, have them take the dentures or partials out
- When dentures are out, they shouldn't be laying on a tray, they should be kept in a denture bath- a container that has water in it
- If a denture is left out of moisture, it can get brittle and break easily
- When the denture or partial is out: clean it and brush it just like it was their teeth. Do this immediately
- Polydent tablets can go into a denture bath.
- When working with dentures or partials, have a towel or water under them. You must always have them over a soft surface.
- If you drop the dentures on a hard surface, they may chip or break.

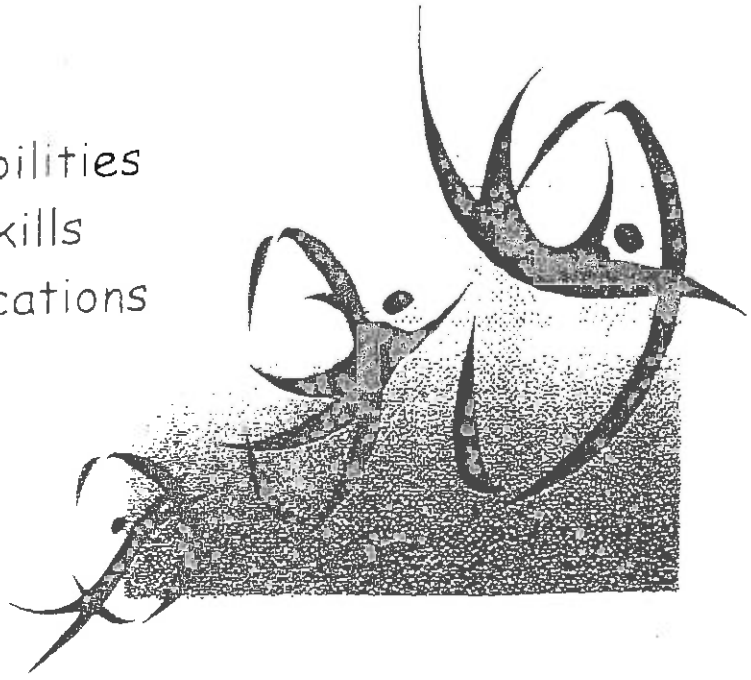
END VIDEO: Total time 11 min. 5 sec.

State Regulation Req. All NSG homes to have an active Rehab NSG program.

RESTORATIVE CARE

Restorative Care focuses on resident's abilities — not their inabilities. It emphasizes the resident's ability to perform tasks as independently as possible. It is directed at:

- Retraining Lost Abilities
- Developing New Skills
- Preventing Complications



INDEPENDENCE IS THE GOAL

ENCOURAGE

Encourage residents to be self-managing.

Assist only as necessary

Break big tasks into smaller tasks - may take them longer to be patient

Encourage movement and exercises

Provide training as needed

Help increase strength and ability

Encourage use of assistive devices and adaptive equipment

ASSISTIVE DEVICES

- Prosthesis
- Devices that help a resident dress and groom
  - Zipper pulls
  - Button hooks
  - Combs / brushes with long handles
  - Special feeding utensils
- Vision aids (eyeglasses)
- Mobility aids
  - Wheelchairs
  - Canes / crutches
  - Walkers

RANGE OF MOTION

- Exercises that involve moving each joint and muscle
- Increases the mobility of joints and prevent contractures and atrophy
- Care plan should specify exactly if and how the ROM is to be done (PROM OR AROM)

AMBULATION

- Resident's physically able should be encouraged to ambulate whenever possible
- The resident's care plan should define type and amount of activity as well as assistance required, etc.

POSITIONING

- The placement of the body for lying or sitting
- Proper positioning and good body alignment:
  - Promote good circulation
  - Increase comfort and well-being
  - Prevent joint contracture and deformities
  - Prevent loss of muscle tone
  - Prevent edema
  - Prevent pressure sores

SUM

- ✓ Restorative Care focuses on mak ing resident's as independent a possible.
- ✓ Help residents be as self managing as possible with ADL's.
- ✓ Encourage use of assistive de vices.
- ✓ Help residents maintain strength, flexibility and function with ROM exercises.
- ✓ Follow each resident's care plan and Facility Procedures.

DAILY START-UP ROUTINE
RESPIRATORY THERAPY

1. ROUND EVERY MORNING, CHECKING VENT CARTS FOR ORDER AND CLEANLINESS
    a. Are the carts stocked
    b. Are there items left on the carts that should not be there (scissors, old dressings, etc)
    c. REPORT ALL NEGATIVE FINDINGS

2. MAINTAIN ORDERING AND INVENTORY OF O2, TRACH, EQUIPMENT AND SUPPLIES

3. MAINTAIN ORDER AND CLEANLINESS OF BACK STORAGE ROOM

4. KEEP DOORS ON VENT CARTS CLOSED WHEN NOT IN USE

5. KEEP ALL VENT/TRACH TUBINGS DATED AND CHANGED AS NEEDED

6. KEEP/MONITOR THE NEED FOR O2 SIGNS ON THE DOORS

7. MONITOR TO ENSURE O2 TUBING IS BEING CHANGED, ENSURE TUBING IS DATED. (Check for pressure areas from the tubing and report to the nurse if any + findings)

8. ASSIST WITH STAFF EDUCATION (UNIT AND FACILITY INSERVICES)

9. MONITOR INFECTION CONTROL WITH RESPIRATORY ISSUES

10. REVIEW RESPIRATORY POLICIES AND MAKE SUGGESTIONS (CLIP)

11. ENSURE ALL SUCTION MACHINES ARE COVERED

12. MONITOR AND KNOW WHO ALL IS ON O2 IN THE FACILITY

13. MAINTAIN O2 CONCENTRATOR FILTER CLEANING AND LOG ON FILTER LOG

Respiratory Therapy Rounds

1. Once weekly (goal is to check same day each week) go to each unit and check all residents in the facility that is on Oxygen. Check to see that the concentrator is in good working order, correct oxygen flow, filter clean and that tubing is dated with initials.
2. Weekly check and clean the oxygen concentrator filters.
3. Weekly check all trach stomas in the facility, making a note in the nurses notes regarding the stoma.
4. Initially check all charts of trach stoma residents to ensure that orders are written for stoma checks weekly and to provide daily stoma care and that it is put on the Treatment Record.
5. Monthly check charts to see that trach stoma orders are being carried over to Telephone orders and treatment records.
6. In-service all new nurses to Willow to the Vent and have them sign in-service form
7. Send a monthly report of the oxygen concentrator filter log to Paula/Shelley by the 5th of each month for the previous month
8. Send a monthly report of all residents who are on or have been on Oxygen during the month to Paula/Shelley by the 5th of each month for the previous month.

OXYGEN FILTER LOG

Date	Resident Name	Unit	O2 Concentrator #	Cleaned	Time	Initial

OXYGEN CONCENTRATOR LOG

SERIAL #	BORROWING UNIT	RESIDENT	ROOM #	DATE/SIGN OUT	VENDOR	DATE/INITIAL

RETURN ADMISSION CHECKLIST

- ☐ 1. RN Assessment and documentation.
- ☐ 2. Transcribe physician orders from hospital (fax to pharmacy, lab, dietary, etc)
- ☐ 3. Transcribe orders to MAR/TAR, etc
- ☐ 4. Notify MD on call of orders for review and document
- ☐ 5. Notify family of return to unit and document
- ☐ 6. Obtain readmission body/skin audit and complete on body audit form as well as document in the nurses notes
- ☐ 7. Notify skin team/PT if needed for skin/wound treatments; Rehab for OT, ST or PT
- ☐ 8. MUST obtain vital signs and weight and put in graphics
- ☐ 9. Place on Hot Rack
- ☐ 10. Document every 2 hours for first 24 hours then Q shift x 3 days unless otherwise indicated (This does not exclude any other documentation that needs to be done)
- ☐ 11. Review code status to ensure proper dot is in place
- ☐ 12. Make any changes necessary to update the Resident Information Sheet
- ☐ 13. Notify care plan coordinator for updates to the care plan
- ☐ 14. If any new restraint orders are received, be sure to notify the SW/RN for consent from family (can obtain a verbal consent while waiting for paper consent to be returned)
- ☐ 15. Off shift RN F/U documentation Q Shift for at least 24° - unless otherwise indicated for longer time frame.
- ☐ 16. Reapply/check security bracelet on resident with orders and/or check alarm bracelet or both for working order.
- ☐ 17. Hydration Assessment.

This is not an all inclusive list, but is to be used as a guidance tool for a return admission. If there are other unit specific orders, please include them according to your unit.

LPN _____ Date _____

RN _____

RN Nursing Services Follow-Up (3-11, 11-7 and Weekends)

_____ _____
Signature (3-11 shift) Date

_____ _____
Signature (11-7 shift) Date

_____ _____
Signature (Weekend shift) Date

Forward COMPLETED Return Admission Checklist to the Unit RN Supervisor. The Resident Body Audit Upon Admission/Readmission form should be filed under the Treatment Tab Skin Sub-tab and attach a copy of the body audit to the Return Admission Checklist.

Revised April 2011

RESIDENT BODY AUDIT

Addressograph Name Plate

This form should be utilized at the time of admission/discharge/readmission of a resident as well as anytime an I and A form is filled out. Please check appropriate box below.

☐ Admission ☐ Discharge ☐ Readmission ☐ Other _____

DATE: _____ TIME: _____ Weight: _____ Height: _____

Vital Signs: B/P_____ P. _____ R. _____ T. _____

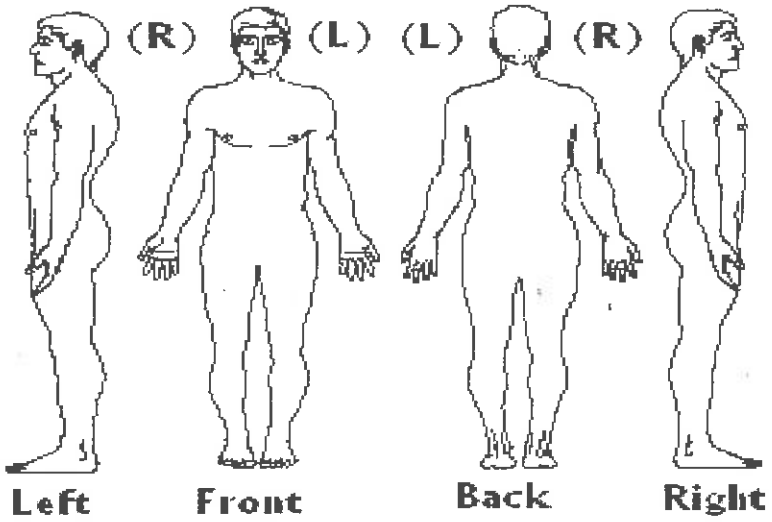
(Circle one) Dentures/Teeth Yes _____ No _____ Glasses Yes _____ No _____

SKIN: ☐ Warm ☐ Cold ☐ Dry ☐ Moist ☐ No Skin Abnormalities Noted

☐ Normal ☐ Pale ☐ Dusky ☐ Cyanotic ☐ Jaundiced ☐ Flushed

Note: If any skin abnormalities are present, mark the diagram for location and size. Beside diagram, describe sizes, stage, odor, drainage, etc.

Diagram Code:
B = Burn
C = Contusion
D = Decubitus
E = Erythema
F = Fracture
H = Hematoma
I = Infection
L = Laceration
P = Petechiae
R = Rash
S = Scar
T = Poor Turgor
W = Wound/Incision



*F – if fracture with cast or splint - ◆ Do the following Peripheral Vascular Assessment

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ (Continue on Back as Necessary)

Done by: _____ **Date:** _____

Form 1161-A3

Name: _____

Unit: _____

(Stamp with resident Addressograph plate here.)

Hydration Assessment (file behind the Nursing Summary Tab under a Sub tab of HYDRATION)

This form is to be completed on admission/ readmission to AHC, when a resident have refused food and fluids for 24 hours, when a significant decline in food and fluid intake is noted, or as needed.

Fax a copy to dietary and provide a copy to the MDS coordinator.

If any items are checked in Part 2 in addition to above actions notify MD, follow orders, and notify the family.

PART 1

To determine if a resident may be at increased risk for dehydration, decide if any of the statements below are true. Check all statements that apply, if any items are checked **"yes"** resident is @ risk

STATEMENT	YES	NO
Needs assistance to feed self, or drink from cup or glass.		
Has trouble swallowing liquids.		
Has current or recurrent vomiting, diarrhea, fever, constipation, or excessive urine output.		
Has been diagnosed with dehydration within the past 30 days, or has been diagnosed with dehydration more than once in the past 180 days.		
Is easily confused or frequently tired and is difficult to arouse.		
Drinks less than 6 cups of liquids per day.		
Has current infection, frequent UTI's, or **uncontrolled** diabetes.		
Has refused food and fluids for 24hrs or frequently refuses meals.		
Exhibits agitation, disorientated behavior, or resists food or fluid intake.		
Medications include frequent use of laxatives, enemas, or diuretics.		
Is Resident a gastric tube-feeder?		

PART 2

To determine if a resident has signs and symptoms of dehydration, decide if any of the symptoms are present. Check all that apply, if any items checked **"yes"** the resident may be dehydrated.

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Dry mouth			Poor skin turgor		
Cracked lips			Labs indicative of dehydration		
Sunken eyes			Increased confusion or decreased LOC		
Dizziness			Nausea or loss of appetite		
Thirst			Concentrated urine		
Constipation			Decreased blood pressure		
Fever			Increased pulse rate		
Dry Skin					

Hydration Notification Checklist:

- ☐ 1. Faxed a copy to Dietary @ (860-0781)
- ☐ 2. Provide a copy to unit MDS Coordinator for update (s) to Plan of Care
- ☐ 3. Notify M.D. New Orders: _____
- ☐ 4. Notify family
- ☐ 5. Assessment documented in nurse's notes
- ☐ 6. Notify Lab, skin team/PT if needed

Justification for Assessment &/or Comments:

Signature upon completion: _____ **Date:** _____

WEEKLY SKIN ASSESSMENTS

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be considered an all-inclusive list

PERMANENT BODY AUDIT-should be performed on admission of resident and documented on the permanent body audit form

WEEKLY SKIN ASSESSMENT-each resident will have a skin assessment completed Q week and documented on the weekly skin assessment sheet

HIGH RISK SKIN AUDIT-High risk audit will be completed daily/nightly on schedule for residents who trigger according to the Braden scale. This will be documented on the daily skin observation sheet and kept in the high risk audit book

1. **All skin concerns** are faxed to the skin treatment team at 860-0779
2. Develop a schedule for weekly skin assessments and educate all nurses as to when assessments are to be completed
3. As part of the start-up routine review the documentation of skin assessments for the previous day to ensure assessments are completed as assigned. Address any areas of concerns
4. Identify residents with an identified skin concern and check to ensure the physician and family has been notified and a treatment order obtained if indicated
5. Compare all skin assessment documentation to the current physician's order for treatment. Every site identified should have a separate/specific treatment order.
6. Resident's identified with a skin concern must have a detailed description of the lesion/skin problem. i.e, pressure sores should have documentation as to location, stage, size, depth, odor, drainage, treatment in process, effectiveness, etc.
7. Skin concerns regarding dry skin, skin tears, etc. also require a notation regarding location, size, treatment, etc. on the daily skin observation sheets

Arkansas Health Center Nursing Quality Assurance

Skin Team Treatment Notification Form

Instructions: Complete **"ONLY"** when the skin problem is **NOT** the result of an injury; for example, this form would be used for pressure ulcer, rash, skin irritation, or medical skin condition.
Fax this completed form to Skin Team @ 860-0779 and Rehab @ 860-0794. Place original in physician folder on the unit for RN Unit Supervisor to review, assess & notify physician.

Unit: _____ **Date:** _____ **Time:** _____

Resident Name: _____ **Room#** _____

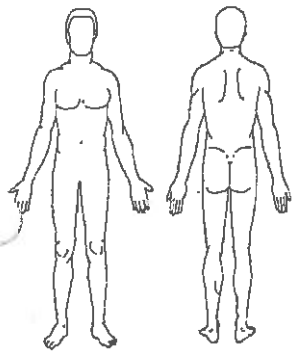
Narrative of Assessment: _____

_____

_____

Treatment/Preventative Measures implemented: _____

_____



Identify site on diagram

Q.A. Checklist:

Physician notified: _____	Yes or No
Relative/ Responsible party notified:	Yes or No
RN Supervisor notified: _____	Yes or No
Attached copy of physician order	Yes or No
Record assessment of skin issues in (nurse's notes):	Yes or No
Document skin issues in weekly body audit book	Yes or No
Placed on Hot Rack follow-up documentation every shift X 72hrs	Yes or No
The skin issue is not the result of abuse, injuries or neglect	Yes or No
Unit Direct Care Staff notified of new skin issues	Yes or No

_____ _____

RN/LPN Signature Date

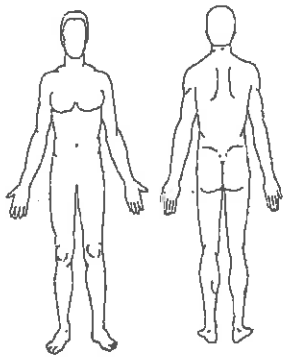
This is a QA/communication tool and is not a part of the medical record.

Revised April 2011

ARKANSAS HEALTH CENTER
DAILY SKIN OBSERVATIONS

CNA INSTRUCTIONS: Use the diagram to mark the location/describe skin concerns. i.e. pressure ulcers, bruises, rashes, dry skin, skin tears, etc. Report to charge nurse.

Date: _____ **Time:** _____

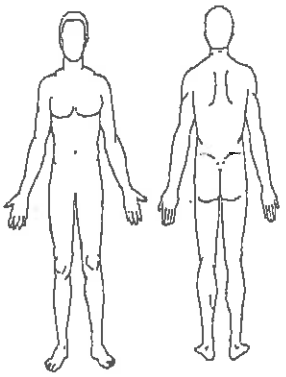


Signature/CNA: _____

Signature/LPN: _____

Signature/Treatment Nurse: _____

Date: _____

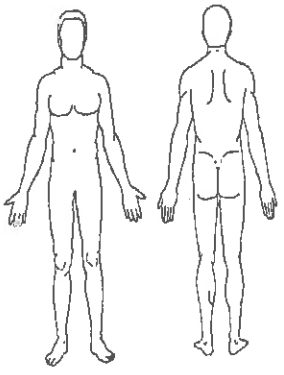


Signature/CNA: _____

Signature/LPN: _____

Signature/Treatment Nurse: _____

Date: _____



Signature/CNA: _____

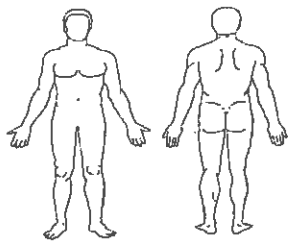
Signature/LPN: _____

Signature/Treatment Nurse: _____

WEEKLY SKIN ASSESSMENT

Use the diagram to mark the location of any skin concerns. Document skin concerns i.e. bruises, rashes, dry skin, skin Tears, etc. If resident has an ulcer, please check the Appropriate box below.

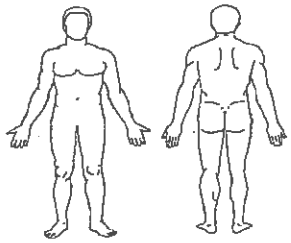
Date: _____ **TIME:** _____



☐ Refer to Wound Report

Signature/Title: _____

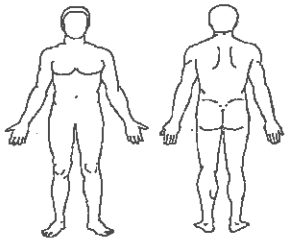
Date: _____ **TIME:** _____



☐ Refer to Wound Report

Signature/Title: _____

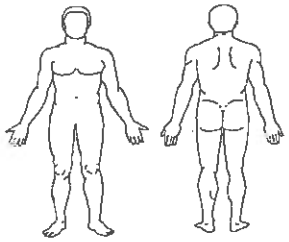
Date: _____ **TIME:** _____



☐ Refer to Wound Report

Signature/Title: _____

Date: _____ **TIME:** _____



☐ Refer to Wound Report

Signature/Title: _____

Policy Type	Subject of Policy	Policy No.
Nursing	Skin Integrity and Assessment	NS

1. **PURPOSE**: The purpose of this policy and procedure is to assure that the skin integrity of residents is preserved through adequate nutrition and hydration, daily inspection of the skin, compliance with proper body alignment and positioning, and maintenance of maximum mobility. In addition to provide information regarding identification and assessment of resident at risk for wounds/pressure ulcers.

2. **SCOPE**: All nursing personnel under supervision and direction of licensed nurse

3. **POLICY**: It is the policy of Arkansas Health Center

   a. Residents who have suffered loss of skin integrity receive appropriate treatment.
   b. The physician and/or the wound care Therapist/Nurse see residents with any broken skin problems.

4. **PROCEDURE**:

A. Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. See policy and procedure for specific task, such as bathing, incontinence care, repositioning.
3. Review the resident's Braden Scare score.
4. Inspect resident skin to ensure clean, dry and well lubricated and to identify areas for potential breakdown on a daily basis
5. Assess for mobility level, hydration-nutrition status, and presence of irritants such as tight clothing or topical substances.

B. Guidelines

1. Residents that are at risk will have a daily skin audit, performed by a licensed nursing staff or C.N.A. staff. Any negative findings will be reported to the staff nurse on duty, and the treatment team. A treatment will be started when/with discovery and reporting of negative findings.
2. All residents will have a weekly skin audit, within a seven (7) day interval, performed by the licensed nursing staff.
3. Residents with a change in condition will have a skin audit by the licensed nursing staff, a review of the Braden Scale, and review of care plans, by the units MDS Coordinator.
4. Each new admission will have a complete skin assessment. This assessment will be completed by the licensed nursing staff, a completed Braden Scale, and plan of care implemented within 24 hours of admission, by the units MDS Coordinator.
5. Review of weekly skin assessment, Braden Scale, and plan of care will be completed by the unit MDS Coordinator weekly for the first (4) four weeks after admission.

6. According to the Braden scale, all residents will have an individualized plan of care implemented within (24) twenty-four hours of admission for, but not limited to, the primary risk factor identified. These care plans will be re-evaluated after each new Braden Scale assessment. The MDS Coordinator will ensure that the risk factors are addressed in an initial care plan and placed in the residents chart.
7. The licensed nurse/therapist will document the condition of areas being treated once a week that includes size, depth, drainage, healing, medication, and devices used to reduce pressure.
8. Evidence of interventions will be documented in the nursing notes and ADL flow-sheets by the licensed nursing staff and the CNA staff.
9. All residents at risk will have a visual reminder placed by the admitting nurse or CNA on the wall above the resident's bed.
10. Use of pressure relief mattresses (or other devices) on beds of resident's that are at risk for areas of pressure breakdown.
11. Each unit physician should document a diagnosis for all non-pressure related skin ulcers/wounds. The clinician will document the clinical basis that differentiates the ulcer/wound type. (e.g. underlying condition, wound edges, wound bed tissue, location, shape and peri-wound (surrounding tissue) condition. Non-pressure related ulcers could be either arterial, diabetic naturopathic ulcer, or venous insufficiency ulcers. The RN Supervisor/designee will review the non-pressure ulcer/wound information with the unit physician to obtain confirmation diagnosis.
12. Newly identified and admitted pressure ulcers will have a confirmation diagnosis by the unit physician within (1) one week of identification to assist with accurate MDS coding and treatment orders. The RN Supervisor/designee will review the pressure ulcer information with the unit physician to obtain confirmation diagnosis.

C. Measures: Residents with Risk Factors

1. **Risk Factor – Moisture**
   a. Use a moisture barrier.
   b. Use absorbent pad or adult briefs.
   c. Provide clean, unwrinkled sheets.
   d. Place resident on a minimum of a q 2 hour check and change program.
   e. Provide personal hygiene care/bath (teach staff to avoid leaving soap residue) to remove perspiration, bacteria and promote comfort.
   f. Frequency will be dictated both by facility routine and resident need.
   g. A resident who perspires profusely may need to receive more frequent care.
   h. Address cause of moisture if possible (e.g., bladder training, scheduled toileting).

2. **Risk Factor – Friction and Shear**
   a. Use an overhead trapeze if indicated.
   b. Allow resident to use a side rail as an enabler if indicated.

c. Use a draw sheet to assist in moving resident from side to side and up in the bed.
d. Provide a sitting support surface that does not cause the resident to slide.
e. Use a draw sheet or other mechanical device for lifting.
f. Avoid placing resident on tubing (e.g., catheter should not be placed under the resident's leg). Nasal oxygen may need to be monitored for pressure to the ears and under the nose.
g. Monitor the placement of splints and casts to assure they are not placing friction or pressure on the resident's skin.
h. Positioning devices (e.g., pommel cushions) must be monitored to assure pressure is not being placed on the labia/scrotum.
i. Shoes need to be monitored for proper fit to avoid development of blisters, corns and calloused areas.
j. Contractures need to be addressed and managed to prevent skin integrity disruption.
k. Skin to skin contact needs to be avoided by placement of pillows, folded sheets or clothing.
l. Use a mechanical lift for residents who may be at risk of experiencing shearing during transfer.
m. Protect bony prominences as needed.

3. **Risk Factor – Bed-fast**
   a. Change position at least every two hours and more frequently as needed for each resident's requirements.
   b. Use a special mattress that contains foam, air, gel, or water, as indicated. Check to ensure resident is not bottoming out when sitting up in the bed. Only use one sheet under resident if using special mattress as recommended by the manufacture.
   c. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments and medical necessity.
   d. Consider off-loading pressure hourly if the head of the bed is greater than 30 degrees (e.g., for residents with tube feeding or respiratory issues).
   e. Unless resident has both sacral and ischial pressure ulcers, avoid placing directly on the greater trochanter for more than momentary placement.

4. **Risk Factor – Chair-fast**
   a. Postural alignment, weight distribution, sitting balance and stability should be evaluated.

b. Residents who are able to cooperate and understand should be taught to shift weight every 15 minutes while sitting in a chair.

c. Change position at least q 1 hour.

d. Avoid use of wheelchairs with sling seats for prolonged periods. Consider the need for pressure relief/reducing device.

e. Change positions at least every hour and use foam, gel or air cushion as indicated to relieve/reduce pressure.

f. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging.

g. Do not use donut-shaped cushions.

h. Refer resident to rehabilitation and/or a restorative nursing program as indicated. Coordinate care and services to encourage participation.

5. **Risk Factor - Immobility**
   a. See bed-fast and chair-fast.
   b. Use pillows or wedges to keep bony prominences such as knees or ankles from touching each other. Do not massage bony prominences.
   c. When in bed, every attempt should be made to "float heels" (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician.
   d. Refer resident for a therapy evaluation and/or restorative nursing program (may include range of motion, transfer and ambulation programs).

6. **Risk Factor – Bowel/Bladder Incontinence**
   a. Check resident for incontinence at least q 2 hours and clean skin when soiled.
   b. Assess and treat urine leaks.
   c. If moisture cannot be controlled use absorbent pads and/or briefs with a quick-drying surface and protect skin with moisture barrier.

7. **Risk Factor – Poor Nutrition**
   a. Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment.
   b. Monitor nutrition and hydration status.
   c. Monitor laboratory values, notify physician when appropriate.
   d. Encourage proper dietary and fluid intake.
   e. If a normal diet is not possible, talk to physician about supplements.
   f. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations.

g. Refer resident to a dentist if needed.

h. Provide mouth care daily and as needed to meet each resident's needs.

8. **Risk Factor – Lowered Mental Awareness**
   a. Choose preventive actions appropriate to individual risk factors and adjust for cognitive impairment of the resident. For example, if the person is chair-fast, refer to the specific interventions for that risk factor, adjusting for any limitations in resident's understanding of instructions or ability to participate in preventive actions.

The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk.

1. Impaired/decreased mobility and decreased functional ability;
2. Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;
3. Drugs such as steroids that may affect wound healing;
4. Impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
5. Resident refusal of some aspects of care and treatment;
6. Cognitive impairment;
7. Exposure of skin to urinary and fecal incontinence;
8. Under nutrition, malnutrition, and hydration deficits; and
9. A healed ulcer/wound. The history of a healed pressure ulcer/wound and its stage/thickness (if known) is important, since areas of healed pressure ulcers/wounds are more likely to have recurrent breakdown

D. Equipment and Supplies

The following equipment and supplies will be necessary when providing preventive skin care.

1. Tools for assessing skin and pressure ulcer risk:
   a. Pressure ulcer risk assessment form.
   b. Resident's medical record, including admission assessment and MDS.
   c. Skin assessment form.
2. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

E. Resident's Rights Protocol

1. Knock and gain permission before entering the resident's room.
2. Verify the identity of the resident.
3. Identify yourself and ask the resident's permission to provide skin care to prevent the development of pressure ulcers.
4. If the resident refuses the care, inform your supervisor.
5. If permission is obtained from the resident, explain the procedure, answer any questions and proceed.
6. If visitors are present, ask them to wait outside unless the resident allows the visitor(s) to remain in the room.
7. Close the room entrance door.
8. Pull the privacy curtain.
9. Close drapes/lower shades/close blinds, as applicable.
10. Upon completing the procedure, place the side rails in the appropriate position as indicated in the resident's plan of care.

F. Infection Control and Procedure Steps

1. Wash and dry your hands thoroughly.
2. Loosen and remove the bed covers as needed. Avoid unnecessary exposure of the resident's body.
3. Don gloves and personal protective equipment, as indicated.
4. If the resident is incontinent, clean the resident of urine and/or feces as necessary.
5. Assess the resident's skin, according to facility protocol.
6. Assess the resident for factors that increase the risk of developing pressure ulcers.
7. For residents with risk factors, implement preventive measures as indicated.
8. Position the resident in a comfortable position. Use supportive devices as instructed.
9. Reposition the top covers. Leave the bed covers loose so that air can circulate to all parts of the body.
10. Place the call light within easy reach of the resident.
11. Wash and dry your hands thoroughly.
12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

G. Documentation

The following information should be recorded in the resident's medical record:

1. The type of skin care given.
2. The date and time skin care was given.
3. The position in which the resident was placed.
4. The name and title of the individual who gave the care.
5. Any change in the resident's condition.
6. The condition of the resident's skin (i.e., the size and location of any red or tender areas).
7. How the resident tolerated the procedure or his/her ability to participate in the procedure.
8. Any problems or complaints made by the resident related to the procedure.
9. If the resident refused the care and the reason(s) why.
10. Observations of anything unusual exhibited by the resident.
11. The signature and title of the person recording the data.
12. Documentation of advance directives (See MDS Section AA).

H. Reporting

1. Notify the supervisor, physician, and family member if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

Director of Nursing		**Date**
Medical Director		**Date**
Clinical Director		**Date**

SUICIDAL BEHAVIOR THREAT

IMMEDIATLEY PLACE RESIDENT ON 1:1 OBSERVATION

NOTIFY MD

NOTIFY SUPERVISOR ON DUTY (DOCUMENT TIME)

NOTIFY THE DON/ADON, ADMINISTRATOR

NOTIFY SOCIAL WORKER
(MAY LEAVE MESSAGE ON PHONE)

NOTIFY FAMILY/RESPONSIBLE PARTY

FOLLOW SUICIDE PACKET
COMPLETE SUICIDAL FORMS AND LOGS
(REMOVE ANYTHING THAT THE RESIDENT COULD USE TO CAUSE SELF HARM)

COMPLETE A 1910 AND INCLUDE WITNESS STATEMENTS

NOTIFY MDSC AND
REVIEW RESIDENT CARE PLAN TO SEE IF RESIDENT HAS A HISTORY OF BEHAVIORS

IF CARE PLANNED, FOLLOW STEPS OUTLINED IN CARE PLAN

DOCUMENT TIMES OF ALL NOTIFICATIONS IN NURSES NOTES

PLACE ON HOT RACK AND DOCUMENT BEHAVIORS FOR **7 DAYS**
(NOT 72 HOURS)

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

Revised April 2011

Arkansas Health Center

Suicide Precaution Risk Assessment

Addressograph

Resident Name: _____ Date: _____ Time: _____

Reason for Referral: _____

_____

_____

Diagnoses: _____

_____

_____

Current Psychotrophic Medications / Last Medication Adjustment (Reduction or Increase):

_____

_____

_____

_____

Does the resident have a suicide plan, if so, describe: _____

_____

_____

Describe resident's physical appearance and affect: _____

_____

_____

Has the resident verbalized / engaged in the following:

1. Has the resident verbalized thoughts of death and/or made verbal, signed or gestured threats to harm self? _____ Yes _____ No

2. Does the resident have a feasible plan to harm themselves?
_____ Yes _____ No

3. Are signs and symptoms of depression indicated (e.g. signs of hopelessness, giving away possessions, sleep disturbance, weight fluctuation, recent change in behavior)?
_____ Yes _____ No

4. Are dangerous acting-out behaviors present?
_____ Yes _____ No

addressograph

Level I: Only answered yes to question #1.
Level II: Answered yes to question # 1, # 2, and #3.
Level III: Answered yes to question #4 (could have answered yes to other questions also)

Describe any recent life event that may contribute to suicidal ideation or thoughts of death:

List the mood and/or behavior symptoms that triggered on the most current MDS:

Is the resident in a situation that is becoming significantly worse or painful, if so, describe.

Level of Precaution needed: (check one)

_____ Level I 15 Minute Check (visual assessment and log activity every 15 minutes on the Resident Observation Form 1160-C)

_____ Level II Continuous Watch (continuous visual assessment and log activity every 15 minutes on the Resident Observation Form 1160-C)

_____ Level III Continuous Contact Watch (continuous visual assessment and staff at arms length and log activity every 15 minutes on the Resident Observation Form 1160-C)

_____ None of the above

Signature and Title of Staff Member completing form: _____

ARKANSAS HEALTH CENTER

Suicide Precaution Alert

Resident: _____

Date: _____

Level: _____

Addressograph

Please sign below indicating you are aware of the above listed information.

Name:	Title:	Name:	Title:

ARKANSAS HEALTH CENTER RESIDENT OBSERVATION FORM

Identification Info: Current Date: _____

Resident Name: _____

Original Order Date: _____

Original Start Time: _____

Physician: _____ RN: _____

All supervision levels require completion of Identification and Sections 1, 2, 3, 5, & 6.

Section 4 is completed when a resident verbalizes suicidal ideations.

addressograph

1. Observation Level Ordered: (check appropriate box)

☐ 1:1 ☐ Visual/LOS ☐ q 15 min ☐ q 30 min

2. Reason for Observation.

☐ Self Destructive ☐ Suicidal behavior ☐ Agitation

☐ Elopement risk ☐ Violent/Aggressive towards others

☐ Falls ☐ Other _____

3. Safety Meaure

☐ Shoes/Dangerous objects removed

☐ Other _____

4. Suicide Risk Assessment - Level of Intervention determined per risk assessment.

ALL LEVELS OF SUICIDE PRECAUTION REQUIRE DOCUMENTATION EVERY 15 MINUTES

☐ Level I 15 Minute Check (visual assessment)

☐ Level II Continuous Contact Watch - Line of Sight/Visual Observation.

☐ Level III 1:1 Continuous Contact Watch - continuous visual assessment and staff at arm's length.

5. Location Code	6. Behavior Code:				
A Resident Rm	1 Standing Still	10 Socializing	18 Quiet	26 Wheelchair	34 Brief changed
B Bathroom	2 Walking	11 Interact/Staff	19 Crying	27 Amb-Walker	35 Bathing
C Hallway	3 Pacing	12 Interact/Therapy	20 Reading	28 Relaxation	36 Restraint released
D Nurse Station	4 Sitting	13 Interact/Visitors	21 Withdrawn	29 Fluids offered	37 Restraint added
E Kitchen	5 Laying	14 Engaged Activity	22 Talking	30 Food offered	38 Other
F Activity Room	6 Sleeping	15 Yelling/Screaming	23 Diversion	31 Toilet offered	
H Family Room	7 Awake	16 Disrobing	24 Redirection	32 Toilet/BM	
I Off Unit	8 Watching TV	17 Combative	25 Verbal	33 Toilet/Void	
J Other	9 Isolating				

Time:	Initials:	Code:	Time:	Initials:	Code:
0000			0600		
0015			0615		
0030			0630		
0045			0645		
0100			0700		
0115			0715		
0130			0730		
0145			0745		
0200			0800		
0215			0815		
0230			0830		
0245			0845		
0300			0900		
0315			0915		
0330			0930		
0345			0945		
0400			1000		
0415			1015		
0430			1030		
0445			1045		
0500			1100		
0515			1115		
0530			1130		
0545			1145		

Signature:	Initials:	Signature:	Initials:

ARKANSAS HEALTH CENTER RESIDENT OBSERVATION FORM

Identification Info: Current Date: _____

Resident Name: _____

Original Order Date: _____

Original Start Time: _____

Physician: _____ RN: _____

All supervision levels require completion of Identification and Sections 1, 2, 3, 5, & 6.

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addressograph

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☐ 1:1 ☐ Visual/LOS ☐ q 15 min ☐ q 30 min

2. Reason for Observation.

☐ Self Destructive ☐ Suicidal behavior ☐ Agitation

☐ Elopement risk ☐ Violent/Aggressive towards others

☐ Falls ☐ Other _____

3. Safety Meaure

☐ Shoes/Dangerous objects removed

☐ Other _____

4. Suicide Risk Assessment - Level of Intervention determined per risk assessment.

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I Off Unit	8 Watching TV	17 Combative	25 Verbal	33 Toilet/Void	
J Other	9 Isolating				

Time:	Initials:	Code:	Time:	Initials:	Code:
1200			1800		
1215			1815		
1230			1830		
1245			1845		
1300			1900		
1315			1915		
1330			1930		
1345			1945		
1400			2000		
1415			2015		
1430			2030		
1445			2045		
1500			2100		
1515			2115		
1530			2130		
1545			2145		
1600			2200		
1615			2215		
1630			2230		
1645			2245		
1700			2300		
1715			2315		
1730			2330		
1745			2345		

Signature:	Initials:	Signature:	Initials:

Resident Name/Unit

MENTAL ANGUISH ASSESSMENT (MAA)

Social Services or Nursing staff are to interview the resident immediately following an allegation of maltreatment or resident to resident altercation to determine if they have experienced any of the following. To complete the assessment, staff should review nursing notes, A & I, 1910, behavior report, and interview residents and witnesses. Check all signs/symptoms that apply to the resident that are considered different from his/her baseline of functioning.

Residents account of incident _____

_____

_____

□ Angry with resident/staff (Name of resident/staff _____) Why?_____
□ Fearful of resident/staff (Name of resident/staff _____) Why? _____
□ Spoken to in a way that made you feel uncomfortable _____
□ Touched in a way that made you hurt or feel uncomfortable
□ Depressed mood: Circle all that apply: Crying, sad, helpless, hopeless, angry
□ Anxious mood Circle all that apply: Worrying, jumpy, can't sit still, insomnia, angry
□ Difficulties sleeping: Circle appropriate response: increased need for sleep or decreased need for sleep
□ Nightmares while sleeping since incident

MOOD & BEHAVIOR OBSERVATIONS

Check all signs/symptoms below that describe the resident at the time of the incident.

□ Tearful □ Pacing □ Clenched jaw □ Clenched fist □ Red/Flushed Face
□ Intrusive (invading personal space of others) □ Verbally aggressive: Explain:_____
□ Physically aggressive: Explain: _____ □ Withdrawal from activities or interests
□ Sad facial expression □ Angry facial expression □ Painful facial expression
□ Happy/Normal facial expression □ Agitated as evidenced by _____
□ Restless as evidenced by _____

CURRENT ASSESSMENT

Resident shows □ minimal □ moderate □ severe or □ no signs/symptoms of mental anguish.

INTERVENTIONS/FOLLOW-UP PLAN

Resident will be re-assessed every___ hours for _____days.
Resident will be referred to □ Psychiatrist □ Psychology □ Social Work □ OT □PT □ ST □ Rec/Activities
Resident was sent to _____Hospital for _____.
Resident was placed on □ line of sight □ 15 minute observation or □ 1:1 observation.
Other_____

_____
Signature of Staff Completing Form Date

Policy Type	Subject of Policy	Policy No.
Administrative	Resident Observation	AP 406

PURPOSE. The purpose of this policy is to provide guidelines for monitoring residents for medical or behavioral reasons.

SCOPE. This policy is applicable to all Arkansas Health Center (AHC) personnel.

POLICY. All AHC residents requiring medical or behavioral observation will be accounted for as determined by the physician's order. There are three levels of documented monitoring. These levels range in degree of staff to resident observation. The use of one to one observation, line of sight or visual contact and time check observation of residents will be provided for medical or behavioral reasons when ordered by a physician. Note: In cases of emergency when a physician is unable to be obtained within the first 15 minutes of the event, a nurse may institute this procedure. However, a physician's order must be obtained via telephone before the end of that nurses' shift or the resident will not remain on an ordered observation. Once the physician's verbal order has been obtained, it must be signed by the physician within 48 hours.

A. Time Check Observation is the observation of a resident at least every 15 minutes for the purpose of monitoring the resident's behavioral and/or medical condition. Time check observation will require the assignment of a staff member to observe and briefly evaluate the resident at least every 15 minutes.

B. Line of Sight Supervision or Visual Contact is the continuous observation of up to three residents by one staff member for the purpose of monitoring the behavioral and/or medical conditions. There is no defined distance between the observer and residents, but the observer must be able to see the actions of all residents assigned at all times.

C. One-to-One Observation is the constant observation of a resident by staff for the purpose of continuous visual monitoring and observation of the resident's behavioral and/or medical condition. One-to-one observation will require the assignment of staff to be within close proximity (approximately within arms length) of the resident at all times unless otherwise specified by physician's order. One to One Observation may be modified by a physician' order according to the individual resident in cases where arms length is determined to cause agitation, aggression, or anxiety. When performing one to one observation, staff should NEVER leave the resident alone nor cease observation of the resident regardless of the amount of space deemed appropriate between the assigned staff member and the resident. One to one observation is ordered for the purposes of ensuring safety of the resident and others. The assigned staff member should be aware of the resident's behavioral and/or medical status at all times so they can intervene in a quick and effective manner when necessary.

PROCEDURE.

A. The use of time check observation, line of sight/visual contact observation, or one-to-one observation will be based upon the clinical assessment of the resident by the physician and will require a physician's order.

B. The physician's order will include the specific level of observation, the duration of the observation and reason for the observation.

C. The physician must reassess the resident within 72 hours of the initial order for the specified type of observation. The physician will write a one to one modification order if one to one continues to be required and arms length proximity is determined to be too close for medical or behavioral reasons.

D. The physician will document in the Physician Notes the rationale for use of the specific observation technique.

E. The order will stand as written and will be reviewed at least every seven days after the initial 72 hour reassessment period.

F. The assigned staff (Nursing, Social Work, Psychology) will monitor the resident for suicidal ideation or attempt, escape intent or attempt, or any other behavioral or medical problems, and report any occurrences of the above to the nurse immediately. The assigned staff will document the resident's behavior every 15 minutes on the AHC 1160-C.

G. Nursing personnel will document the status of the resident at least one time per shift in the Nurse's Notes.

H. The nurse will document on the Behavior Report Form what interventions were utilized and the resulting outcomes.

I. A resident on one-to-one observation is restricted to the building except for medical emergencies or appointments unless otherwise specified in the physician's orders (e.g. smoking privileges).

J. One to one resident observation orders written by a physician are to be verified by the on duty RN or LPN supervisor before the staffing coordinator assigns extra staff to any building on any shift.
   (1) The unit nurse on duty will contact the designated RN or LPN Supervisor to advise of the number of CNA's present on the unit and to request additional assistance as needed to comply with the physician's order.

(2) The RN or LPN supervisor will direct the staffing coordinator to assign staff as available.
(3) The "pulled" or agency staff member will be instructed by the unit nurse what behaviors or medical issues are to be addressed, observed and reported to the nurse.

K. If the time check observation, line of sight/visual contact or one-to-one observation does not appear to provide the level of protection required, the assigned staff will notify the nurse who will notify the physician.

L. If a resident requires indefinite or long term one-to-one observation for medical purposes such as prevention of falls, they should be assessed by appropriate medical professionals for alternate sources of safety (e.g. obtain a physician's order for an evaluation by the appropriate rehabilitation professional, etc.). The procedure should be utilized to attempt the least restrictive protective devices. The physician should write an order for a modified one to one if this type of observation continues to be required, but there is no reason for the assigned staff to be within arms length.

M. If a resident requires indefinite or long term one-to-one observation for behavioral purposes such as aggressive behaviors, suicidal ideation or attempt, self-injurious behaviors, etc., then the resident should be referred for appropriate behavioral interventions (Social Services or Psychology Consult Services). This procedure should be utilized to attempt the least restrictive services.

N. All residents requiring time check observations, line of sight/visual contact observation or one-to-one observation should be reviewed on a weekly basis at the Care Team Meeting with the goal of attempting to find alternative methods of treating the resident and providing a safe environment for the resident and the other residents of the unit.

AHC Director _____ Date _____

ARKANSAS HEALTH CENTER
TELEPHONE ORDER PROCESS

1. All orders shall be written on a Telephone Order. The nurse will use black ink and print eh order legibly. DO NOT USE FELT TIP PENS as this may not show up on the carbon copies. If at any time, a physician writes an order on anything other than a telephone order, the order will be clarified and re-written on a telephone order.
   a. Original prescriptions shall be re-written as a telephone order. The prescription shall be sent to the pharmacy that filled the prescription
   b. Verbal orders: Verbal orders given by the physician shall be written on a telephone order. However, there must be indication that the order was received as a verbal order (V.O.) on both the telephone order and when transcribing the order to the physicians orders form.
   c. Copied orders: Any order received from outside the facility, (example) Clinic, hospital, etc, will be written on a telephone order
      a) EXAMPLE: Resident goes to clinic and sees Dr. Smith. Resident returns to unit with a new order for Tylenol 325mg (2) tabs PO BID. The nurse will notify the primary MD of the order. In this example, Dr. J. Doe is the primary MD. The order will be written on the telephone order as follows:

         5/25/03 1345 Tylenol 325 mg (2) tabs PO QD (pain)
         w.o. Dr. Smith/Nurse Nancy, LPN

2. Orders are to be countersigned by the primary physician with in seven (7) days after issuing the order
3. Orders are to be written and filed in the medical record in reversed chronological order i.e., most recent first
4. The telephone order shall include the following information
   a. Residents full name
   b. Facility Name and address/Name of court
      (AHC 6701 Highway 67 Benton Pine Court)
   c. Room number and bed
   d. Date and time order was received
   e. Actual order written clearly and accurately along with any corresponding diagnosis
   f. Name of MD who gave order
   g. Signature and title of person receiving the order
   h. The nurse will then complete the bottom portion of the order by initialing each space as he/she completes the documentation-transcription of the order

ARKANSAS HEALTH CENTER
TELEPHONE ORDER PROCESS

5. The order will be transcribed (word for word) to the current physicians order form. Transcribed orders shall contain the following information:
    a. The date and time the order was received
    b. The actual order (word for word)
    c. The origin of the order (T.O., V.O. etc)
    d. Name of MD giving the order
    e. Name and title of the nurse receiving the order

Note: If the computer printed Physicians Order form is full or if for some reason the order was received on the first day of the month prior to the current computerized Physician orders being placed in the chart, use a blank physician's order form to transcribe the order. Complete the appropriate information on the bottom of the blank form (i.e., Name of resident, date of birth, room number, physician, etc) and place this form in the chart.
In other words…all orders must be written on the physicians order form for the corresponding month, i.e., orders written for 12/1/02 cannot be written on the P.O form dated for 11/1/02-11/30/02

6. Processing Telephone Orders: Refer to guidelines for writing and processing orders
    a. Orders for medications:
        i. Transcribe order to the MAR
        ii. Copy the telephone order and fax to pharmacy. Attach confirmation to the copied order and place in Medication ordering and receiving notebook. If necessary, follow up with a phone call to the pharmacy or pharmacist on call for orders received after hours (nights, weekends, holidays) or STAT orders. Please remember all orders for medication MUST be faxed to the pharmacy. This includes orders to discontinue t a medication.
    b. Orders for Labs:
        i. Complete a lab request form and fax to lab
    c. Orders for Diet Change
        i. Notify dietary of changes/new orders by faxing the order to the dietary office
    d. Orders for treatments
        i. Transcribe order to the Treatment Administration Record
7. A telephone order must be written to discharge a resident, transfer a resident to another health care institution or unit or to release the body. Medications, including controlled substances, may be discharged with the resident as long as a telephone order is written stating "Discharge resident to _____ with all medications".
8. After completing the telephone order, the nurse will remove both the original (white copy) and the first carbon copy (Pink copy) from the chart and place the orders in the designated location at the nurses' station. The yellow copy will remain in the medical record.

ARKANSAS HEALTH CENTER
TELEPHONE ORDER PROCESS

9. The Unit RN supervisor/designee will review these orders as part of the routine start up. The unit RN supervisor/designee will conduct a telephone order audit to ensure all documentation requirements have been completed.
10. The original (white copy) will be placed in the designated location for the MD to review and sign.
11. After the MD has signed the original telephone order, the Administrative assistant will file the order in the resident's medical record by removing the adhesive tape from the yellow carbon copy and placing the original over the corresponding carbon copy. All telephone orders are to be signed and filed in the medical record with in seven (7) days
12. The unit RN supervisor/designee will give the pink carbon copy to the MDSC to input the order into the computer and update the care plan if indicated. The pink copy may be destroyed after the order has been processed completely.

TRAINING FOR NURSES
TELEPHONE ORDERS/CHARTING ORDERS

1. With all orders the Responsible party or the resident must be notified of change in the plan of care. All orders with medications or treatments must be faxed to the pharmacy.

2. If you are the nurse to initiate the order, YOU MUST be the nurse to CARRY it throughout the ENTIRE process (take off the order, note the order, apply to MAR/TAR, ensure responsible party or resident is notified, fax to pharmacy, pull/dc medication, place change of direction sticker, "place dummy card", etc) THIS CANNOT BE PASSED ON TO ANOTHER NURSE TO COMPLETE!

3. All lab orders must be faxed to Lab (860-0811). (Orders must also be documented in the lab book, and may need to be placed on the calendar as a reminder) with any Repeat cultures, the nurse has to obtain, must be placed on the MAR.

4. All Diet orders must be faxed to dietary (860-0781). If the diet includes thicken liquids or assistive devices, it must be faxed to Rehab Director (860-0794) and also notify Speech Therapist of orders for thicken liquids or texture change. The ADL book along with the Resident information sheet and 24 hour report must be kept updated.

5. All treatment orders must be faxed to the Skin Team (860-0779).

    a. All new admit with stage III or IV pressure sores, the orders must be faxed to rehab (860-0794 and skin 860-0779)
    b. All new admissions will have a body audit completed and a copy of any orders must be faxed to skin team (860-0779)

6. The telephone order check list will be utilized when any problems are noted with a nurse taking off orders to ensure the process is complete and accurate.

7. All restraint orders must be faxed to rehab (860-0794) and or changed on the ADL book and resident information sheet. All rehab orders (OT, PT, ST) will be faxed to 860-0794.

8. Changes made to the Resident information sheet will be faxed to nursing services 860-0779.

April 2011

TELEPHONE ORDERS CHECKLIST

Unit: _____ **Shift:** _____

Name of Nurse: _____

Resident Name _____ **Date:** _____

Physician orders: _____

** There must be indication that orders was received as a verbal order (V.O) or written orders (W.O) or telephone order (T.O) on both telephone order and when transcribing the order to the physician's orders form. Example: 05/25/07 1300 Tylenol 325mg (2) tabs PO QD (Pain) w.o Dr. Suddereth/ Nancy Nurse, LPN			YES	NO	N/A	COMMENTS
ORDER WRITTEN ON A TELEPHONE ORDER (COMPLETE ALL SECTIONS ON TELEPHONE ORDER SHEET AND INITIAL BELOW FOR TRANSCRIPTION COMPLETION TO PHYSICIAN ORDER, MAR, TAR, ETC.						
TELEPHONE ORDER COMPLETED CORRECTLY WITH ALL NECESSARY INFORMATION INCLUDING DATE, TIME, ACTUAL ORDER, RESIDENT'S NAME, UNIT, ROOM NUMBER, (ADMISSION NUMBER), ETC.						
ORDER TRANSCRIBED CORRECTLY TO THE PHYSICIAN'S ORDERS FORM (AND NOTED) USING DATE, TIME AND SIGNATURE.						
ORDER TRANSCRIBED TO THE MEDICATION ADMINISTRATION RECORD OR TREATMENT ADMINISTRATION RECORD WITH DATE AND INITIALS.						
TELEPHONE ORDER COPIED AND FAXED TO THE PHARMACY, CONFIRMATION ATTACHED TO ORDER AND BOTH PAGES PLACED IN THE MEDICATION ORDERING & RECEIVING BOOK.						
NOTATION MADE IN NURSE'S NOTES WHICH INCLUDE ORDER RECEIVED, MEDICATION ORDERED FROM PHARMACY (INCLUDE TIME), FAMILY MEMBER NOTIFIED (INCLUDE NAME OF PERSON NOTIFIED AND TIME), ETC.						
DIET ORDERS: DIETARY NOTIFIED OF NEW ORDER AND THIS IS DOCUMENTED						
LAB ORDERS: LAB NOTIFIED VIA FAX/PHONE AND THIS IS DOCUMENTED						
ORDERS FOR APPOINTMENTS: CLINIC NOTIFIED AND THIS IS DOCUMENTED						
ORDERS FOR THERAPY: APPROPRIATE THERAPIST NOTIFIED AND THIS IS DOCUMENTED						
ORDERS FOR A MEDICATION MUST INCLUDE						
Name of Medication	Ibuprofen	MOM				
Strength of Medication	200 mg					
Dose to administer	(2)	30				
Form of medication	TABS	cc				
Route of medication	PO	PO				
Frequency of administration	BID	Q HS				
Diagnosis	Arthritis	Constipation				
Special Instructions						
Stop Date						
Was the blister pack removed from the medication cart (excluding Controlled substances) OR a sticker placed on the card to indicate a Change in directions						
Was information placed on the 24-hour nursing shift report?						
Was the order placed in the appropriate location?						
Was resident placed on Hot Rack List if indicated						

AUDITOR:

. **Each time a nurse has a transcription, he/she will be required to complete one of these sheets.

DATE

A copy of the Telephone order will be attached to this check-list and forwarded to the Unit RN Supervisor for auditing.

April 2011

GUIDELINES FOR WRITING AND PROCESSING ORDERS FOR MEDICATIONS

1. ORDERS FOR MEDICATION MUST INCLUDE THE FOLLOWING:
   a. Name of the medication
   b. Strength of the medication
   c. Dosage to administer
   d. Form of the medication
   e. Route of the medication
   f. Frequency of administration
   g. Special instructions
   h. Stop date if applicable
   i. Justification for medication (diagnosis/reason)

Example 1:
Ibuprofen 200mg (2) tabs PO BID (Arthritis)
(a) (b) (c) (d) (e) (f) (i)

Example 2:
MOM 30 cc PO QHS (Constipation)
(a) (c) (d) (e) (f) (i)

Example 3:
Levaquin 500mg (1) tab PO BID x 7 days (URI)
(a) (b) (c) (d) (e) (f) (h) (i)

Example 4:
Phenytoin (Dilantin) 125mg/5ml Give 10 ml PO BID (Seizures)
(a) (b) (c) (d) (e) (f) (i)

Example 5:
Tylenol 500mg (2) Caps PO Q 6 Hrs PRN for Temp >101
(a) (b) (c) (d) (e) (f) (i)

MEDICATION INSERVICE

*What four letter word GUARANTEES a successful medication pass the first time?

READ Read what??? THE MAR

5 (6) RIGHTS (STANDARDS OF PROPER MEDICATION ADMINISTRATION)

1) **RIGHT DRUG
   READ the medication label 3 times
   When? Removing from the cart, preparing the dose, and returning to the cart

2) **RIGHT RESIDENT
   Check photo ID
   Address the resident upon entering the room
   Have a staff person verify the identity of resident

3) **RIGHT ROUTE
   Sublingual, Otic, Optic, Suspension, Oral, Suppository, Etc

4) **RIGHT DOSE
   "Shake", liquids measure

5) ** RIGHT TIME
   Administer within one (1) hour of the prescribed meals (before or after)

AGAIN: CHARTING MEDS NOT AVAILABLE IS NOT AN OPTION

6) ** RIGHT DOCUMENTATION

*Surveyors must see more than one route of administration which could include:

Oral
Eye Gtts
Inhaler
G-tube
Crushed

*Every med listed on the MAR MUST be available. Do not write on the back of the MAR, "Med not available"! Get in touch with someone above you if you are unable to obtain a med from the pharmacy in a timely manner

*New admissions must have all of their meds in by the next med pass

*Common Errors in the med pass are:

**OTC's (example) MD orders a Multi-vitamin and the nurse administers Multi-vitamin with iron

**EYE GTTS: (example) Not waiting 3 minutes before administering next drop to same eye. (Doesn't matter if it is the same medication with 2 gtt ordered)

**Not wearing gloves or washing hands

**INHALERS: (Example) Not waiting 1 minute between puffs

**SUSPENSIONS: (Example) Not shaking the bottles thoroughly

**LIQUIDS: (Example) Not measuring correctly; not utilizing syringes to measure…just eye-balling the amount

MEDICATION

COMPETENCY

MEDICATION ADMINISTRATION

1. The narcotic control count is performed by:
   a. the charge nurse
   b. a nurse going off duty
   c. a nurse coming on duty
   d. two nurses: one from the shift leaving, one from the shift coming on duty.

2. The prn medication record is completed:
   a. when the patient asks for a controlled substance
   b. when the controlled substance is removed
   c. immediately after administering the drug
   d. when the degree of pain relief is assessed and documented.

3. Ordered: aspirin 650 mg qid
   On hand: aspirin 325 mg tablets
   Give:_____tablets

4. The doctor orders cyclandelate (Cyclospasmol) 200mg qid x 4 Days, then 400mg/day bid.
   On hand is 200mg and 400mg tablets.'
   How many 200mg tablets would be needed to administer the first 4 days of dosages?

5. Ordered: Furosemide 40mg PO, stat
   On hand: Furosemide 20mg tablets
   Give._____tablet(s)

6. The 6th right of medication administration stresses
   a. right patient
   b. right documentation
   c. right dose
   d. right time

SIX RIGHTS OF MEDICATION ADMINISTRATION

Name the 6 rights and give a brief summary about each:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Name_____ Unit_____ Shift_____

MEDICATION ADMINISTRATION

1. The narcotic control count is performed by
   a. the charge nurse
   b. a nurse going off duty
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   (d) two nurses: one from the shift leaving, one from the shift coming on duty.

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   On hand: aspirin 325 mg tablets
   Give. 2 tablets

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   On hand is 200mg and 400mg tablets.
   How many 200mg tablets would be needed to administer the first 4 days of dosages? 16

5. Ordered: Furosemide 40mg PO, stat
   On hand: Furosemide 20mg tablets
   Give. 2 tablet(s)

6. The 6th right of medication administration stresses
   a. right patient
   (b) right documentation
   c. right dose

11n

SIX RIGHTS OF MEDICATION ADMINISTRATION

Name the 6 rights and give a brief summary about each

1. Right

2. Pt.

3. Dose

4. Route

5. Time

6. Documentation

Name_____ Unit_____ Shift_____

Arkansas Department of Health

Telephone Directory

PHYSICIAN'S ORDERS

PHYSICIAN	SOCIAL SECURITY #
NOTIFY 1:	DATE OF BIRTH:
NOTIFY 2:	ADMISSION DATE:
DIAGNOSIS	ALLERGIES

RESIDENT NAME	COURT	ROOM/BED

PHYSICIAN'S ORDERS

9/4/01 Dilantin 100mg (1) cap PO BID ... Seizures

9/4/01 Dilantin 100mg (2) caps PO QHS...Seizures

9/4/01 Iron Sulfate 325mg (1) tab PO BID....Anemia

9/4/01 Tylenol 500mg (2) caps PO TID.....DX

9/4/01 Oxygen 2l/m via NC continuously for dyspnea

9/4/01 Prozac 20mg (1) cap PO QHS..Depression

9/4/01 Ativan 0.5mg (1) tab PO QD...Anxiety

Diet: Reg NCS

Restraints:
Side rails up x two for safety due to inability to ambulate without assistance, history of falls, poor safety awareness r/t dementia

Activity:
Activity as tolerated

Supplement:
Ensure (1) can PO at 1000 and 1400

PHYSICIAN: Dr. Smith	SOCIAL SECURITY # xxx-xx-xxxx
NOTIFY 1: Jane Doe Wife 555-5555	DATE OF BIRTH: xx-xx-xxxx
NOTIFY 2: Peter Doe Son 555-5555	ADMISSION DATE: xx-xx-xxxx
DIAGNOSIS ANEMIA, STAGE 4 DECUBITUS, SEIZURES, DEPRESSION	ALLERGIES NKA

RESIDENT NAME	COURT	ROOM/BED
JOHN DOE	MAPLE	27 A

FORM #2001

PHYSICIAN'S ORDERS

Copyr

11.1.98 Cleanse (R) heel c̄ normal saline - Apply Neosporin ointment and cover c̄ 4x4 daily. T.O. Dr. Randy Steele / Judy Gipson	Noted 11.1.98 Am - Judy Gipson Rn
11-2-03 Lanoxin 0.125gr p.o. q̄D Tylenol 325mg ii p.o. q 4° prn Back pain. ADD Dx of Arthritis spine CHF	noted 11-2-03 8:00 Am. Nancy Nurse, R.N.

1-800-451-5351

PHYSICIAN Randy Steele, M.D.
ALT PHYSICIAN John Brown, M.D.
PHARMACY CPC
NOTIFY 1 Jane White, sister
NOTIFY 2 Jerry Black, Brother

MEDICAID # 11111111
MEDICARE # 22222
SOC. SEC # 430-00-0000
OTHER INS. # —

DIAGNOSIS

Diabetes, CVA, Glaucoma, CHF, Arthritis spine

ALLERGIES	NOTES/ALERTS
Penicillin	

RESIDENT ID #	BIRTH DATE	ADMISSION DATE	FROM DATE	THRU DATE	PRINTING DATE
10016	12-8-20	5-1-03	11-1-03	11-30-03	10-30-03

RESIDENT NAME	SEX	STATION	ROOM / BED	FINANCIAL CLASS	CARE LEVEL	PAGE
Jones, Joe	M	W	101-A	M	5	2