CHAPTER 2 – OBTAINING A LICENSE

2.B. Appointment of Administrator
Each licensee shall appoint an administrator for each facility. The licensee and the administrator may be one and the same person.

2.C. First Church of Christ, Scientist Homes
Nursing facilities conducted in accordance with the practice and principle of the body known as the Church of Christ, Scientist, shall be subject to the provisions for licensure by the Department. Approval shall be based upon conditions of public safety and sanitation. Certification shall be required by the First Church of Christ, Scientist, Boston, Massachusetts, that the home is operated in accordance with the practice and principle of that body, and the public shall be informed through the name of the home and any publicity thereon that such home is operated in accordance with the practice and principle of the Church body as indicated above. Nothing in these rules and regulations shall be construed to authorize any medical supervision, regulation or control of the remedial care and treatment of residents in certified Christian Science facilities.

2.E.5. Transfer Agreement
Each applicant for a skilled nursing facility or nursing facility license shall provide a copy of all transfer agreements with licensed hospitals, upon request of the Department.

2.E.7. Compliance with Local Laws
A letter from the appropriate municipal official having jurisdiction over the premises where the facility is to be located indicating compliance with all local laws or codes relative to the type of facility for which licensure is requested.

2.F.2. Multilevel Facility License
For multilevel facilities, a single license will be issued by the Department, identifying each level of service.

2.F.3. Facilities Located in Two Structures on the Same Grounds
When one owner, organization or corporation has separate facilities located in physically separated structures on the same grounds, separate licenses shall not be required.

2.F.4. Facilities Operated by Same Management on Different Premises
Facilities operated by the same management on different grounds shall be required to have in effect a separate license for each facility.

2.J. Posting of License
The license shall be conspicuously posted in an area highly visible to residents and the public.

CHAPTER 4 - ADMINISTRATION

4.A. Administrator
4.A.1. Qualifications
The administrator of a facility licensed pursuant to these regulations shall have a current administrator’s license or a temporary permit issued by the Nursing Home Administrators Licensing Board. Hospital based facilities are not required to have a licensed nursing home
The administrator designated on the license shall be responsible for:

a. Carrying out the policies of the facility;
b. The day-to-day operation and management;
c. The control, conservation and utilization of physical and financial resources;
d. The hiring of an adequate number of qualified, competent personnel;
e. The discharge of such functions as the licensee may properly delegate to him/her;
f. Ensuring that the facility is in compliance with State licensing and Federal certification regulations.

4.A.2. Functions
An individual, authorized to act in the absence of the administrator during the normal working day, shall be designated. Any planned absence of the administrator for a period longer than thirty (30) days shall be reported in writing to the Department.

If the licensee of a licensed skilled nursing facility and/or a nursing facility is required to secure a new administrator as a result of an unexpected vacancy, he/she may, upon seventy-two (72) hours notice to the Department and in accordance with the rules and regulations thereof, place the facility in charge of an acting administrator qualified through current experience in administrative long term care responsibilities. This shall be for such limited time mutually agreed upon between the Department and the licensee, as may be necessary to permit the securing of a licensed administrator, but in no event to exceed sixty (60) days. When a licensed administrator has been secured, the provisions of Section 2.H.6., Change of Administrator, shall apply. If unable to secure a licensed administrator within sixty (60) days, the facility shall submit to the Department written evidence of action taken to secure an administrator.

4.A.5. Full-Time Administrator
Each nursing facility larger than forty (40) beds in size shall have a full-time administrator.

4.A.6. Part-Time Administrator
a. Each nursing facility of forty (40) beds or less in size, may have a part-time administrator.
b. All duties and schedules of working hours of part-time administrators of nursing facilities shall be outlined in the policies of the facility.

4.A.7. Shared Administrator
a. Separately licensed nursing facilities and/or assisted living facilities may share the same administrator as long as the number of beds for which the administrator is responsible does not exceed one hundred (100), subject to approval of the Department.
b. Requests to the Department for exceptions to (a) above may be made in writing when administrative functions for two (2) or more licensed facilities are carried out in a central office. Such requests shall define the functions being handled centrally. The Department shall indicate in writing whether or not the request for an exception is granted.
c. Any sharing of the same administrator shall be defined and the duties and schedule of working hours for each facility shall be outlined in the policy material of the facilities involved.

4.A.8. Administrator In Training
Any facility that has an administrator in training (AIT) must ensure that a licensed administrator or designee other than the AIT is in charge of the facility. No AIT is to be
listed on any facility license as the administrator.

4.B. Register
4.B.1. There shall be a waiting list for facility admissions which shall be maintained in a bound book, updated as necessary and available for public review.
4.B.2. There shall be a resident admission and discharge register in a bound book or on a computer identifying each resident and the date admitted to and discharged from the facility.

4.C. Daily Census Each facility shall maintain a daily census of residents, including the following:
4.C.1. Admissions;
4.C.2. Discharges;
4.C.3. The number and bed locations of each resident in the facility as of midnight each day.

4.D. Transfer Agreement
4.D.1. Requirements
Each facility shall have in effect a written agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of residents and their records, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's residents when needed.
4.D.2. Content
a. The transfer agreement shall provide for the transfer of written information pertaining to the care which the resident has been receiving.
b. The transfer agreement shall provide for the transfer of written information relative to personal effects of significant value.
4.D.3. Execution
Each transfer agreement shall be signed by the administrator or authorized representative of each facility participating in the agreement.

4.E. Outside Resources
4.E.1. Requirements
If the facility does not employ a qualified professional person such as a physical therapist, occupational therapist or speech therapist to render a specific service to be provided by the facility, there shall be arrangements for such a service through a written agreement with an outside resource, a person or agency, that will render direct service to residents or act as a consultant.
4.E.2. Contents of Agreement
a. The responsibilities, functions, objectives, and terms of the agreement, including financial arrangements and charges, of each such outside resource shall be delineated in writing.
b. The agreement shall specify that the facility retains administrative responsibility for the services rendered.
c. When the agreement is with a consultant, there shall be provision for dated, signed reports to the administrator of assessments and/or recommendations. These shall be retained by the administrator for follow-up action and evaluation of performance.
4.E.3. Execution
The agreement shall be signed by the administrator or authorized representative and the person or agency providing the service.

4.F. Rebating Prohibited
No owner, administrator, employee or representative of a licensed facility shall directly or indirectly pay any commission, bonus, or gratuity in any form whatsoever to any physician, organization, agency or person for residents referred.

4.G.2. Deceased Residents
A facility shall comply with all appropriate Maine statutes and regulations pertinent to deceased residents.

4.H. Quality Assurance Committee
All nursing facilities must maintain a quality assurance committee, which may act as a committee of the whole, and which reports to the administrator or the Governing Body.

4.H.1. Composition of Committee
a. The Director of Nursing Services;
b. The Medical Director;
c. A Pharmacist;
d. At least three (3) other members of the facility staff.

4.H.2. Responsibilities of the Committee
a. Meet at least quarterly;
b. Monitor the quality, quantity and necessity of services. Identify and document problems or deficiencies.
c. Develop and implement appropriate plans of action to correct identified problems or deficiencies which shall be available for review upon request of the Department.

4.H.3. Components and Functions of the Committee
a. Infection Control. Assure policies and procedures are based upon current standards and Centers for Disease Control guidelines for:
   a. Prevention of infection;
   b. Universal precautions;
   c. Employee and resident infections;
   d. Linen handling;
   e. Food handling;
b. Accident Prevention. Monitor and analyze incident reports and recommend policies and procedures for accident prevention.
c. Pharmaceutical Services. Monitor pharmaceutical practices, identify concerns, and recommend changes, when necessary.
d. Utilization Review. Establish and monitor a Utilization Review plan that shall include:
   1. Monitoring of admissions (regardless of payment source), and necessity of services;
   2. Review of all residents (regardless of payment source), continued stays and discharge planning; and
   3. Review the implementation of monitoring of appeal rights and the process of transfer and discharge notice.

4.I. Complaints
4.I.2. A system must be established for the review, within forty-eight (48) hours, of each complaint received by the administrator and/or any designated member of the facility staff. A report of findings and action taken shall be prepared and submitted to the Quality Assurance Committee, and be available for review upon request of the Department.
CHAPTER 5 – FACILITY POLICIES

5.A. Professional Policy Group

5.A.1. Requirements
Each facility shall have written policies which govern all areas of services provided and are developed with the advice of, and with provisions for, annual review by a group of professional personnel including the administrator, Director of Nurses, a physician, a registered pharmacist, and such other professional personnel as necessary.

5.A.2. Meetings
The professional policy group shall meet as necessary, but at least annually, to review written policies and reports of the Quality Assurance and other Committees. All members of the group should be present or have input and minutes of meetings shall be recorded and reflect the activities.

5.A.3. The professional policy group meetings may be incorporated within the Quality Assurance Committee.

5.B. Written Policies

5.B.1. The written policies of each facility shall be consistent with State licensing and Federal certification requirements and shall include:
   a. Specific reference to indicate the person or persons responsible for the execution of such policies;
   b. A written outline of the objectives of the facility;
   c. Provision for these written policies to be available at all times to residents, families, admitting physicians, sponsoring agencies, staff, and the public;
   d. Provision for implementation of policies and training of staff;

5.B.2. Policies shall address all areas of services provided and facility practices regarding:
   a. Resident Rights, including advanced directives for care and treatment, and grievance procedures;
   b. The types and extent of services that are available in the facility;
   c. The extent of medical and nursing practices that may be provided by the facility;
   d. The type of residents that the facility will accept, based on sex, mental status, source of referral, etc. Policies should also provide that residents will be accepted regardless of race, color, national origin, sexual orientation or reimbursement source;
   e. the waiting list for facility admissions;
   f. the Quality Assurance Committee;
   g. admissions, transfers and discharges:
      1. provision for prevention of resident transfer from one part of the facility to another, except from a private room, solely because of Medicaid status;
      2. provision for prevention of discharging a patient from a nursing facility solely because of Medicaid status;
      3. nursing facility must establish and follow written readmission policies which are consistent with all applicable regulations and statutes.
   h. Physician services;
   i. Emergencies;
   j. Pharmaceutical services;
   k. Dietary services;
   l. Diagnostic and other services, including the tests which may be done within the facility;
m. Written agreements with outside resources;
n. Social services;
o. Independent and group activities;
p. Physical and chemical restraints;
q. Resident records;
r. Maintenance, laundry and housekeeping services;
s. Infection control and waste management;
t. Smoking restrictions;
u. Dental services;
v. Disaster preparedness;
w. Reporting of abuse, neglect and/or misappropriation of resident property;
x. Nursing services;
y. Staff orientation and inservice;
z. Rehabilitative services.

CHAPTER 8 - PERSONNEL

8.A. Personnel Policies
The facility shall have policies that address all personnel practices.

8.B. Staff Qualifications
8.B.1. The facility must employ, on a full time, part time, or consultant basis those persons necessary to carry out the provisions of these regulations.
8.B.2. Staff must be licensed, certified, or registered in accordance with applicable State laws.

8.C. Employees
8.C.1. Nursing Staff
a. Licensed Staff
R.N.s and L.P.N.s must hold a current State of Maine license or permit, which must be verified prior to employment and upon each renewal.
b. Certified Nursing Assistant
1. A facility must not employ anyone as a nursing assistant for more than four (4) months, on a full-time, temporary, per diem, or other basis, unless that individual has completed a training and/or competency evaluation program that is based upon the standard curriculum established by the Maine State Board of Nursing and approved by the Department of Education, or has been granted reciprocity or has been deemed competent under Maine State Board of Nursing rules.
2. When an individual has not performed paid nursing services for a continuous period of twenty-four (24) consecutive months since the most recent completion of a training and competency evaluation program, the individual must meet qualifications for competency established by the Maine State Board of Nursing.
3. A facility may not use staff of outside agencies to perform nursing assistant duties, unless that person is a CNA.
4. The facility must check with the State of Maine Registry of Certified Nursing Assistants to assure that the prospective CNA is listed on the Registry and has no record of a conviction or a substantiated complaint of resident abuse, neglect or misappropriation of residents’ funds or property.
8.C.2. Non-Nursing Personnel
There shall be adequate numbers of non-nursing personnel to perform the necessary services and meet the needs of the residents and the facility. These persons shall not give resident care, unless staffing patterns, training, qualifications and job descriptions reflect the activities of such multi-purpose personnel.

8.C.3. In-Service Program
a. There shall be an orientation program for all new employees that includes review of all applicable facility policies, including resident rights, job description, and related responsibilities.
b. The facility must provide at least twelve (12) hours per year for CNA staff and periodic in-service education to all other employees.
c. The in-service program shall be planned and include at least one program per year relating to resident rights, disaster preparedness, workplace safety and the identified educational needs of the staff.
d. In-service education must include specific training for staff providing nursing and nursing related services to residents with cognitive impairments including but not limited to people with Alzheimer’s or dementia and for those conditions which may be applicable to the resident population of the facility. For facilities with units specific to residents with Alzheimer’s or dementia, refer to Chapter 23 of these Regulations.
e. Records shall be maintained which indicate the content of and staff participation in all such orientation and staff development programs.

8.C.5. Employment Restrictions
The facility must not employ individuals who have been convicted by a court of law or have had complaints substantiated by the Department of abusing, neglecting, or mistreating individuals or misappropriating funds or property in a health care or related setting.

8.C.7. Age Requirement
No person under the age of sixteen (16) shall fulfill the staffing requirements for CNAs.

8.C.8. Grievances
Employees may voice grievances and register complaints with the administrative staff or appropriate outside agencies without fear of reprisal or discharge and shall expect prompt response and disposition of the grievance. No facility may take any action toward an employee which would create a fear of reprisal or a fear of discharge.

8.D. Personnel Records
8.D.1 Employee Record on File
a. Employment History
A record shall be completed for each employee, kept on file in the facility, and shall be available to Department personnel for inspection. Each record shall contain documentation of references and checks, dates of employment, home address, education or background, social security number, occupational license number if applicable, past experience or type of employment, where previously employed, type of position employed for in this facility and last day employed (if no longer in present facility). The current occupational license number, when applicable, shall be on file.
b. In-services Records shall be maintained of staff attendance at in-services and other educational programs.
c. Work Performance A record shall be kept for each employee of signed performance evaluations.
d. Illness and Accidents A record shall be kept for each employee of all illnesses and of all accidents occurring on duty.
e. Feeding Assistants
All nursing facilities shall maintain a record of the individuals who have successfully completed a State approved feeding assistance program. Feeding assistants shall not feed residents who require the assistance of staff with more specialized training, such as residents with recurrent lung aspirations, difficulty swallowing, on feeding tubes, and parenteral or IV feedings.
8.E. Weekly Time Schedule
Each facility shall post a dated employee weekly time schedule in a convenient place for employee use. This shall contain each employee’s name, job title and location, hours of work and days off for each day of the week. Any changes in staff or hours of work are to be posted on the time schedule. These weekly time schedules shall be kept on file in the facility for one year and shall be available to Department personnel for inspection.
8.F. Laws of the Maine Department of Labor The current regulations of the Maine Department of Labor shall be followed.
8.G. Identification Badges
All direct care staff shall, at all times, wear identification badges reflecting their name and title, except in situations in which wearing an identification badge would create a safety hazard.

CHAPTER 9 – RESIDENT CARE STAFFING

9.A. Minimum Nursing Staff Requirements
Director of Nursing - Responsibilities The Director of Nursing shall be responsible and accountable to the Administrator for:
...Assuring the delivery of orientation programs and staff development...
9.B.2. Certified Nursing Assistants
The nursing tasks assigned to a CNA shall only be those for which the CNA has been trained and which are within the scope of the duties, as defined by the Maine State Board of Nursing rules and regulations.
9.B.3 Nursing Assistant
a. Prior to the initial assignment of a nursing task to a nursing assistant, the Registered Professional Nurse shall determine if the individual is enrolled in a course preparing nursing assistants. The Registered Professional Nurse may assign to that individual only those tasks for which the individual has been satisfactorily prepared as documented by the instructional staff. Such training program or course must be satisfactorily completed within four (4) months from the date of employment.
b. When a nursing assistant is waiting for a training program to start, he/she may participate in non-direct care activities, such as making unoccupied beds and passing trays, and water and linens.

CHAPTER 10 – RESIDENTS’ RIGHTS

10.A. Written Policies
Written policies shall be established by the governing body of each facility regarding the rights and responsibilities of the residents.

10.B. Procedures
Procedures shall be developed and adhered to for training of facility staff concerning these policies and procedures, and for making the policies available to residents, to any guardians, next of kin, sponsoring agencies or representative payees.

CHAPTER 13 – NURSING SERVICES

13.A.12. Laboratory Services
The facility shall have policies and procedures which:
a. List the laboratory services being performed within the facility;
b. Ensure that the necessary certification is received under the Clinical Laboratory Improvement Amendments of 1988; and
c. Outline procedures for obtaining tests from outside laboratories.

CHAPTER 16 – PHYSICIAN SERVICES

16.A.11. Medical Director
a. There shall be a medical director who is responsible for the medical direction and coordination of medical care in the facility.
b. The duties, responsibilities and availability of the medical director, and the terms of agreement, shall be delineated in writing. The agreement shall be signed by the physician serving as medical director and by an authorized representative of the facility.
c. The medical director is responsible for the:
   1. Overall coordination of medical care;
   2. Liaison with attending physicians;
   3. Participation in the Quality Assurance Committee and the Professional Policy Committee.

CHAPTER 17 – PHARMACEUTICAL SERVICES

17.C. Supervision of Drugs and Biologicals
17.C.2. Responsibilities of the Pharmacist Consultant:
   ...i. Participates in the Professional Policy Committee and Quality Assurance Committee meetings to review and make recommendations relating to pharmaceutical services.

17.H. Reporting of Medication Errors and Adverse Reactions
17.H.3. Incident Reports
There shall be an incident report made out for each medication error and/or adverse reaction. These reports shall be kept together on the premises of the facility, reviewed by the Quality Assurance Committee and be made available for review by representatives of the Department.
CHAPTER 19 - RECORDS

19.A. Clinical Records
The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices.
19.A.1. All current clinical information pertaining to a resident’s stay shall be available at the nurses station.
   a. The resident's records must be kept in the facility at all times. The record may be in paper or electronic format.
   b. All recording is done in the facility.
   c. The records are immediately available to resident care personnel.
19.A.2. Pertinent, non-clinical information shall be kept current, including address and phone number of the resident's legal representative or interested family member.

19.B. Retention of Records
19.B.1. Active Clinical Records
The following current records shall be available and retained at the nurses station as indicated:
   a. Identification sheet - retain permanently.
   b. Physician Records
      1. History and latest complete report of physical examination.
      2. Progress notes - for at least past 12 months.
      3. Order sheets - for at least past 12 months.
      4. Consultations - for past 12 months.
   c. Professional Services
      1. All MDS forms for the past 15 months.
      2. RAPS summary forms for the past 15 months.
      3. Documentation of interventions, significant changes, observations, acute episodes, and progress notes for the past 12 months.
   d. The Care Plan - for the past 12 months.
   e. Results of any preadmission/annual screening - permanently.
   f. Assessments by any additional professional discipline not included in the comprehensive assessment by the multidisciplinary team - for the past 24 months.
   g. Medication and treatment sheets for past 6 months.
   h. Diagnostic reports, lab, x-ray and diabetic records for past 12 months, unless frequent lab work, then 6 months.
   i. Vital signs and weights for past six (6) months.
   j. Personal care records - for past three (3) months.
   k. List of valuables.
   l. Transfer information.

19.B.2. Purging of the Active Clinical Record
Active clinical records may be purged after the period(s) of retention listed in 19.B.1. above. These purged records must be available at, or easily accessible to the nurses station.

19.C. Miscellaneous Records
19.C.1. Miscellaneous records shall be maintained and retained as follows:
   a. Monthly activities schedule - retain for 12 months.
b. Staffing schedule - retain for 5 years for auditing purposes.
c. Menu plans - retain for 3 months.
d. Food purchase orders - retain for 5 years for auditing purposes.
e. Reports of fire drills - retain for 12 months.
f. Incident reports - in a separate file. Current file should include 12 months - retain for 5 years.
g. Quality Assurance Committee and utilization review reports - keep together for 12 months and retain for 5 years.
h. Minutes of Committee meetings, inservice, etc. keep together for 12 months and retain for 5 years.
i. Consultant reports - keep together for 12 months and retain for 5 years for auditing purposes.
j. Reports of surveys, inspections, water tests, permits - keep together for 12 months and retain for 3 years.

19.D. Inactive Clinical Records
19.D.1. Clinical records must be retained for:
   a. The period of time required by State law or five years from the date of discharge, whichever is greater.
   b. For a minor, three years after a resident reaches legal age under State law.
19.D.2. Before filing, each sheet should be checked to be sure that it is completed as appropriate.
19.D.3. Purged records shall be arranged in chronological order and filed in the inactive files.
19.D.4. For discharged/closed records, all material pertaining to the resident, including the clinical record, administrative record and care plan shall be filed together and according to accepted Medical Record standards.

19.E. Readmissions
19.E.1. When a facility readmits a resident within one month, the resident's clinical record must contain the following documentation:
   a. New physician orders;
   b. Updated physical exam;
   c. A comprehensive assessment; and
   d. A current note by all appropriate professionals.
19.E.2. For readmission after more than one month of discharge, a new record must be completed.

19.F. Transfers and Discharges
19.F.1. For transfers within a facility with distinct parts, the current record may be continued.
19.F.2. Before a facility transfers or discharges a resident from one facility to another facility, institution or agency, the facility must prepare a referral form. The referral form is forwarded at the time a resident is transferred. A copy is to be retained in the resident’s record. To ensure the optimal continuity of care, the referral form shall contain an appropriate summary of information about the discharged resident.

...19.H. Individual Administrative Records
Records must be kept in the facility, but not necessarily in the nurse’s station. Each resident shall have a separate folder which may include:

19.H.1. Resident rights acknowledgment;
19.H.2. Contract with resident;
19.H.3. Statement of who is responsible for personal needs monies;
19.H.4. Records of personal needs monies, including receipts, bank books, or statements and any relevant documentation. These may be filed in inactive files after twelve (12) months;

19.I. Confidentiality
The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

19.I.1. Transfer to another health care institution;
19.I.2. Law;
19.I.3. Third party payment contract;
19.I.4. The resident; or
19.I.5. The Department.

19.J. Access
The facility must:
19.J.1. Permit each resident and his/her authorized representative to inspect his or her records within twenty-four (24) hours of request. Such inspection shall occur at reasonable times and in the presence of a member of the facility's staff.
19.J.2. Provide copies of the records to each resident no later than two (2) business days after a written request from a resident, at a photocopying cost not to exceed the amount customarily charged in the community.
19.J.3. Records shall be made available for inspection and/or copying by representatives of the Department.

19.K. Storage of Records
19.K.1. The facility must safeguard clinical record information against loss, destruction, or unauthorized use.
19.K.2. All records shall be completed prior to filing, and shall be filed in a manner to facilitate retrieval of the complete record when needed. Provision shall be made for adequate facilities and equipment, conveniently located, for the safe storage of all records and accessibility when needed.
19.K.3. In the event of change in ownership of any licensed facility, all resident records and registers shall remain the property of the facility.

CHAPTER 20 – PHYSICAL PLANT

a. All facilities shall develop a written disaster plan and procedures to meet the needs of the facility. The disaster plan shall be written to identify emergencies and disasters most likely to occur.
   1. plan for a disaster within the facility which could encompass moving residents from one area of the facility to another area of the facility or to another building within the community, (i.e., fire, loss of heat, power, or water, structural damage, etc.) The plan must
specify the source of emergency power and the methods that will be used to meet the requirements contained in Chapter 20.B.5.

2. second plan for a disaster outside the facility (in the community) which would not necessarily mean moving residents, but which provides a means for heat, lights and food if the existing facility does not have an emergency generator.

3. third plan shall address other potential emergencies, (i.e., severe weather, missing residents, etc.)

b. copy of the disaster plan shall be provided to the Department. Revisions shall be submitted when they occur.

c. employee Instruction

Employees shall be trained when they begin to work in the facility in the use of fire fighting equipment, and in the evacuation of residents from the scene of the fire and other emergencies. Orientation to the Disaster and Emergency Preparedness Plan shall be provided upon employment, with annual training provided thereafter.

d. Posting of Fire Regulations and Evacuation Plan

Fire regulations and evacuation plans shall be posted in a conspicuous place on each floor of each section of the facility, setting forth the emergency steps to be taken on discovery of a fire.

e. Drills

Drills, constituting rehearsal of the disaster plan, shall be conducted at irregular intervals twelve (12) times a year. There shall be at least three (3) drills a year for each shift. A record shall be kept of each drill, showing date and time, staff performance, results of each drill, and corrective measures being taken as directed thereby.

20.O. Housekeeping

20.O.3. Infection Control

The facility shall provide a hygienic environment for residents and staff by having procedures for:

...e. Maintaining liaison with the Quality Assurance Committee as necessary;

CHAPTER 21 – INFECTION CONTROL AND BIOMEDICAL WASTE

21.A. Infection Control

The facility must establish an active program for the prevention, control, and investigation of infection according to current standards and Center for Disease Control (CDC) guidelines, which includes:


CHAPTER 23 – ALZHEIMER’S/DEMENTIA CARE UNITS

23.B. Alzheimer’s/Dementia Care Unit Program Disclosure

23.B.1. Disclosure Required

An entity that offers to provide or provides care for individuals with Alzheimer’s disease or a related disorder through an Alzheimer’s/Dementia Care program shall disclose the form of care or treatment it provides that distinguishes it as being especially applicable to or suitable for those individuals. The disclosure must be made to the Department and to any individual seeking placement within an Alzheimer’s/Dementia Care Unit or the individual’s
guardian or other responsible party. The Department shall examine and verify the accuracy of all disclosures as part of an entity's license renewal procedure.

23.B.2. Disclosure Content
The disclosure must explain the additional care provided in the Alzheimer’s/Dementia Care Unit and include, at a minimum:

a. The program’s written statement of its philosophy and mission that reflect the needs of individuals afflicted with dementia;
b. The process and criteria for placement in, or transfer or discharge from the program;
c. The process used for the assessment and establishment of a plan of care and its implementation, including the methods by which the plan of care evolves and remains responsive to changes in an individual’s condition;
d. The program’s staff training and continuing education practices;
e. Documentation of the program’s physical environment and design features appropriate to support the functioning of cognitively impaired adult individuals;
f. The frequency and types of individuals’ activities provided by the program;
g. A description of family involvement and the availability of family support programs;
h. An itemization of the costs of care and any additional fees; and
i. A description of security measures provided by the facility.

23.C.2. Staffing and Staff Training [Alzheimer’s/Dementia Care Unit]
Every effort must be made to provide residents with familiar and consistent staff members in order to minimize resident confusion. All direct care staff assigned to the Alzheimer’s/Dementia Care Unit shall be specially trained to work with residents with Alzheimer’s Disease and other dementias.

a. Staffing
Only staff trained as specified in Subsections (2)(b) and (2)(c) of this rule shall be maintained and assigned to the unit. Staffing shall be sufficient to meet the needs of the residents and outcomes identified by the individual care plan and sufficient to implement the full day and evening care program. Staffing levels on the night shift will depend on the sleep patterns and needs of residents (without control of sleep by medications). Staffing shall be sufficient to enable each resident to maximize their functioning, self-care and independence.

b. Training
1. Pre-Service Training
The goals of training and education for staff of Alzheimer’s/Dementia Care Units are to enhance staff understanding and sensitivity toward the unit residents, to allow staff to master care techniques, to ensure better performance of duties and responsibilities and to prevent staff burnout. The trainer(s) shall be qualified individuals with experience and knowledge in the care of individuals with Alzheimer’s disease and other dementias. The facilities shall provide a minimum of eight (8) hours of classroom orientation and eight (8) hours of clinical orientation to all new employees assigned to the unit. In addition to the usual facility orientation, which would include such topics as basic resident rights, confidentiality, emergency procedures, infection control, facility philosophy related to Alzheimer’s dementia care, wandering/egress control, the eight (8) hours of classroom orientation should also include the following topics:
   a) A general overview of Alzheimer’s disease and related dementias;
(b) Communication basics;
(c) Creating a therapeutic environment;
(d) Activity focused care;
(e) Dealing with difficult behaviors; and
(f) Family issues.
2. Inservice Training
Ongoing inservice training shall be provided to all medical and non-medical staff who may be in
direct contact with residents of the unit. Staff training shall be provided at least quarterly.
The facility will keep records of all staff training provided and the qualifications of the
trainer(s). Any training provided under the Alzheimer's/dementia curriculum may be credited toward the required twelve (12) hours of training/contact hours for CNAs. At least four (4) of the following topics shall be trained each quarter, so that after six months, staff will have been trained on all of the topics listed. Inservice training will be more comprehensive than what was provided during pre-service orientation.
(a) An overview of Alzheimer's disease and related dementias, to include possible causes,
general statistics, risk factors, diagnosis, stages and symptoms, and current treatments and
research trends;
(b) Communication, to include communication losses that result from
Alzheimer’s/dementia, nonverbal communication techniques (i.e. body language, facial
expressions and touch), techniques to enhance communication, validation as an approach
to communication and environmental factors that affect communication. Any training
provided under the Alzheimer's/dementia curriculum may be credited toward the required
twelve (12) hours of training/contact hours for CNAs;
(c) Creating a therapeutic environment, to include safety issues, effective and ineffective
strategies for providing care (do's and don'ts), background noise, staff behavior,
consistency, wayfinding and temperature;
(d) Activity-focused care, to include personal care (dressing, bathing and toileting),
nutrition and
dining, structured leisure (gross motor activities, social activities, crafts, sensory
enhancement,
outdoor activities, spiritual activities, normative activities, and music - see also Section
23.C.5. -
Therapeutic Activities) and sexuality;
(e) Dealing with difficult behaviors, which should include strategies to deal with common
behavioral issues such as wandering, sundowning, catastrophic reactions, combativeness,
paranoia, ignoring self-care; and
(f) Family issues, such as grief, loss, education and support.