10.07.02.02 LICENSE REQUIRED.

B. Separate License Required. Separate licenses are required for facilities maintained on separate premises, even though they are operated under the same management. Separate licenses may be required for separate buildings on the same grounds.

C. Other License Required. A facility having a dual function, including care of the sick requiring hospital facilities in addition to rendering other care services, is required to be licensed for each level of health care rendered.

D. Posting of License Application and Instructions for Written Comment.

1. At least 50 days before the anticipated date of the new license or relicensure, a facility shall conspicuously post:

   a. Its application for initial license or license renewal; or
   b. A notice describing where in the facility the application for licensure or relicensure may be found.

2. The posting shall be near the entrance, in a manner which is plainly visible and easily read by the public.

3. The posting shall include instructions for filing written comments to the Department.

E. Posting of License. A facility shall conspicuously post its license on the premises, at or near the entrance, in a manner which is plainly visible and easily read by the public.

10.07.02.03. LICENSING PROCEDURE.

B. Restrictions of License.

1. Nomenclature. Comprehensive care facilities or extended care facilities licensed under this regulation may not use in their title the words "Hospital", "Sanitorium", or "Sanitarium".

2. Local Law or Ordinance, Where Applicable. Comprehensive care facilities or extended care facilities located in political subdivisions which require them to meet certain standards shall submit proof to the Secretary that they meet local laws, regulations, or ordinances at the time application for license is submitted.

10.07.02.07 ADMINISTRATION AND RESIDENT CARE.

A. Responsibility.

1. The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.

2. The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient’s Bill of Rights Regulations under COMAR 10.07.09.

B. Delegation to Administrator.

1. The licensee, if not acting as an administrator, shall appoint as administrator a responsible person who is qualified by training and experience, and is licensed by the Board of Examiners of Nursing Home Administrators for the State. The administrator shall be responsible for the control of the operation on a 24-hour basis and shall serve full-time, except that an administrator may, with the Department's approval, serve on a less than full-
time basis for a maximum of two nursing facilities, one of which shall have a licensed capacity of 35 beds or less.

(2) The Department shall consider the following factors when considering whether to approve an administrator to serve on a less than full-time basis:

(a) Geographical location of the facilities;
(b) Ownership of the facilities;
(c) Organizational structure of the facilities;
(d) Size of the facilities; and
(e) Background and experience of the administrator.

C. Absence of Administrator. In the absence of the administrator, the facility at all times shall be under the direct and personal supervision of an experienced, trained, competent employee. When the director of nursing serves as relief for the administrator, he shall designate an experienced, qualified registered nurse to direct the nursing service. The relief director of nursing shall be freed from other responsibilities.

D. Excessive Absenteeism of Administrator. If the administrator is absent from the facility an excessive amount of time, and the Department determines that the director of nursing’s absence from nursing service is having an adverse effect on patient care, the Department may require the designation of a specific registered nurse who shall be named the "assistant director of nursing". The Department shall be notified of the name of the assistant director of nursing. When the designee is replaced, the Department shall be notified of the name of the registered nurse filling the vacancy.

E. Character. The administrator shall be of good moral character, in good physical and mental health, and shall demonstrate a genuine interest in the well-being and welfare of patients in the facility.

F. Staffing.

(1) The administrator shall employ sufficient and satisfactory personnel as specified in this chapter to give adequate patient care and to do feeding, maintenance, cleaning, and housekeeping.

G. Educational Program. An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the facility’s personnel, including training related to problems and needs of the aged, ill, and disabled. Records shall be maintained reflecting attendance, by name and title, and training content. In-service training shall include at least:

(1) Prevention and control of infections;
(2) Fire prevention programs and patient related safety procedures in emergency situations or conditions;
(3) Accident prevention;
(4) Confidentiality of patient information;
(5) Preservation of patient dignity, including protection of the patient’s privacy and personal and property rights;
(6) Psychophysical and psychosocial needs of the aged ill;
(7) Receipt by each employee of appropriate orientation to the facility and its policies, and to the employee’s position and duties;
(8) Approval by the Department of the orientation and training programs.

H. Employment Records. A written application shall be on file for each employee and shall contain:

(1) Employee’s social security number.
Home address.
Educational background.
Past employment with documentation that references have been considered by the facility. If the employee formerly worked in a nursing home, consideration shall be given to the record as it relates to abuse of patients, theft, and fires. The licensure of personnel employed as registered or licensed practical nurses shall be verified by the facility.

I. Supportive Personnel. To support placement in a specific position, there shall be sufficient documentation in the employee's record reflecting his training and experience. In instances when an aide is to be assigned to a particular service such as dietary, physical therapy, or occupational therapy, the person in charge of the service shall be responsible for the evaluation and approval of the qualifications.

J. New Supportive Personnel. New supportive personnel shall be credited for 50 percent of their working time until the employee's orientation program, as approved by the Department, is completed. The person in charge of the service to which the employee is assigned shall have input into the contents of the orientation program. Policies for the orientation program shall include the number of hours of orientation required for the various levels of supportive personnel. Following the period of orientation the person responsible for the orientation program and the person in charge of the service shall indicate satisfactory completion of the orientation program of the employee. The responsible department's approval shall be in writing, signed by the appropriate department head whose license number, if applicable shall be recorded in the record. In new facilities the director of nursing and supervisors of the various services, dietary, housekeeping, rehabilitation, and social services, shall be responsible for orienting the new supportive personnel to the facility's policies and procedures and to the physical plant. There shall be a complete orientation for all the employees in life safety and disaster preparedness. The number of daily admissions of patients shall be controlled to allow sufficient time for on-the-job training. Before the opening of the facility all supportive personnel shall have a minimum of 2 days of orientation training.

K. Relief Personnel. Provision shall be made for qualified relief personnel during vacations or other relief periods.

L. Availability of Information. The administrator shall make available to the Secretary such information as may be requested to insure that the facility is meeting the requirements of these and other applicable regulations.

10.07.02.07-1 EMPLOYEE TRAINING ON COGNITIVE IMPAIRMENT AND MENTAL ILLNESS.

A. The following employees shall receive a minimum of 8 hours of training on cognitive impairment and mental illness within the first 90 days of employment:

1. Any employee who is licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland; and

2. Any employee whose job duties include assisting residents with activities of daily living.

B. The training on cognitive impairment and mental illness shall be designed to meet the specific needs of the facility's population as determined by the staff trainer, including the following as appropriate:

1. An overview of the following:
   a. A description of normal aging and conditions causing cognitive impairment;
   b. A description of normal aging and conditions causing mental illness;
(c) Risk factors for cognitive impairment;
(d) Risk factors for mental illness;
(e) Health conditions that affect cognitive impairment;
(f) Health conditions that affect mental illness;
(g) Early identification and intervention for cognitive impairment;
(h) Early identification and intervention for mental illness; and
(i) Procedures for reporting cognitive, behavioral, and mood changes;
(2) Effective communication including:
(a) The effect of cognitive impairment on expressive and receptive communication;
(b) The effect of mental illness on expressive and receptive communication;
(c) Effective verbal, non-verbal, tone and volume of voice, and word choice techniques; and
(d) Environmental stimuli and influences on communication;
(3) Behavioral intervention including:
(a) Identifying and interpreting behavioral symptoms;
(b) Problem solving for appropriate intervention;
(c) Risk factors and safety precautions to protect the individual and other residents; and
(d) De-escalation techniques;
(4) Making activities meaningful including:
(a) Understanding the therapeutic role of activities;
(b) Creating opportunities for productive, leisure, and self-care activities; and
(c) Structuring the day;
(5) Staff and family interaction including:
(a) Building a partnership for goal-directed care;
(b) Understanding families’ needs; and
(c) Effective communication between family and staff;
(6) End-of-life care including:
(a) Pain management;
(b) Providing comfort and dignity; and
(c) Supporting the family; and
(7) Managing staff stress including:
(a) Understanding the impact of stress on job performance, staff relations, and overall facility environment;
(b) Identification of stress triggers;
(c) Self-care skills;
(d) De-escalation techniques; and
(e) Devising support systems and action plans.
C. Employees who are not licensed, certified, or registered or who do not assist residents with activities of daily living shall receive a minimum of 2 hours of training on cognitive impairment and mental illness within the first 90 days of employment. The training shall include:
(1) An overview of the following:
(a) A description of normal aging and conditions causing cognitive impairment;
(b) A description of normal aging and conditions causing mental illness;
(c) Risk factors for cognitive impairment;
(d) Risk factors for mental illness;
(e) Health conditions that affect cognitive impairment;
(f) Health conditions that affect mental illness;
Early identification and intervention for cognitive impairment;
(h) Early identification and intervention for mental illness; and
(i) Procedures for reporting cognitive, behavioral, and mood changes;
(2) Effective communication including:
(a) The effect of cognitive impairment on expressive and receptive communication;
(b) The effect of mental illness on expressive and receptive communication;
(c) Effective verbal, non-verbal, tone and volume of voice, and word choice techniques; and
(d) Environmental stimuli and influences on communication; and
(3) Behavioral intervention including risk factors and safety precautions to protect the individual and other residents.
D. Ongoing training in cognitive impairment and mental illness shall be provided annually and consist of, at a minimum:
(1) 2 hours for employees who are licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland, or who assist residents with activities of daily living; and
(2) 1 hour for all other employees.
E. The training that is described in this chapter may be provided through various means including:
(1) Classroom instruction;
(2) In-service training;
(3) Internet courses;
(4) Correspondence courses;
(5) Pre-recorded training; or
(6) Other training methods.
F. When the training method does not involve direct interaction between faculty and the participant, the facility shall make available to the participant during the training a trained individual to answer questions and respond to issues raised by the training.

10.07.02.09 RESIDENT CARE POLICIES.

A. Written Policies. Comprehensive care facilities and extended care facilities shall develop written policies, consistent with these regulations, to govern the nursing care and related medical or other services they provide covering the following:
(1) Admission, transfer, and discharge policies including categories of patients accepted and not accepted by the facility, or those who are required to transfer to another level of care. The facility's admission policy shall include a statement as to whether or not medical assistance patients will be admitted and if admitted, under what circumstances.
(2) Physician services.
(3) Patients' rights.
(4) Nursing services.
(5) Dietetic services.
(6) Specialized rehabilitative services—occupational therapy services, physical therapy services, speech pathology and audiology services.
(7) Pharmaceutical services.
(8) Laboratory and radiologic services.
(9) Dental services.
(10) Social services.
(11) Patient activities.
(12) Clinical records.
(13) Reports and action required in unusual circumstances.
(14) Utilization review.
(15) Infection control.
(16) Tuberculosis Surveillance. All comprehensive care facilities and extended care facilities shall have written policies and procedures, acceptable to the Department, for tuberculosis surveillance of all residents. See Regulation .21G of this chapter for tuberculosis surveillance requirements.
(17) Disaster plan.
(18) Housekeeping services, pest control, and laundry.
(19) Patient care management.

B. The patient care policies shall be developed with the advice of the principal physician (or medical staff or medical director, if applicable), and at least one registered nurse. Policies shall be reviewed at least annually by a group of professional personnel including one or more physicians and one or more registered nurses. Written policies shall be kept current with the policies used to administer the facility. For reference purposes, copies of the patient care policies shall be readily available to all personnel responsible for patient care.

C. Policies and Procedures.
(1) Upon the request of the Secretary or the Secretary's designee, the facility's policies and procedures shall be made available to the Secretary for onsite review.
(2) The licensee shall submit to the Department any significant substantive changes to the policies and procedures which have occurred since review of the policies and procedures within 2 weeks of implementation of the changes.

10.07.02.11-1 MEDICAL DIRECTOR RESPONSIBILITIES.

A. General Responsibilities. The medical director is responsible for:
(1) Overall coordination, execution, and monitoring of physician services;
(2) Monitoring and evaluating the outcomes of the health care, including clinical and physician services provided to the facility's residents; and
(3) Designating an alternate medical director with sufficient training and experience to perform the responsibilities of the medical director as described in the regulations of this chapter.

B. Practitioner Oversight. The medical director shall:
(1) Oversee all physicians and other licensed or certified professional health care practitioners who provide health care to the facility's residents;
(2) Ensure that there is a procedure for the review of the practitioners' credentials and the granting of privileges for licensed or certified professional health care practitioners who treat residents of the nursing facility; and
(3) Recommend rules governing the performance of physicians and other licensed or certified professional health care practitioners who admit residents to the facility.

C. Defining the Scope of Medical Services.
(1) The medical director, in collaboration with the facility, shall recommend written policies and procedures that are approved by the licensee, delineating the scope of physician services and medical care.
(2) The facility shall make these policies and procedures available to a resident or resident's representative upon admission and whenever a substantive change is made.
D. Ensuring Physician Accountability. The medical director, in collaboration with the facility, shall recommend policies and procedures that cover essential physician responsibilities to the residents and the facility, including:

1. Accepting responsibility for the care of residents;
2. Supporting resident discharges and transfers;
3. Making periodic, pertinent resident visits in the facility;
4. Providing adequate ongoing medical coverage;
5. Providing appropriate resident care;
6. Providing appropriate, timely medical orders;
7. Providing appropriate, timely, and pertinent documentation;
8. Advising residents and families about formulating advance directives; and
9. Any other responsibilities as determined by the facility and the medical director.

E. Quality Assurance. The medical director shall actively participate in the facility’s quality improvement process. Participation shall include:

1. Regular attendance at, and reporting to, the facility’s quality improvement committee meetings; and
2. Routine participation in ongoing facility efforts to improve the overall quality of the clinical care, including facility efforts to evaluate and address the causes of various care-related problems and deficiencies cited by the Office of Health Care Quality.

F. Employee Health Oversight. The facility, in consultation with the medical director and other physicians, if necessary, shall establish and maintain surveillance of the health status of employees, including:

1. Advising on the development and execution of an employee health program, which shall include provisions for determining that employees are free of communicable diseases according to current acceptable standards of practice; and
2. Ensuring that the facility plans and implements required immunization programs.

G. Other Related Duties. The medical director shall perform other essential duties related to clinical care and physician practices, including:

1. Advising the administrator and the director of nursing on clinical issues, including the criteria for residents to be admitted, transferred, or discharged from the nursing facility;
2. Working with the nursing facility to establish appropriate relationships with area hospitals and other pertinent institutions to improve care of the residents;
3. Advising and consulting with the nursing facility staff regarding communicable diseases, infection control, and isolation procedures, and serving as a liaison with local health officials and public health agencies that have policies and programs that may affect the nursing facility’s care and services to residents;
4. Providing or arranging for temporary physician services as needed to ensure that each resident has continuous physician coverage;
5. Participating as appropriate in facility committee projects and meetings concerning clinical care and quality improvement that require physician input; and
6. Educating or overseeing the education of, and informing, all attending physicians about their roles, responsibilities, and applicable rules and regulations.

H. Medical Director Oversight Plan.

1. Based upon physician and medical director responsibilities in nursing facilities, as described in this chapter, the medical director shall develop and implement a plan describing how the medical director will carry out the responsibilities for the:
(a) Overall monitoring, coordination, and execution of physician services and medical care to residents of the nursing facility; and
(b) Systematic review of the quality of health care, including medical and physician services, provided to the facility's residents.

(2) Minimum Requirements of the Plan. The medical director oversight plan shall include, at least, a plan to ensure that physicians:
(a) Accept appropriate responsibility for residents under the physicians' care in the nursing facility;
(b) Provide appropriate, timely medical care consistent with widely identified medical principles relevant to the facility's population; and
(c) Provide appropriate, timely, and pertinent medical documentation and orders.

(3) Documentation Regarding Medical Director Activities.
(a) The medical director shall keep documentation regarding the medical director’s activities in relation to designated responsibilities.
(b) The documentation required in this subsection may include:
(i) Notes;
(ii) Minutes;
(iii) Copies of faxes, letters, and telephone communications with attending physicians, other facility staff and departments, the administration, the governing body, and others regarding concerns, inquiries, and interventions.
(c) The documentation required in this subsection shall show evidence of the medical director's interventions and follow-up of the effectiveness of those interventions.

I. Quality Assurance Committee Minutes. Committee minutes shall reflect monthly input from the medical director regarding physician issues and general facility clinical care issues.

10.07.02.11-2 FACILITY'S RESPONSIBILITIES IN RELATION TO THE FACILITY'S MEDICAL DIRECTOR.

A. The nursing facility shall:
(1) Be responsible for working with the medical director to ensure adequate resident care and practitioner performance;
(2) Inform the physician of explicit requirements as a medical director and assist the medical director in gaining the necessary information and tools to properly execute those responsibilities; and
(3) Ensure that the medical director has the necessary support and authority to perform medical director duties effectively and to hold practitioners accountable.

B. When the attending physician and medical director document a resident’s medical need for a particular treatment, assistive device, or equipment, that treatment, assistive device, or equipment shall be provided by the facility unless the facility documents in the quality assurance committee minutes the reason or reasons why the treatment, assistive device, or equipment should not be provided.

C. When the attending physician and medical director agree that a particular facility-developed protocol is required to ensure that quality medical care is delivered to the facility's residents, that protocol shall be implemented unless the facility documents in the facility's patient care committee minutes the reason or reasons why the protocol should not be implemented.

D. Evaluation of Medical Director's Performance.
(1) The facility shall have a mechanism for evaluating the medical director’s performance and for providing the medical director with feedback about that performance.

(2) The criteria for evaluation shall be based on explicit medical director responsibilities and shall facilitate the medical director’s improvement and performance of functions and duties.

10.07.02.12 NURSING SERVICES.

...B. Director of Nursing. The facility shall provide for an organized nursing service, under the direction of a full-time registered nurse except that a licensed practical nurse serving as director of nursing as of the effective date of these regulations may continue to serve as director of nursing in the comprehensive care facility in which employed.

...E. Director of Nursing’s Vacancy Exceeding 30 Days. If the position of director of nursing remains vacant for a period of 30 days, the license may be revoked unless the administrator and the governing body are able to demonstrate that they have made every effort to obtain a replacement.

...U. Inservice Educational Program. There shall be a continuing inservice educational program in effect for all nursing personnel in addition to a thorough job orientation for new personnel. There shall be documentation of content of programs and names and titles of participants. The program which shall be the responsibility of the director of nursing shall be approved by the Department.

V. Director of Nursing’s Continuing Education. The director of nursing shall assume responsibility for maintaining his own professional competence through participation in programs of continuing education.

10.07.02.14 SPECIALIZED REHABILITATIVE SERVICES — OCCUPATIONAL THERAPY SERVICES, PHYSICAL THERAPY SERVICES, SPEECH PATHOLOGY AND AUDIOLOGY SERVICES.

...I. Proof of Licensure. The facility shall maintain a file which includes proof of current licensure of all the rehabilitative services’ personnel.

10.07.02.14-1 SPECIAL CARE UNITS — GENERAL.

A. A facility which holds a current and valid operating license may establish special care units with the approval of the Office of Licensing and Certification Programs and the Department’s Division of Engineering and Maintenance.

B. A facility may notify the Department of its intention to establish a special care unit before developing and submitting the required documents for approval as described in §C of this regulation.

C. The facility shall obtain Departmental approval of the following pertaining to the special care unit:

(1) A description and scope of services to be provided;
(2) An organization chart of the special care unit and its inter-relatedness to the rest of the nursing facility;
(3) A description of staffing patterns;
(4) Qualifications, duties, and responsibilities of personnel;
(5) A quality assurance plan which includes:
   (a) Assignment of responsibility for monitoring and evaluation activities;
   (b) Identification of the most important aspects of care provided;
(c) Identification of indicators and appropriate clinical criteria for monitoring the most important aspects of care;
(d) Establishment of thresholds (levels or trends) for the indicators that will trigger evaluation of care;
(e) Monitoring of the important aspects of care by collecting and organizing data for each indicator;
(f) Evaluation of care when thresholds are reached in order to identify opportunities to improve either care or problems;
(g) Taking actions to improve care or to correct the problems;
(h) Assessing the effectiveness of the actions, documenting the improvement in care, and assessing the quality assurance process; and
(i) Communication of the results of the monitoring and evaluation process to relevant individuals or services;
(6) Policies and procedures, including:
(a) The transfer or referral of residents who require services that are not provided by the special care unit;
(b) The administration of medicines unique to the needs of the special care residents;
(c) Infection control measures to minimize the transfer of infection in the special care unit;
(d) Pertinent safety practices, including the control of fire and mechanical hazards; and
(e) Preventive maintenance for equipment in the special care unit;
(7) Protocols for obtaining specialized services, such as arterial blood gases or other STAT services;
(8) Protocols for emergency situations; and
(9) An inventory of the specialized equipment to be housed in the unit to provide services in the special care unit.
D. A facility that has been approved to establish a special care unit shall meet all applicable requirements of this chapter.
E. Physician Coordinator.
(1) If the facility’s medical director does not have special training and experience in the discipline of the assigned special care unit, the facility shall hire a physician who is appropriately trained and experienced to provide:
(a) Overall medical supervision of the special care unit; and
(b) Coordination of all services for the assigned special care unit.
(2) The facility shall verify the candidate’s credentials before employment as physician coordinator.
(3) The physician coordinator, or a designee who meets the requirements of §E(1) of this regulation, shall:
(a) Respond personally or arrange for another qualified physician to respond to situations warranting medical intervention; and
(b) Be available to provide any required consultation.
F. Staffing. The facility shall ensure that each unit is sufficiently staffed with qualified personnel to provide appropriate treatment and special care needs of the residents.
G. Nursing Services.
(1) The director of nursing shall designate a registered nurse who has education, training, and experience in caring for the needs of the special care residents to coordinate all nursing care within the special care unit.
(2) Nursing staff shall be:
(a) Knowledgeable about the emotional and rehabilitative aspects of the special care unit residents; and
(b) Capable of initiating appropriate therapeutic interventions when needed.

H. Design.
(1) A special care unit shall meet the general construction requirements of Regulations .06 and .26 of this chapter, and the requirements in this regulation.
(2) The facility shall ensure that floor space allocated to each bed meets minimum requirements listed in Regulation .28C of this chapter, and is sufficient to accommodate the special equipment necessary to meet the needs of residents.

I. Radiologic and Laboratory Services. The facility shall ensure that diagnostic radiologic and clinical laboratory services are available 24 hours a day. The services may be provided through contractual arrangements with providers that meet applicable federal and State laws and regulations.

J. Quality Assurance Program. The facility shall:
(1) Develop a quality assurance plan to monitor and evaluate the care provided in each special care unit; and
(2) Monitor and evaluate the quality and appropriateness of care provided by the special care unit as part of the facility's overall quality assurance program.

10.07.02.14-2 SPECIAL CARE UNITS—RESPIRATORY CARE UNIT.

A. A respiratory care unit shall meet the:
(1) General requirements established for all special care units as outlined in Regulation .14-1 of this chapter; and
(2) Requirements of this regulation.

B. The facility shall submit to the Department and obtain approval of the following:
(1) All documents required in Regulation .14-1C of this chapter;
(2) Policies and procedures for all aspects of care as outlined in Regulation .14-1C(6) of this chapter, and the following:
   (a) Qualifications, duties, and responsibilities of staff, including the staff who are permitted to perform the following procedures:
      (i) Cardiopulmonary resuscitation;
      (ii) Obtaining arterial blood gas samples and their analyses;
      (iii) Pulmonary function testing;
      (iv) Therapeutic percussion and vibration;
      (v) Bronchopulmonary drainage;
      (vi) Coughing and breathing exercises;
      (vii) Mechanical ventilatory and oxygenation support for residents; and
      (viii) Aerosol, humidification, and medical gas administration;
   (b) Weaning from mechanical ventilatory support and discharge planning for residents of the respiratory care unit; and
   (c) The procurement, handling, storage, and dispensing of medical gases.

C. Physician Coordinator. If the facility's medical director does not have special training and experience in diagnosing, treating, and assessing respiratory problems, the facility shall hire a physician who has the special knowledge and experience to provide:
(1) Overall medical supervision of the respiratory care unit; and
(2) Coordination of all services for the respiratory care unit.

D. Staffing. The facility shall ensure that:
(1) Respiratory care services are provided by a sufficient number of qualified personnel;
(2) Respiratory care personnel provide respiratory care services commensurate with their
documented training, experience, and competence; and
(3) As appropriate, respiratory care personnel are competent in the following:
   (a) The fundamentals of cardiopulmonary physiology and of fluids and electrolytes;
   (b) The recognition, interpretation, and recording of signs and symptoms of respiratory
dysfunction and medication side effects, particularly those that require notification of a
physician;
   (c) The initiation and maintenance of cardiopulmonary resuscitation and other related life-
support procedures;
   (d) The mechanics of ventilation and ventilator function;
   (e) The principles of airway maintenance, including endotracheal and tracheostomy care;
   (f) The effective and safe use of equipment for administering oxygen and other therapeutic
gases and for providing humidification, nebulization, and medication;
   (g) Pulmonary function testing and blood gas analysis, when these procedures are
performed within the respiratory care unit;
   (h) Methods that assist in the removal of secretions from the bronchial tree, such as
hydration, breathing and coughing exercises, postural drainage, therapeutic percussion and
vibration, and mechanical clearing of the airway through proper suctioning technique;
   (i) Procedures and observations to be followed during and after extubation; and
   (j) Recognition of and attention to the psychosocial needs of residents and their families.
E. Design.
(1) Emergency Power. The facility unit shall meet all applicable requirements in Regulation
.26F of this chapter for emergency electrical power, including the provision of:
   (a) Emergency lighting in the respiratory care unit where life support equipment is used; and
   (b) Duplex receptacles connected to the facility’s emergency generator to provide
emergency power to operate life support equipment and nonflammable medical gas
systems in the respiratory care unit.
(2) Ventilator Alarms. The facility shall ensure that each ventilator is equipped with an
alarm on both the pressure valve and the volume valve for safety.
F. The facility shall provide pulmonary function testing, and blood gas or pulse analysis
capability onsite or through contractual arrangements with providers who meet applicable
State and federal laws and regulations.
G. Contractual Services. When any respiratory care services are provided by an outside
contractor, the facility shall:
   (1) Approve the contractor based on the contractor’s credentials, training, and experience;
   (2) Ensure that all contractors:
       (a) Provide services 24 hours a day;
       (b) Meet all safety requirements;
       (c) Abide by all pertinent policies and procedures of the facility;
       (d) Provide services in accordance with all laws and regulations governing the facility; and
       (e) Participate in the monitoring and evaluation of the appropriateness of services
provided as required by the facility’s quality assurance program; and
   (3) Ensure that all contractual services receive overall medical supervision and
coordination by the facility’s physician coordinator of the respiratory care unit.
10.07.02.15 PHARMACEUTICAL SERVICES.

A. Facility Responsible for Pharmacy Services. Pharmaceutical services shall be provided in accordance with accepted professional principles and appropriate federal, State, and local laws. Any regulation in this chapter shall govern if higher.

E. Pharmacist Supervises Services. If the facility does not employ a licensed pharmacist, it shall arrange for, by written contract, a licensed pharmacist to provide consultation on the administering of the pharmacy services in accordance with the policies and procedures established by the pharmaceutical services committee. The pharmaceutical services shall be under the general supervision of a qualified pharmacist who shall:

(1) Be responsible, with the advice of the pharmaceutical services committee, to develop, coordinate, and supervise the pharmaceutical services and provide in-service at least twice yearly.

10.07.02.16 LABORATORY AND RADIOLOGIC SERVICES.

A. Approved Source. Laboratory services provided by the facility shall meet the applicable conditions established under COMAR 10.10.01 Medical Laboratories in Maryland.

B. Provisions of Services. If the facility does not provide laboratory and radiologic services, arrangements shall be made for obtaining these services from a physician’s office, a licensed laboratory in a hospital or nursing facility, a licensed independent laboratory, or a State-approved portable X-ray supplier.

C. Physician’s Order Required. All services shall be provided only on the orders of the attending physician.

D. Reports of Findings. The attending physician shall be notified promptly of the findings. Signed and dated reports of diagnostic services shall be filed with the patient’s medical record.

E. Transportation. The facility shall assist the patient, if necessary, in arranging for transportation to and from the source of service.

F. Blood and Blood Products—Blood Handling and Storage. Blood handling and storage facilities shall be safe, adequate, and properly supervised.

G. Storage and Transfusion. If the facility provides for maintaining and transfusing blood and blood products, it shall meet the standards in COMAR 10.10.02 Blood Banks.

H. Transfusion Services. If the facility does not provide its own facilities but does provide transfusion services alone, it shall meet at least the requirements in Regulation .09F—H under COMAR 10.10.02.

10.07.02.17 DENTAL SERVICES.

...B. Advisory Dentist. There shall be an advisory dentist, licensed to practice in the State, who shall:

...(3) Provide direction for in-service training to give the nursing staff an understanding of patients’ dental problems.

10.07.02.20 CLINICAL RECORDS.

A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices.

B. Contents of Record. Contents of record shall be:
(1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;
(2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;
(3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;
(4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);
(5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);
(6) Medical and social history of patient;
(7) Report of physical examination;
(8) Diagnostic and therapeutic orders;
(9) Consultation reports;
(10) Observations and progress notes;
(11) Reports of medication administration, treatments, and clinical findings;
(12) Discharge summary including final diagnosis and prognosis;
(13) Discipline assessment; and
(14) Interdisciplinary care plan.
C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions.
D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.
E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.
F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.
G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).
H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval.

10.07.02.21 INFECTION CONTROL PROGRAM.
A. Infection Control Program. The facility shall establish, maintain, and implement an effective infection control program that:
(1) Investigates, controls, and prevents infections in a timely manner through a system that enables the facility to:
(a) Analyze patterns of infected individuals;
(b) Analyze changes in prevalent organisms;
(c) Analyze increases in the rate of infection; and
(d) Obtain surveillance data for the prevention and control of additional cases;
(2) Determines the procedures, such as appropriate precautions, that are to be applied to an individual resident;
(3) Maintains a record of infections in the facility, and the corrective actions that were taken related to infections; and
(4) Monitors and evaluates the:
(a) Effectiveness of the infection control program by surveying rates of infection, especially of those residents who have an especially high risk of infection; and
(b) Effective implementation of the policies and procedures that are outlined in §F(1) of this regulation.
C. Effective January 1, 2005, the facility’s infection control coordinator shall attend a basic infection control training course that is approved by the Office of Health Care Quality and the Office of Epidemiology and Disease Control Program for the Department.

10.07.02.23 TRANSFER AGREEMENT.

A. Written Agreement. A written agreement with at least one acute hospital shall be effected which shall provide for the following actions:
(1) Planning to ensure that all services required for the continuity of patient care will be made available promptly;
(2) Advance discussion with the patient regarding the reason for the transfer and any available alternatives;
(3) Notification to the next of kin or responsible person regarding the anticipated transfer;
(4) Interchange of medical and other information necessary in the care and treatment of patients transferred between the facilities;
(5) Timely admission to the hospital when the attending physician determines acute hospital care is medically appropriate;
(6) Safe transportation and care of the patient during transfer;
(7) Security and accountability for the patient’s personal effects;
(8) Prompt readmission to the comprehensive care facility or the extended care facility at the end of the hospital stay (when program fiscal controls permit);
(9) Annual review of execution of transfer arrangements (by utilization review committee or other designated group) to assure that each party is fulfilling the needs of both the patients and the providers (the hospital and the comprehensive care facility or the extended care facility);
(10) If needs are not being met, it is the responsibility of the administrator of the comprehensive care facility or the extended care facility to act on recommendations of the reviewing group and to effect compliance;
(11) Before licensure, the comprehensive care facility or the extended care facility shall submit to the Department a copy of the written agreement, signed by persons authorized to execute the agreement on behalf of the facilities;
(12) Each facility shall maintain a signed copy of the agreement.
B. Facilities Under Common Control. If two facilities are under common control, a written agreement is not required; policies and procedures of both facilities shall provide assurance that § A(1)--(12) will be the practice of the facilities.
C. Exception for Comprehensive Care Facility. If a comprehensive care facility is unable to effect a transfer agreement with a hospital in the community and can document its attempts to secure an agreement, the facility shall be considered to have such an agreement in effect.

Agency Note: It is recommended that the comprehensive care facility arrange for a similar transfer agreement with an extended care facility.

**10.07.02.24 EMERGENCY AND DISASTER PLAN.**

A. Emergency and Disaster Plan.

(1) The licensee shall develop an emergency and disaster plan that includes procedures that shall be followed before, during, and after an emergency or disaster, including:

(a) Evacuation, transportation, or shelter in place of residents;
(b) Notification of families and staff regarding the action that will be taken concerning the safety and well-being of the residents;
(c) Staff coverage, organization, and assignment of responsibilities for ongoing shelter in place or evacuation, including identification of staff members available to report to work or remain for extended periods; and
(d) The continuity of services, including:
   (i) Operations, planning, and financial and logistical arrangements;
   (ii) Procuring essential goods, equipment, and services to sustain operations for at least 72 hours;
   (iii) Relocation to alternate facilities or other locations; and
   (iv) Reasonable efforts to continue care.

(2) The licensee shall have a tracking system to locate and identify residents in the event of displacement due to an emergency or disaster that includes at a minimum the:

(a) Resident's name;
(b) Time that the resident was sent to the initial alternative facility or location; and
(c) Name of the initial alternative facility or location where the resident was sent.

(3) When the nursing facility relocates residents, the facility shall send a brief medical fact sheet with each resident that includes at a minimum the resident's:

(a) Name;
(b) Medical condition or diagnosis;
(c) Medications;
(d) Allergies;
(e) Special diets or dietary restrictions; and
(f) Family or legal representative contact information.

(4) The brief medical fact sheet for each resident described in §A(3) of this regulation shall be:

(a) Updated upon the occurrence of any change of information on the medical fact sheet;
(b) Reviewed at least monthly; and
(c) Maintained in a central location readily accessible and available to accompany residents in case of an emergency evacuation.

(5) The licensee shall review the emergency and disaster plan at least annually and update the plan as necessary.

(6) The licensee shall:

(a) Identify a facility, facilities, alternate location, or alternate locations that have agreed to house the licensee’s residents during an emergency evacuation; and
(b) Document an agreement with each facility or location.

(7) The licensee shall:
(a) Identify a source or sources of transportation that have agreed to safely transport residents during an emergency evacuation; and
(b) Document an agreement with each transportation source.

(8) Upon request, a licensee shall provide a copy of the facility’s emergency and disaster plan to the local emergency management organization for the purposes of coordinating local emergency planning. The licensee shall provide the emergency and disaster plan in a format that is mutually agreeable to the local emergency management organization.

(9) The licensee shall identify an emergency and disaster planning liaison for the facility and shall provide the liaison’s contact information to the local emergency management organization.

(10) The licensee shall prepare an executive summary of its evacuation procedures to provide to a resident, family member, or legal representative upon request. The summary shall, at a minimum:
(a) List means of potential transportation to be used in the event of evacuation;
(b) List potential alternative facilities or locations to be used in the event of evacuation;
(c) Describe means of communication with family members and legal representatives;
(d) Describe the role and responsibilities of the resident, family member, or legal representative in the event of an emergency situation; and
(e) Notify families that the information provided may change depending upon the nature or scope of the emergency or disaster.

B. Evacuation Plans. The facility shall conspicuously post individual floor plans with designated evacuation routes on each floor.

C. Orientation and Drills.
(1) The licensee shall:
(a) Orient staff to the emergency and disaster plan and to their individual responsibilities within 24 hours of the commencement of job duties; and
(b) Document completion of the orientation in the staff member’s personnel file through the signature of the employee.

(2) Fire Drills.
(a) The licensee shall conduct fire drills at least quarterly on all shifts.
(b) The licensee shall:
(i) Document completion of each drill;
(ii) Have all staff who participated in the drill sign the document; and
(iii) Maintain the documentation on file for a minimum of 2 years.

(3) Semiannual Emergency and Disaster Drill.
(a) The licensee shall conduct a semiannual emergency and disaster drill on all shifts during which the facility practices evacuating residents or sheltering in place so that each is practiced at least one time a year.
(b) The drills may be conducted via a table-top exercise if the licensee can demonstrate that moving residents will be harmful to the residents.

(c) Documentation. The licensee shall:
(i) Document completion of each drill or training session;
(ii) Have all staff who participated in the drill or training sign the document;
(iii) Document any opportunities for improvement as identified as a result of the drill; and
(iv) Keep the documentation on file for a minimum of 2 years.
(4) The licensee shall cooperate with the local emergency management agency in emergency planning, training, and drills and in the event of an actual emergency.

10.07.02.25 LOCATION AND COMMUNICATION.

The site of the facility shall be approved by the Department. It shall be located in an area convenient to professional personnel and other employees. The environment shall be free from excessive noise and air pollution. In new facilities sound transmission limitations shall be in accordance with Standard No. E 90 of the American Society for Testing and Materials (ASTM), as revised from time to time. The facility shall be located on a well-drained site not subject to flooding. If it is served by private access roads, the facility shall maintain the roads in passable condition at all times. The following criteria shall control location of a facility proposed to be located near an airport:

A. Class I, Military Airports Handling Heavy Aircraft. Medical facilities may not be located beneath the approach/departure corridors. The corridor shall be defined as 2 miles wide and 5 miles long beginning at the end of the runway. Medical facilities may not be located beneath the airport traffic pattern, the pattern being defined as a 1 mile wide track centered on the nominal traffic pattern.

B. Class II, Commercial Airports Handling Heavy Commercial Aircraft. Medical facilities may not be located beneath the approach/departure corridor. The corridor shall be defined as 2 miles wide and 5 miles long beginning at the end of the runway.

C. Class III, Military and Commercial Airports Handling Light Aircraft and General Aviation. Medical facilities may not be located beneath the approach/departure corridor or traffic pattern. The corridor shall be 1 mile wide and 3 miles long beginning at the end of the runway, the traffic pattern restriction being defined as a 1 mile wide track centered on the nominal pattern.

D. Applicant’s Responsibility to Supply Traffic Pattern Data. It shall be the responsibility of the applicant to furnish all data on corridors and patterns as described above for the purpose of site approval. This data shall be submitted at the same time the facility submits information to Comprehensive Health Planning. The Department’s response to the facility shall be made within the same time frame required for Comprehensive Health Planning.

E. New Facilities. In new construction the noise level may not exceed 40dB(A).

F. Class IV, Heliports. No restrictions when used exclusively for health care purposes. Facilities located near heliports used for purposes other than health care shall meet sound transmission limitations in accordance with Standard No. E 90 of the American Society for Testing and Materials (ASTM), as revised from time to time.

G. All existing facilities and those facilities approved by the Department before the adoption of these regulations shall be exempt from the location requirements of these regulations.

10.07.02.39 GERIATRIC NURSING ASSISTANT PROGRAM.

A. Facility Responsibilities.

(1) Each facility shall conduct or arrange a nurses’ aide training program for unlicensed personnel assigned direct patient care duties. This requirement does not extend to physical or occupational therapy assistants or to other employees performing delegated, non-nursing functions. The facility may use an outside program if it has been reviewed and approved by the Department.
(2) Each facility shall submit a written proposal to the Department for satisfying the developmental training program requirement.

(3) A nurse aide is deemed to satisfy the requirements of this chapter if that individual has successfully completed a training program approved by the State before July 1, 1990, or has been "grandfathered" under previous regulations.

(4) Other persons hired as nurse aides after July 1, 1990 shall complete an approved program within 120 days of employment.

(5) The facility shall record the satisfactory completion of the program in each employee’s personnel record. A certificate evidencing completion of the program shall be issued to the employee. The signature of the program’s teacher or trainer shall be required for authentication.

B. Course Structure.

(1) Effective with employees hired on or after July 1, 1990, the training program course shall consist of 75 hours or more, and include at least 37.5 hours of classroom instruction and not less than 37.5 hours of supervised clinical experience in long-term care.

(2) The course content shall adhere to the Geriatric Nursing Assistant Program curriculum in Regulation .40 of this chapter.

(3) The course instructor shall have overall supervisory responsibility for the operation of the program, and shall:

(a) Be a registered nurse licensed in Maryland;

(b) Have at least 2 years of nursing experience, at least 1 year of which shall have been in caring for the elderly or chronically ill in the past 5 years; and

(c) Have attended a program of instruction in training methodologies approved by the Department.

(4) Supplementary instructors shall be drawn from qualified resource personnel such as registered nurses, licensed practical/vocational nurses, pharmacists, dieticians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physicians, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and residents’ rights experts, as well as persons with relevant experience, such as residents or experienced aides.

(5) Adequate numbers of instructors are required to ensure that each trainee is provided effective assistance and supervision which does not endanger the safety of residents.

(6) Each training program shall have behaviorally stated objectives for each unit of instruction, stating measurable performance criteria.

(7) Each trainee shall be clearly identified as a trainee during all skills training portions of the training.

(8) During training, a trainee may provide only that care for which the trainee has demonstrated competency to the satisfaction of the appropriate program instructor.

(9) An orientation program shall be provided to trainees for a nursing facility in which training is to occur. This program shall consist of:

(a) An explanation of organizational structure, policies, and procedures;

(b) Discussion of the philosophy of care;

(c) Description of the resident population; and

(d) Employee rules.

(10) The orientation may not be included in the required 75 hours of the training course.

(11) A training program shall provide at least 16 hours of training prior to a trainee’s direct assignment to resident care. This instruction shall include the following topics:
(a) Infection control;
(b) Safety and emergency procedures;
(c) Promoting residents' independence;
(d) Respecting residents’ rights; and
(e) Communication and interpersonal skills.

10.07.02.40 Curriculum for the Geriatric Nursing Assistant Program.

A. Introduction.

(1) Role of nursing assistant;
(2) Relationships of nursing assistant to health care team;
(3) Purpose of long-term care;
(4) Patient's rights.

B. Approaches of Caring for the Aging Patient.

(1) Observation/reporting:
   (a) Changing function and behavior--normal vs. abnormal,
   (b) Confidentiality;
(2) Communication:
   (a) Forms (examples, body language, verbal and nonverbal),
   (b) Patient, family and staff;
(3) Cultural and social needs:
   (a) Background—past/present views,
   (b) Social myths and prejudice;
(4) Spiritual needs;
(5) Family's needs and reaction.

C. Patient Environment.

(1) Safety:
   (a) Protective devices/restraints,
   (b) Fire and disaster;
(2) Infection control:
   (a) Handwashing;
   (b) Signs and symptoms of common communicable disease;
   (c) Basics in isolation techniques;
(3) Maintaining the patient room:
   (a) General environmental cleanliness;
   (b) Age-related consideration (for example, temperature, glare, noise);
(4) Equipment:
   (a) Storage,
   (b) Use,
   (c) Preventive maintenance.

D. Basic Skills. These skills will require instruction, demonstration, and return demonstration by each student.

(1) Bedmaking:
   (a) Supplies,
   (b) Occupied/unoccupied,
   (c) Method,
   (d) Handling of linens (clean and dirty);
(2) Personal grooming:
   (a) Baths:
(i) Types,
(ii) Supplies,
(iii) Nail care,
(iv) Foot care,
(v) Hair care;
(b) Oral hygiene:
(i) Importance,
(ii) Equipment,
(iii) Procedure,
(iv) Special care;
(3) Feedings:
(a) Types,
(b) Assisting,
(c) Independent,
(d) Complete;
(4) Bedpans and urinals:
(a) Precautions,
(b) Positioning;
(5) Body mechanics:
(a) Transfer:
(i) Equipment,
(ii) Principles,
(iii) Types;
(b) Positioning:
(i) Bed,
(ii) Chair.
E. Intermediate Skills. These abilities will require instruction, demonstration, and return demonstration by each student.
(1) Ambulation:
(a) Walker,
(b) Cane;
(2) Enemas:
(a) Types,
(b) Positioning;
(3) Collection and types of specimens (urine, stool, and sputum);
(4) Intake and output—observation and recording;
(5) Vital Signs:
(a) Temperature,
(b) Pulse,
(c) Respirations,
(d) Height,
(e) Weight,
(f) Blood pressure;
(6) Terminal care:
(a) Dying vs. death,
(b) Family—present and past,
(c) Personal possessions,
(d) Cultural benefits,
(e) Postmortem care.
F. Advance Skills. These skills will require instruction, demonstration, and return demonstration by each student.
(1) Bowel and bladder training;
(2) Range of motion;
(3) Reality orientation;
(4) Patient care planning implementation;
(5) Oxygen;
(6) Emergency procedures;
(7) Decubitus care and prevention;
(8) Feeding tube care;
(9) Catheter care and positioning of tube for drainage;
*(10). Impactions—observation and removal;
*(11) Colostomy/ileostomy/ileo‐conduit;
(12) Hot and cold applications;
*(13) Sitz baths. """"""""""""""""'
* Optional procedures.
G. Principles of Body Systems. Objectives of this unit will be to present a basic overview of each system as it relates to patient limitation/condition/disease.
(1) Circulatory;
(2) Respiratory;
(3) Muscular and skeletal;
(4) Sensory/neurological;
(5) Metabolic/endocrine;
(6) Urinary;
(7) Gastrointestinal;
(8) Skin.
H. Dementia. Objectives of this unit will be to enable students to identify and describe behavior and symptoms of dementia, to recognize and report changes in behavior to supervisors, to assist cognitively impaired patients with activities of daily living including personal care and ambulation with the least possible behavior disruptions, to maintain a safe environment for patients with dementia, and to intervene appropriately in behavioral manifestations of dementia.
(1) Introduction.
(a) Definition of dementia disease process;
(b) Misconceptions;
(c) Causes:
(i) Irreversible,
(ii) Reversible;
(d) Delirium:
(i) Recognizing delirium to differentiate delirium from dementia;
(ii) Causes.
(2) Behaviors and Symptoms.
(a) Specific behaviors:
(i) Aggressiveness,
(ii) Agitation/screaming,
(iii) Catastrophic,
(iv) Hallucinations/delusions,
(v) Inappropriate sexual behavior,
(vi) Limited attention span,
(vii) Resistive behavior,
(viii) Rummaging and hoarding,
(ix) Suspiciousness,
(x) Wandering;
(b) Related behaviors:
(i) Anxiety,
(ii) Demanding,
(iii) Depression/withdrawal,
(iv) Irritability,
(v) Sleep changes.
(3) Psychosocial Aspects.
(a) Impact on family;
(b) Impact on other residents;
(c) Coping with losses;
(d) Staff stress and its management.
(4) Responses to Behaviors. Each behavior shall include a description of the behavior, what
to report and when to report, to whom to report, and management aspects (environment,
communication, social/activities, physical management).
10.07.02.42 Geriatric Nursing Assistant Program — Competency Evaluation and Registry.
A. Geriatric Nursing Assistant Competency Evaluation.
(1) The Department shall provide for the evaluation and certification of the competency of
geriatric nursing assistants.
(2) The Department will approve one or more competency evaluation programs meeting
the criteria set forth by the Health Care Financing Administration of the United States
Department of Health and Human Services for registration of nursing aides under Titles
XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.
(3) On or after October 1, 1990, a comprehensive care facility may not employ an individual
in the capacity of geriatric nursing assistant unless the individual has successfully
completed a competency evaluation approved by the Department, except as provided in
Regulations .39A(1) and (3) and .41B of this chapter. The competency evaluation shall
consist of two parts, which are a written evaluation and a clinical skills evaluation.
(4) On or after October 1, 1990, an individual shall be reregistered as a geriatric nursing
assistant if there has been a continuous period of 24 months during which the individual
did not provide nursing assistant duties for monetary compensation since the individual's
last registration.
B. Geriatric Nursing Assistant Registry.
(1) The Department shall establish and maintain a registry of geriatric nursing assistants
properly certified to work in that capacity in comprehensive care facilities or extended care
facilities in Maryland.
(2) Individuals possessing proof of out-of-State registration as a geriatric nursing assistant
as provided under Regulation .41B of this chapter shall submit proof of that registration to
the Department in order to be listed in the geriatric nursing assistant registry in Maryland.
Except as provided in Regulation .39A(3) of this chapter, after the establishment of a registry, a nursing facility may not employ an individual as a geriatric nursing assistant who is not listed in the registry.

The registry shall include the following information concerning individuals listed:
(a) Full name, including maiden name and other surnames used;
(b) Address at the time the competency evaluation is passed;
(c) Date of birth;
(d) Social Security number;
(e) Name of training program and date of completion;
(f) An individual’s last known employer and the date of hiring and termination by the employer;
(g) Date or dates of competency evaluation and date of successful completion of competency evaluation;
(h) Any findings documented by the Department of resident neglect or abuse, or misappropriation of resident property involving an individual listed in the registry; and
(i) A brief statement disputing the findings in §B(4)(h), of this regulation, by an individual, if the individual makes a statement.

Before any finding is included in the registry, the Department shall notify the individual involved, and permit the individual to appeal the finding. The appeal shall be filed within 30 days of the notification by the Department. If an appeal is filed in a timely manner, the finding may not be included until a decision by the Secretary that the inclusion of the findings is appropriate.

A person participating in good faith in these activities is not civilly liable under the provisions of Health-General Article, §19-347(g), Annotated Code of Maryland. Information contained in the registry shall be considered public information under the Maryland Public Information Act and in accordance with federal law.

Renewal and updating of a geriatric aide’s registration is required every 2 years on a schedule set by the State.
Registration fees may be charged to the individual to be listed in the registry.

10.07.02.45 QUALITY ASSURANCE PROGRAM.

A. By January 1, 2001, each nursing facility shall establish an effective quality assurance program that includes components described in this regulation and Regulation .46 of this chapter.

B. The nursing facility shall appoint a qualified individual to manage quality assurance activities within the nursing facility.

C. The nursing facility shall establish a quality assurance committee that includes at least:
(1) A director of nursing;
(2) An administrator;
(3) A social worker;
(4) A medical director;
(5) A dietitian; and
(6) A geriatric nursing assistant of the facility.

D. The Quality Assurance Committee. The quality assurance committee shall:
(1) Designate a chairperson to manage committee activities;
(2) Meet monthly to accomplish quality assurance activities;
(3) Assist in developing and approve the facility’s quality assurance plan;
(4) Submit the quality assurance plan to the Department’s Office of Health Care Quality at the time of licensure or at the time of license renewal;
(5) Submit any change in the quality assurance plan to the Office of Health Care Quality within 30 days of the change;
(6) Review and approve the facility’s quality assurance plan at least yearly; and
(7) Prepare monthly reports for the ombudsman, family council, and residents' council.
E. Quality Assurance Records. For the purposes of ensuring implementation and effectiveness of the quality assurance program, the facility shall make quality assurance records and documents available to the Office of Health Care Quality.
10.07.02.46 Quality Assurance Plan.
A. The facility’s quality assurance committee shall develop and implement a quality assurance plan that includes procedures for:
   (1) Concurrent review;
   (2) Ongoing monitoring;
   (3) Patient complaints;
   (4) Accidents and incidents; and
   (5) Abuse and neglect.
B. Concurrent Review. The quality assurance plan shall include:
   (1) The procedures for conducting concurrent review of each resident including:
       (a) Criteria to determine any change in a resident’s condition;
       (b) A method to document the concurrent review; and
       (c) Identification of the licensed nurse or nurses conducting the concurrent review;
   (2) The procedures to evaluate clinical data for any resident with a change in condition including at least:
       (a) Medications;
       (b) Laboratory values;
       (c) Intake and output;
       (d) Skin breakdown;
       (e) Noted weights;
       (f) Appetite;
       (g) Injuries resulting from accidents or incidents; and
       (h) Any other relevant parameters that may affect the resident’s physical or mental status;
   (3) Procedures to take action when there is a change in the resident’s condition; and
   (4) Procedure for referral of data to the quality assurance committee, when appropriate.
C. Ongoing Monitoring. The quality assurance plan shall include:
   (1) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including:
       (a) Medication administration;
       (b) Prevention of decubitus ulcers, dehydration, and malnutrition;
       (c) Nutritional status and weight loss or weight gain;
       (d) Accidents and injuries;
       (e) Unexpected death; and
       (f) Changes in physical or mental status;
   (2) The methodology for collection of data;
   (3) The methodology for evaluation and analysis of data to determine trends and patterns;
   (4) A description of the thresholds and performance parameters that represent acceptable care for the measured criteria;
(5) Time frames for referral to the quality assurance committee;
(6) A description of the plan for follow-up to determine effectiveness of the recommendations; and
(7) A description of how the quality assurance activities will be documented.

D. Patient Complaints. The quality assurance plan shall include:
(1) A description of a complaint process that effectively addresses resident or family concerns including:
   (a) The designated person or persons and their phone numbers to receive complaints or concerns;
   (b) The method to be used to acknowledge complaints received; and
   (c) The time frames for investigating complaints dependent upon the nature or seriousness of the complaint;
(2) A description of a logging system that will be used including the:
   (a) Name of the complainant;
   (b) Date the complaint was received;
   (c) Nature of the complaint; and
   (d) Date that the complainant was notified of the disposition or resolution of the complaint; and
(3) The procedures for:
   (a) Notifying residents of their right to file a complaint with the Office of Health Care Quality;
   (b) Informing residents, families, or guardians of the complaint process upon admission; and
   (c) Posting the complaint process or making it available without the need to request it.

E. Accidents and Injuries. The quality assurance plan shall include:
(1) A definition of accident and injury that is appropriate to the type of resident served by the nursing home;
(2) A description of the process for reporting accidents and injuries including:
   (a) Who shall report incidents;
   (b) The time frame for reporting incidents; and
   (c) The procedure for reporting incidents;
(3) A policy statement that includes a provision that reporting incidents can be done without fear of reprisal;
(4) A description of how internal investigations of accidents and injuries will be handled including:
   (a) Assessment of any injury;
   (b) Interview of the resident, staff, and witness;
   (c) Review of any relevant records including the resident’s medical records, discharge summary, hospital records, etc.; and
   (d) Time frames for conducting the investigation;
(5) A description of the process for notifying family or guardian about the incident;
(6) A description of a process for the ongoing evaluation of accidents and injuries to determine patterns and trends; and
(7) A description of how relevant information will be referred to the quality assurance committee.

F. Abuse and Neglect. The quality assurance plan shall include:
(1) The process for implementing COMAR 10.07.09.15 concerning abuse of residents;
(2) A description of the process for providing immediate notification to the family, guardian, or responsible party about the incident;
(3) A description of the process for the ongoing evaluation of validated incidents of abuse and neglect to determine patterns and trends; and
(4) A description of how relevant information will be referred to the quality assurance committee.