10.07.02.11 MEDICAL DIRECTOR RESPONSIBILITIES.

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.

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

(5) Participating as appropriate in facility committee projects and meetings concerning clinical care and quality improvement that require physician input...

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:

... (b) Systematic review of the quality of health care, including medical and physician services, provided to the facility's residents.

(3) Documentation Regarding Medical Director Activities.

(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.

10.07.02.14 SPECIAL CARE UNITS — GENERAL.

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

...(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...

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.

...G. Contractual Services. When any respiratory care services are provided by an outside contractor, the facility shall:

...(2) Ensure that all contractors:

... (e) Participate in the monitoring and evaluation of the appropriateness of services provided as required by the facility’s quality assurance program.

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.