

Downloaded January 2011

### **13.A. QUALITY OF CARE**

Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment that is in conformance with the current standards of the Gerontological Nursing Practice of the American Nurses Association.

#### **13.A.1. Activities of Daily Living (ADL)**

Based on the comprehensive assessment of a resident, the facility must ensure that:

- a. A resident's abilities in Activities of Daily Living do not diminish unless circumstances of the resident's clinical condition demonstrate the diminution was unavoidable. This includes the resident's ability to:
  1. bathe, dress, and groom;
  2. transfer and ambulate;
  3. toilet;
  4. eat;
  5. use speech, language or other functional communication systems; and
  6. bed mobility.
- b. A resident is given the appropriate treatment and services to maintain or improve his or her abilities to carry out his/her Activities of Daily Living.
- c. A resident who is unable to carry out Activities of Daily Living receives the necessary services and assistance to meet his/her needs.
- d. A resident is given encouragement and assistance to be up and dressed in his/her own personal clothing which is appropriate to the time of day and season, clean, attractive, and in good repair.

#### **13.A.2. Personal Care**

Each resident shall receive proper nursing care, as defined by the Standards of Care established by the American Nurses Association. These services include, but are not limited to:

- a. Good personal hygiene, such as clean, well-groomed hair, cleaned, trimmed fingernails, clean skin, and freedom from offensive odors, clean mouth and teeth, and absence of dry cracked lips;

b. Appropriate nursing measures including encouraging and assisting resident to change position at least every two (2) hours to stimulate circulation and prevent pressure sores, contractures and deformities.

c. Ensuring clean resident rooms, beds, bed linen and clothing.

d. Ensuring that resident care equipment is in sufficient supply, in good condition, properly cleaned and cared for, well organized and readily available.

### 13.A.3. Mental and Psychosocial Functioning

Based on the comprehensive assessment of a resident, the facility must ensure that:

a. A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem; and

b. A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable.

### 13.A.4. Hydration and Nutrition

The facility must provide each resident with sufficient fluid and nourishment to maintain proper hydration and health.

a. Based on a resident's comprehensive assessment, the facility must ensure that a resident:

1. Maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible; and

2. Receives a therapeutic diet when there is a nutritional problem.

b. The facility assures that good dietary practices are maintained through the use of self-feeding devices, attention to individual food preferences and knowledge of food intake of individual residents. Residents should be offered the opportunity to choose mealtime companions and these groups should be served their meals simultaneously.

c. As appropriate, water and other fluids shall be provided and accessible to the resident.

d. Special eating equipment and utensils must be provided for residents who need them. Syringe feeding may only be done after evaluation by an appropriate professional and according to the plan of care developed by the multidisciplinary team.

### 3.A.5. Nasogastric and Gastrostomy Tubes

Based on the comprehensive assessment of a resident, the facility must ensure that:

a. Nasogastric and gastrostomy tubes are not used, unless the resident's clinical condition demonstrates that use of a naso-gastric or gastrostomy tube was unavoidable and that the need for continued use is monitored and justified; and

b. A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services according to accepted standards of nursing practice.

#### 13.A.6. Vision and Hearing

The facility must ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities. The facility must, if necessary, assist the resident:

- a. In making appointments; and
- b. In arranging for transportation.

#### 13.A.7. Incontinence

Based on the resident's comprehensive assessment, the facility must ensure that:

- a. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.
- b. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.
- c. A bowel and bladder training and management program is initiated when possible.
- d. Any resident with incontinence must be assessed for causal factors for decline, potential for decline or lack of improvement.

#### 13.A.8. Pressure Sores

Based on the comprehensive assessment of a resident, the facility must ensure that:

- a. A resident who enters the facility without pressure sores does not develop pressure sores, unless the resident's clinical condition demonstrates that the pressure sores were unavoidable;
- and
- b. A resident with pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

#### 13.A.9. Restorative Nursing

Based on the comprehensive assessment of a resident, the facility must ensure that:

- a. A resident who enters the facility does not experience reduction in range of motion, unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and
- b. A resident with a limited range of motion receives appropriate treatment and services to maintain or increase range of motion.
- c. The facility shall have an active program of rehabilitation directed towards assisting each resident to achieve or maintain an optimum level of self-care and independence.
- d. The following minimum restorative nursing interventions shall be included in the comprehensive care plans as needed:

1. Assistance in maintaining current level of function and adjustment to disabilities;
2. Assistance in carrying out prescribed exercises; Page 28 of 75 PDF created; 09-26-06
3. Provision of out-of-bed activities as tolerated;
4. Education and encouragement in achieving independence in Activities of Daily Living.

#### 13.A.10. Accidents

The facility must ensure that:

- a. The resident environment remains as free of accident hazards as is possible; and
- b. Each resident receives adequate supervision and assistance devices to prevent accidents.

#### 13.A.11. Special Services

The facility must ensure that residents receive proper treatment and care for the following special services:

- a. Injections;
- b. Parenteral and enteral fluids;
- c. Colostomy, ureterostomy or ileostomy care;
- d. Tracheostomy care;
- e. Tracheal suctioning;
- f. Respiratory care;
- g. Foot care; and
- h. Prostheses.

### **17.H. REPORTING OF MEDICATION ERRORS AND ADVERSE REACTIONS**

#### 17.H.1. Reports to Physician

Medication errors and adverse reactions shall be immediately reported to the resident's physician. Medication errors include omissions, as well as errors of commission. Adverse reactions shall also be reported to the pharmacist consultant and pharmacy.

17.H.2. Clinical Records. An entry of the error and/or adverse reaction shall be made in the resident clinical record.

#### 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.