

MINNESOTA

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4658.0090 USE OF OXYGEN.

A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen.

STAT AUTH: MS s 144A.04; 144A.08; 256B.431

HIST: 20 SR 303

Current as of 01/19/05

4658.0520 ADEQUATE AND PROPER NURSING CARE.

Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:

A. Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.

B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.

C. A shampoo at least weekly and assistance with daily hair grooming as needed.

D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed.

E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips.

F. Proper care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.

G. Bed linen must be changed weekly, or more often as needed. Beds must be made daily and straightened as necessary.

H. Clean clothing and a neat appearance. Residents must be dressed during the day whenever possible.

I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.

J. Recording resident height and weight at the time of admission and weight at least monthly thereafter.

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4658.0525 REHABILITATION NURSING CARE.

Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405 . Continuous efforts must be made to encourage ambulation and purposeful activities

Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without a limited range of motion 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 increase range of motion and to prevent further decrease in range of motion.

Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.

Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and

B. 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.

Subp. 6.

Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:

(1) bathe, dress, and groom;

(2) transfer and ambulate;

(3) use the toilet;

(4) eat; and

(5) use speech, language, or other functional communication systems; and

B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. a resident who has been able to eat enough independently or with assistance is not fed by nasogastric tube or feeding syringe unless the resident's clinical condition demonstrates that use of a naso-gastric tube or feeding syringe was unavoidable; and MS

B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

Subp. 8. Prosthetic devices. A nursing home must assist residents to adjust to their disabilities and to use their prosthetic devices.

Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted.

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4658.1315 UNNECESSARY DRUG USAGE.

Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

A. in excessive dose, including duplicate drug therapy;

B. for excessive duration;

C. without adequate indications for its use; or

D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25(1)(1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

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4658.1320 MEDICATION ERRORS.

A nursing home must ensure that:

A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25(m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:

(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or

(2) the administration of expired medications.

B. It is free of any significant medication error. A significant medication error is:

(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or

(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity.

C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication

errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

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