

Effective Date: 04/03/91

Title: Section 415.36 - Long-term inpatient rehabilitation program for head-injured residents

415.36 Long-term inpatient rehabilitation program for head-injured residents. (a) Definition. A head injury program shall mean a planned combination of services provided in a nursing home unit approved by the commissioner pursuant to Part 710 of this Title as a provider of specialized services for head-injured residents on a designated resident care unit of at least 20 beds. The head-injury program shall be designed specifically to serve medically stable, traumatically brain-injured individuals with an expected length of stay from 3 to 12 months. The program shall provide goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring the individual to the optimal level of physical, cognitive and behavioral functioning. The population served shall consist primarily of individuals with traumatically acquired, nondegenerative, structural brain damage resulting in residual deficits and disability. The program shall not admit or retain individuals who are determined to be a danger to self or others.

(b) General requirements. The nursing home shall ensure:

(1) the development and implementation of a planned and systematic program for monitoring and assessing the quality and appropriateness of resident care to assure care is provided in accordance with current standards of professional practice. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed with written documentation of such reviews. The process shall include but not be limited to reviews of clinical records, resident and family complaints and suggestions, incident reports and the resident's response to discharge plans. There shall be documentation that recommendations are followed up, action is taken to resolve identified problems and results of such action are assessed periodically;

(2) sufficient space, equipment and facilities are available to support the clinical, educational and administrative functions of the program in accordance with standards set forth in Parts 711 and 713 of this title;

(3) transfer agreements are in effect with other facilities, in accordance with section 400.9 of this Title for the acceptance of referrals or the transfer of head-injured residents in need of services not available at the facility;

(4) the development and consistent application of written admission and continued stay criteria for this service which include but are not limited to the use of a generally recognized classification system for measuring each individual's physical, affective, behavioral and cognitive level of functioning and the family's capabilities and functioning, and are consistent with the following requirements:

(i) a resident admitted for long-term rehabilitation shall be a person who has suffered a traumatic brain injury with structural nondegenerative brain damage, is medically stable, is not in a persistent vegetative state, demonstrates potential for physical, behavioral and cognitive rehabilitation and may evidence moderate to severe behavior abnormalities. The resident must be capable of exhibiting at least localized responses by reacting specifically but inconsistently to stimuli;

(ii) a resident admitted for coma management shall be a person who has suffered a traumatic brain injury with structural nondegenerative brain damage and is in a coma. The resident may be completely unresponsive to any stimuli or may exhibit a generalized response by reacting inconsistently and nonpurposefully to stimuli in a nonspecific manner; and

- (iii) a resident who has diffuse brain damage cause by anoxia, toxic poisoning, cerebral vascular accident, or encephalitis may be admitted to this program if considered appropriate for coma management and long-term rehabilitation;
- (5) records are maintained for at least two years identifying persons who were determined by the facility to be ineligible for admission under the head injury program. The records should indicate the reason for ineligibility and any referral action taken;
- (6) inservice and continuing education programs which address the medical, physical, cognitive, psychosocial and behavioral needs of head injured residents are conducted on a regular basis for all personnel caring for such residents;
- (7) educational programs are conducted for personnel not providing direct care but who come in contact on a regular basis with head-injured residents. The programs should familiarize personnel with the specific needs of these residents; and
- (8) education and counseling services are available and offered to the residents and families as needed.
- (c) Program management and staffing. There shall be distinct staffing for the direct care services in the head injury program unit.
- (1) The program shall be administered by a program director who has at least two years of clinical or administrative experience in head injury rehabilitation programs. The program director has specific responsibilities which include but are not limited to: (i) administrative direction and oversight of the program;
- (ii) ongoing review of the program and implementation of program changes as identified; and
- (iii) development and implementation of educational programs on an ongoing basis for staff working with head injured residents.
- (2) A physician who has advanced training and experience in the care of the head injured shall be responsible for the medical direction and medical oversight of the head injury program.
- (3) A qualified specialist in physical medicine and rehabilitation or a physician who has training and experience in the care and rehabilitation of head injured patients or residents shall be responsible for the medical management of each resident.
- (4) Head injury programs admitting and retaining residents who also require treatment for psychiatric disorders shall have on staff qualified specialists in psychiatry sufficient in number to meet the needs of these residents. A qualified specialist in psychiatry shall be designated to assist in the development and implementation of policies and procedures governing the provision of services for residents with psychiatric disorders, including criteria for transfer of such residents to an appropriate program which is licensed under the Mental Hygiene Law.
- (5) A primary interdisciplinary team of health care professional with special interest, training, experience and

expertise in head injury rehabilitation shall be responsible for the assessment, coordinated program and care planning, and direct services for each head injured resident. The interdisciplinary team members shall be specifically assigned to serve head injured resident and the team shall include as a minimum the following types of health care professionals:

- (i) physician;
- (ii) registered professional nurse;
- (iii) physical therapist;
- (iv) occupational therapist;
- (v) speech-language pathologist;
- (vi) social worker;
- (vii) dietitian;
- (viii) therapeutic recreation specialist; and
- (ix) clinical psychologist with at least one year of training in neuropsychology.

(6) Nursing services for the head injury unit shall be under the direction of a registered professional nurse with experience in the provision of rehabilitation nursing for head injured patients or residents.

(7) There shall be at least one registered professional nurse with experience in rehabilitation nursing assigned to each shift on the head injury unit.

(8) Consultative services of qualified specialists shall be available as needed to the head injury program in accordance with resident needs.

(9) Depending upon types of residents being served and individual resident's needs, the program shall provide or make formal arrangements for vocational rehabilitation services and special education services.

(d) Interdisciplinary care planning. (1) A member of the interdisciplinary team managing the resident shall be designated to:

- (i) coordinate the overall plan of care and services and identify unmet needs for each resident including discharge and follow-up plans;
- (ii) serve as a liaison among resident, family and staff to ensure that resident and family concerns are addressed; and
- (iii) serve as a liaison with educational, social and vocational resources in the community which are serving the resident.

(2) A written, comprehensive care plan shall be developed and implemented which establishes rehabilitation goals for each resident. The plan shall be developed on admission by the interdisciplinary team and the attending physician in consultation with the resident, the resident's family and outside agencies, as necessary. The care plan shall be reviewed at least every 14 days and modified according to the resident's needs by the interdisciplinary team. The comprehensive care plan is based upon total and ongoing integrated, interdisciplinary assessments which shall address as a minimum, medical and neurological status, emotional and psychiatric status, nutritional status, the developmental needs of children and adolescents, sensorimotor capacity, cognitive, perceptual and communicative capacity, affect and mood, activities of daily living skills, educational or vocational capacities, sexuality issues and concerns, family counseling and community reintegration needs and recreation and leisure time interests.

(3) A written discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident's family, and as appropriate, any outside agency or resource that will be involved with the resident following discharge.

(4) The family and resident shall receive preparation for discharge through the facility's educational and counseling services. (5) Provision shall be made by the facility for the follow-up of each resident after discharge to assess the resident's response to the discharge plan.

(e) Utilization review monitoring. The facility shall participate with the commissioner or his designee in a program of resident care and services monitoring which shall include but not be limited to review of admissions, care and services provided, continued stays, and discharge planning. The facility shall furnish such records and reports at such frequency as the commissioner or his designee may require and shall make available members of the interdisciplinary resident care team for case conferences as the commissioner or his designee deems necessary.

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