

Department of Medicine and Surgery      M-5, Part II  
Veterans Administration  
Washington, DC 20420      July 19, 1988

1. Transmitted is the new Department of Medicine and Surgery Manual M-5, Part II, "Nursing Home Care." The new manual incorporates programmatic material from M-1, part I, chapter 12; M-2, part I, chapter 16, change 24 and adds new policy for VA Nursing Home and Community Nursing Home Programs.

2. Principal issues are:

- a. **Paragraph 1.02f:** Defines rehabilitation in long-term care setting.
- b. **Paragraph 2.07:** Defines nature of program.
- c. **Paragraph 2.08:** Refines admission guidelines.
- d. **Paragraph 2.16:** Refines discharge planning process.
- e. **Paragraph 3.03:** Incorporates policy on rate negotiations.
- f. **Paragraph 3.07i:** Clarifies policy on nursing home evaluations.
- g. **Paragraph 3.10:** Clarifies policy on followup services.
- h. **Paragraph 3.11:** Reflects regulatory change on extensions.

3. **Filing Instructions**

**Insert pages**

i through vi  
1-1 through 3-9  
App. A-1 through App. B-7

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VETERANS  
ADMINISTRATION

GERIATRICS AND EXTENDED CARE

Nursing Home Care

M-5, Part II  
July 19, 1988

Department of  
Medicine and Surgery  
Washington, DC 20420

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#### FOREWORD

This manual promulgates the policies and mandatory procedures for implementation of the VA Nursing Home and Community Nursing Home Programs at VA health care facilities throughout the country.

This manual accomplishes two goals:

a. It establishes programmatic policy by incorporating many segments of the administrative manual, M-1, part I, chapter 3.12.

b. It provides new program policies for the VA NHCU (Nursing Home Care Unit) and the CNH (Community Nursing Home) Programs.

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#### RESCISSIONS

The following material is rescinded:

1. **COMPLETE RESCISSIONS**

**DM&S Manual**

M-2, part I, chapter 16, change 24

2. **PARTIAL RESCISSIONS**

**DM&S Manuals**

M-1, part I, chapter 12, paragraphs 12.01, 12.02, 12.10, 12.16 through 12.19, 12.21, 12.24 through 12.30, 12.32, 12.33, 12.37, 12.38

M-2, part I, chapter 16, change 24, August 20, 1965

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## CHAPTER 1. NURSING HOME CARE

### 1.01 AUTHORITY

Title 38 U.S.C. 610 authorizes the VA to provide nursing home care in VA owned Nursing Home Care Units. Title 38 U.S.C. 620 authorizes the VA to provide nursing home care in public or private institutions not under the jurisdiction of the Administrator which furnish nursing home care.

### 1.02 DEFINITIONS

a. **Nursing Home Care.** This term means the coordination and delivery of care to convalescents or other persons who are not in need of hospital care, but who require nursing care and related medical or psychosocial services. For veterans in VA NHCU (Nursing Home Care Units) this includes any professionally recommended services, supplies, and equipment. For veterans in community nursing homes, this includes room, meals, nursing care, physician visits, emergency dental care, medicines and drugs, minimal laboratory and radiology services, and other special services and supplies normally provided patients requiring nursing home care. The term includes either intermediate or skilled nursing home care or both. In the case of the VA NHCU, it includes both equivalent levels of care.

b. **VA NHCU.** A specialized nursing facility designed to care for patients who require nursing care and supportive personal care and/or individual adjustment services. Veterans admitted to this program require care which is planned and coordinated by an interdisciplinary team and require the services of a hospital based nursing home.

c. **SNF (Skilled Nursing Facility).** A community nursing home, licensed by the state in which it is located, which provides care prescribed by, or performed under the general direction of a physician and provides nursing, rehabilitative, dietetic, pharmaceutical, laboratory, radiological, social, and spiritual services to the patient.

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d. **ICF (Intermediate Care Facility).** A community nursing home, licensed by the state in which it is located, to provide health care services on a regular basis to individuals who, because of their physical or mental condition, require such care and services, above the level of room and board, as provided in a domiciliary but do not require the intensity or frequency of such services as provided in a SNF. The facility must be certified for participation as a provider of ICF services under Title XIX (State Medicaid Program). If there is no Medicaid program in the state, the ICF must meet the standards for the ICFs as outlined in 42 CFR and meet the additional VA standards outlined in chapter 3, paragraph 3.06.

e. **Medical Center.** This term when used, also applies to the VA Outpatient Clinics in Honolulu, HI, and Anchorage, AK.

f. **Rehabilitation.** Rehabilitation is \* "to restore an individual to his/her former functional and environmental status, or alternatively to maintain or maximize remaining function." When working with patients in long-term care, it is important that staff conceptualize a model of rehabilitation which takes into account the age, frailty, disease process, and level of dysfunction of the individual patient."

\* Williams, T. Franklin, Ed. Rehabilitation in the Aging, Raven Press, New York, 1984.

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Rehabilitation in this population is long-term, often with limited goals. Equally important as the physical rehabilitation of the patient, is the psychological or social rehabilitation which may be required to improve the quality of life for the individual. In this broader definition, it is not valid to ascribe to a patient, a lack of rehabilitation potential.

[g. **Programmatic Responsibility.** Responsibility for management of NHCU programs, i.e., the structured unity of efforts by clinical and administrative services directed toward the mission and goals of the NHCU, in accordance with regulations, policies, and accreditation standards.

h. **Administrative Responsibility.** Responsibility for policies and procedures, fiscal management, internal and external reviews, staffing, interface with hospital management, and with academic and research communities.

i. **Operational Responsibility.** Responsibility for day-to-day activities necessary for the operation of the nursing home, including scheduling of staff and patients, ordering supplies, assuring food delivery and the provision of housekeeping, maintenance services, etc.

j.] **Role of Nursing Home Care Unit Screening Committee.** The Nursing Home Care Unit Screening Committee should determine the need for NHCU placement. The placement should be based on the patient's need for long-term nursing supervision, observation and care by an interdisciplinary team, and/or long-term rehabilitation programs and supportive health services.

**NOTE:** *It is necessary to define the term "custodial care" since the term is sometimes misapplied to nursing home patients. Custodial care is that care which can be rendered by an individual who is not professionally trained to provide that care. Custodial care is the monitoring of a patient to ensure that the patient carries out the activities of daily living, takes prescribed medicine and has a safe environment in which to live. Those patients who have been medically determined to need nursing home care are not custodial care patients. For example, a comatose patient requiring total nursing care, turning, feeding, bathing, proper positioning, etc., is not a custodial care patient. Determining the need for nursing home care recognizes the fact that the patient needs care provided by a licensed professional or under the supervision of a licensed professional.*

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**1.03 ELIGIBILITY**

A prospective patient's eligibility for a VA NHCU and the Community Nursing Home Program will be determined by MAS (Medical Administration Service) prior to admission. For the VA NHCU, MAS will also determine the priority for admission. These policies are found in M-1, part I, chapter 12.

**1.04 OTHER RELATED TOPICS--GENERAL**

The policy on the following issues is found in M-1, part I, chapter 12: releases; outpatient care; institutional awards and NBC status; admission of women veterans; deaths; other administrative procedures; and priorities for nursing home care. The policy on nursing home care in state homes is found in M-1, part I, chapter 3. The policy on reimbursement rates is found in chapter 3, paragraph 3.03.

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CHAPTER 2. VA NURSING HOME CARE UNIT

2.01 ESTABLISHMENT

NHCU (Nursing Home Care Unit) will be established at VA medical centers only after approval by the Chief Medical Director.

2.02 AUTHORITY

Title 38 U.S.C. 610 authorizes the VA to provide nursing home care.

2.03 RESPONSIBILITY

[a. The medical center Director has overall responsibility for the NHCU. Organizationally aligned under the Chief of Staff, or Associate Chief of Staff for Extended care, overall NHCU administration will be the responsibility of the Chief, Nursing Home Care Unit. The Chief may be a registered nurse or a physician, as described in paragraph 2.03 c through e.

b. Under all models, a registered professional nurse designated "Associate Chief, Nursing Service for Nursing Home Care," or "Supervisor, Nursing Home Care Unit," is responsible for the nursing care delivered to patients, while a physician, designated as the Medical Director is responsible for the delivery of medical care. Under a matrix management system, each is responsible to the Chief of the NHCU for programmatic issues, and to his or her clinical service chief for the quality of the professional services provided.

c. **Nurse Administered Unit.** Under this model, the Associate Chief Nursing Service for Nursing Home Care or Supervisor, NHCU has administrative, programmatic and operational responsibility for the NHCU. This model is the one most commonly utilized. Under this model, the nurse would carry the title of Chief, Nursing Home Care Unit, as well as the Nursing Service title.

d. **Physician Administered Unit.** Under this model, a physician has administrative, programmatic and operational responsibility for the NHCU. This model would be useful in heavily academically affiliated tertiary care hospitals where patient care is medically complex and where teaching and research are important components of the NHCU program. Under this model, the physician would carry the dual title of Chief, Nursing Home Care Unit, and Medical Director, Nursing Home Care Unit unless another physician is designated as Medical Director.

e. **Combined Physician/Nurse Administered Unit.** Under this model, the administrative, programmatic, and operational responsibility for the unit are shared or divided by the ACNS and the physician. Division of responsibility will vary from

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site to site since leadership depends on demonstrated expertise in particular areas of management. This nurse/physician model would, like model d. be appropriate for heavily academically affiliated, tertiary care hospitals or for very large NHCU where division of responsibility may achieve a more efficient and effective use of staff.

(1) Where responsibilities in the broad management functions are shared, that is, where both nurse and physician participate in programmatic, administrative and operational management of the nursing home, it would be appropriate to designate both a Chief and an Associate Chief, Nursing Home Care Unit. If this is done, it must be decided locally, whether the nurse or the physician is designated as Chief or Associate Chief.

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(2) Where management responsibilities are divided between physician and nurse, it would be appropriate to designate a Chief, Nursing Home Care Unit and a Director of the particular management function assigned to the nurse or physician. For example, if the nurse were responsible for administrative and operational functions, and the physician for programmatic functions, the nurse would be designated as Chief, Nursing Home Care Unit and Associate Chief Nurse for Nursing Home Care, while the physician would be designated Program Director and Medical Director, NHCU, or vice versa.

f. Other models for management of the Nursing Home Care Unit must be submitted to the Office of Geriatrics and Extended Care, VA Central Office for approval.

#### **2.04 FUNCTION OF NURSING HOME CARE UNIT**

The threefold function of the NHCU is to provide:

(1) Compassionate care to those patients needing rehabilitation to restore them to their optimum level of functioning;

(2) Care that will prevent or delay deterioration of those patients having profound physical disabilities and/or behavior management deficiencies, and

(3) Supportive care to patients and families through the dying process.

#### **2.05 PROCESS OF CARE**

a. Delivery of care typically occurs over an extended period of time, 3 months and longer, and is directed toward those patients who demonstrate a potential for improvement or toward patients whose rehabilitative goal is the maintenance of existing functions.

b. Ongoing evaluation of the self-help status of the patient should provide the basis for decisions about the amount of support services which are required now as well as those that should ultimately result in the development of maximal independence for the patient and the enhancement of the individual's self-esteem and feeling of usefulness. All staff should be constantly aware of the goals and plan of care for each patient. If the patient's rehabilitative goal allows a return to a more independent living status, alternatives such as Hospital Based Home Care, Adult Day Health Care, Domiciliary, Community Residential Care, or another appropriate setting should be arranged. If hospital care is indicated, arrangements for referral to the medical center are required. The services to be provided in support of these goals are listed in subparagraphs 2.05c through 2.05g.

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c. Medical services include direct medical intervention and supervision of medical care by a physician who is appointed full-time or part-time as Medical Director. The Medical Director supervises the physician assistants and nurse practitioners and monitors the quality and appropriateness of medical services.

d. Nursing services include the assessment, planning, intervention, and evaluation of nursing care to patients. These functions are performed by a registered professional nurse who also supervises the activities of the non-professional staff; i.e., licensed practical nurse and nursing assistant. A rehabilitative/restorative nursing program is an integral part of nursing services and is directed toward achieving and/or maintaining optimum levels of functioning and independence in patients.

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e. Dietetic services include the provision of appetizing and nutritionally adequate meals, as well as the full range of clinical nutritional services. Supplemental feedings are provided when medically and nutritionally indicated. The clinical dietitian specializing in geriatric nutrition will assure that the goal of achieving adequate nutritional status is the primary focus of dietary regimes. Meals and meal service will be provided in a socially stimulating atmosphere with a rehabilitative focus. All patients are screened to determine nutritional status and nutrient deficits.

f. Social work services include a comprehensive psychosocial assessment of the patient, the patient support network including the family, and the community health and social resources needed to facilitate discharge planning, as appropriate. The social worker promotes coordination and integration of the treatment and discharge planning process; provides consultation and assistance to the treatment team concerning social factors affecting health care outcomes; and facilitates the full involvement of the patient and family in the resolution of problems affecting the plan of care during and following NHCU placement.

g. Dental services are designed to meet the dental needs of patients and include oral examination, diagnosis, treatment planning, and treatment provided by a dentist, assigned full-time or part-time to the program, or by an appropriate member of the dental staff.

h. Personal services include training patients in the performance of activities of daily living; e.g., personal hygiene, grooming, dressing, transfer, ambulation, and other related types of activities. When the patient is limited in performing the activities of daily living, the provision of personal services constitutes therapy in support of the overall treatment plan. The objective of providing personal services is to decrease dependence and maximize independence by encouraging patients to assume as much responsibility for their care as possible. The assessment of these needs is performed by the interdisciplinary team planning process and identified services are provided by the appropriate member of the team.

i. Socialization, recreation, and other motivational programs specially geared to the limitations of the patient should be provided. All staff must constantly seek ways and means of providing patients with opportunities to participate in individual and group activities that are meaningful and purposeful. Special care must be taken to include planning for those patients who are bedfast, severely cognitively impaired, or who exhibit disruptive behavior as these are the ones who are apt to become socially isolated. In addition to the interdisciplinary team, family members, volunteers, and community based organizations, such as recreational, educational, spiritual, and other service groups, should be encouraged to participate in these activities.

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**2.06 PHILOSOPHY**

a. Patients admitted to VA NHCUs have the right to expect care that is specifically planned to meet their physical, psychological, social, and spiritual needs. This can best be accomplished by utilizing an interdisciplinary team planning process to assess needs and to plan, implement, and evaluate treatment goals. Both the patient and the family are encouraged to play significant roles in the process. Treatment goals are directed to rehabilitation where possible, maintenance of the current level of function, or supportive care through the dying process.

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b. Although the NHCU is institutional in nature, every effort is expended to provide as home-like an atmosphere as possible. Quality of life, as defined by the patient, is an important consideration in the planning for the daily operation of the NHCU. The NHCU program should:

(1) Assist patients to achieve and maintain optimal levels of functional independence.

(2) Assure that administrative policies and procedures enhance rather than constrain freedom of choice in the establishment of appropriate life styles/behavior patterns.

(3) Preserve the individuality and dignity of patients in all staff-patient interactions.

(4) Enhance the quality of life through the patient's involvement in the development of individualized treatment plans.

(5) Facilitate the patient's return to a community setting whenever possible.

(6) Assure that programs are founded and developed on a sound knowledge base of geriatrics and long-term care.

**2.07 GENERIC NATURE OF NHCU PROGRAM**

a. NHCU beds have been placed at designated medical centers because of the projected demand for nursing home care. The NHCU beds are considered generic and should remain available for any patient who has been determined to need nursing care, the services of an interdisciplinary team and the intensity of services which can only be provided in a hospital based nursing home. Therefore, it is inappropriate to dedicate NHCU beds for patients in certain diagnostic related groups or in specialized programs for those requiring specialized treatments. For this reason the following are examples of the inappropriate use of NHCU beds:

(1) Ambulatory Care patients admitted to receive renal dialysis, chemotherapy, or radiation therapy because the commuting distance is too great between their home and hospital;

(2) Hospice patients whose care needs exceed the NHCU program's capacity;

(3) Geriatric Evaluation Units;

(4) Units specializing in Alzheimer's Disease and other dementing disorders;  
and

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(5) Rehabilitation Units.

b. The establishment of clinical programs, designed to meet the special care needs of patients in the NHCU, is appropriate, and encouraged.

#### **2.08 ADMISSION GUIDELINES**

a. The need for placement in the NHCU is based on medical and nursing care considerations. Specifically, the patient should require long-term nursing supervision, observation and care by an interdisciplinary team, and/or long-term rehabilitation

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programs and supportive health services. The outcome for the patient will vary depending upon the disease process, presence of permanent or residual disability, response to rehabilitative intervention, and presence or absence of a support system outside of the institution. For example:

(1) Patients with nonreversible pathological conditions, such as Amyotrophic Lateral Sclerosis, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, cancer, etc., should be admitted to the NHCU if the life expectancy is greater than 3 months.

(2) Patients with permanent or residual disabilities should be admitted to the NHCU to determine if a higher level of functioning can be obtained or to provide care that will maintain their current level of functioning.

(3) Patients having the potential for rehabilitation, which will take place over an extended period of time, should be admitted to the NHCU.

b. Those patients for whom admission to the NHCU would be considered inappropriate include:

(1) Those who are not medically stable.

(2) Those who require medical care on a day-to-day basis, need frequent laboratory studies and clinical monitoring (by medicine or nursing), require intensive medical care, or whose behavior cannot be managed in a nursing home setting, or are terminally ill with a life expectancy of less than 3 months.

(3) Those who are receiving parenteral nutrition, except when a Nutritional Support Team is available for care and management.

(4) Those who are able to meet their own self-care needs or do not require the resources available in the NHCU and the medical center.

**2.09 SCREENING COMMITTEE**

a. An interdisciplinary Screening Committee will be appointed and will consist of the Supervisor, NHCU (or Associate Chief, Nursing Service for Nursing Home Care), the physician directly responsible for the care of patients in the NHCU, a social worker, a rehabilitation therapist, a dietitian, a MAS representative, and other appropriate professional staff. The Chairperson will be designated by the Chief of Staff.

b. Following the eligibility determination by MAS, the Screening Committee will review all applications and make recommendations to the Chief of Staff for

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admission. The Screening Committee may request whatever information is deemed necessary to arrive at an appropriate recommendation.

c. The Screening Committee will meet as often as necessary to expedite action on all applications. All actions of the Screening Committee will be reflected in minutes, logs, patient records, and MAS recurring reports. These source documents should adequately reflect the reasons for a patient being accepted or rejected for nursing home placement.

d. Applicants who are currently hospitalized or domiciled at the same medical center where the NHCU is located will not be given preference over applicants from other VA medical centers.

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e. When considering applications for admission, the Screening Committee must carefully consider the services required by the applicant and determine whether the institution has the resources available to meet those needs.

#### **2.10 ADMISSION PROCEDURES**

a. Request for admission to a NHCU will be initiated by the patient's physician and will be supported by sufficient medical findings to show that the applicant meets the requirements of paragraph 2.08. VA Forms 10-10, 10-10m, 10-10f and 10-10i, as appropriate, must accompany applicants from the community. Additional information, as necessary, may be requested by the Screening Committee.

b. The Chief, MAS will be responsible for the initial screening of applicants to establish eligibility, assign a priority, and assure that all required documentation is available for the Screening Committee.

c. The Chief, MAS is responsible for prompt referral of all requests for admission to the NHCU to the Screening Committee and for prompt action and notification to all concerned after a decision is made.

d. The ACNS/NHC or Supervisor, NHCU will notify MAS as vacancies occur in the NHCU and will coordinate admissions with MAS.

#### **2.11 WAITING LIST**

a. A waiting list will be maintained by MAS for admission to the NHCU. The waiting list will be established by priorities and date of application.

b. Each applicant on the waiting list shall be provided with an honest appraisal of the time-frame for admission. The applicant will remain on the waiting list until admission, the request is removed, or for any other reason is no longer a candidate for the NHCU.

c. If an applicant is accepted for admission and placed on the waiting list, it is appropriate for the Screening Committee to make referral of this applicant to another program (e.g., Hospital Based Home Care, Adult Day Health Care, Community Nursing Home).

d. Individuals on the waiting list will be contacted no less than annually to determine if interest and need still exist for admission to a VA NHCU.

e. Selection of patients from the waiting list will be made according to priorities and earliest date of application.

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**2.12 ABSENCES FROM CARE**

a. VA nursing home patients who require admission to the hospital will be placed on Absent Sick-in-Hospital status. Those who remain in the hospital for 30 days or less will be assured a bed in the nursing home unit when released from hospitalization (see VHS&RA manual M-1, pt. I, ch. 10).

b. Weekend passes and trial visits home (see VHS&RA manual M-1, pt. I, ch. 10), when properly utilized with appropriate planning, may be an excellent way to prepare both the patient and the family for eventual discharge home. These visits home should be part of the interdisciplinary planning process.

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### **2.13 INTERDISCIPLINARY TEAM**

a. The care provided the patient should be planned and coordinated by an interdisciplinary team. This team of professionals is representative of a variety of disciplines. Interdisciplinary team members share common team goals, collaborate, and work interdependently in planning, problem solving, decision making, implementing, and evaluating team related tasks, and share the right and responsibility for assuming leadership roles and functions for team progress. Because interdisciplinary team members work interdependently to assure the efficient provision of comprehensive and coordinated, quality care, they give great import to the interactional processes of their team. Communication, role negotiation, and other critical teamwork skills are practiced, and regular evaluations of the team process are undertaken by all members.

b. The interdisciplinary team consists of a core team and adjunct team. The core team should consist of health professionals from the following services: medicine, nursing, social work, dietetics and rehabilitation medicine. If the members of the core team do not possess the expertise required to deal with the patient's needs, then the appropriate adjunct team member should be called upon. The adjunct team complements the services of the core team and may include audiology and speech pathology, dental, optometry, pharmacy, podiatry, psychiatry, psychology and recreation services. The membership of the core team may be expanded and the adjunct team membership may vary from nursing home to nursing home, depending upon local emphasis and available resources.

### **2.14 TREATMENT PLAN**

A written plan of care will be developed and maintained for each patient in accordance with the Accreditation Manual for Long-Term Care Facilities developed by the JCAHO (Joint Commission of Accreditation of Healthcare Organizations). The plan of care should be based on an assessment of each patient and be developed by an interdisciplinary team. All members of the team should sign the patient's plan of care. The plan of care is utilized as a tool for providing care by all staff caring for the patient. Overall coordination and maintenance of the plan of care should be the responsibility of the interdisciplinary team. The treatment plan should be shared with the patient and family who should also sign the plan as active participants in the treatment program.

### **2.15 QUALITY ASSURANCE**

A process of systematic internal review of the NHCU program should be integrated into the medical center's overall Quality Assurance program. Examples include SCEM (Standards, Criteria, Evaluative Algorithms, and Measuring Instruments); Accreditation Manual for Long-Term Care Facilities developed by the

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JCAHO; program guides developed by the services within the Department of Medicine and Surgery; etc. The evaluations should be scheduled as ongoing periodic reviews with written reports made of the results. Action for followup should be initiated and documented. Deficiencies germane to the NHCU program which are identified during the external review process should be clearly identified and resolved. These reviews are conducted by the Joint Commission and SERP (Systematic External Review Program) teams.

#### **2.16 DISCHARGE TO HOME OR ALTERNATIVE LEVEL OF CARE**

a. Discharge planning is an integral component of the treatment program. The discharge planning process will be initiated as soon as possible following admission to the

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NHCU and will be based upon the interdisciplinary assessment of the patients' needs. Discharge planning will be reevaluated throughout the patient's stay at the NHCU.

b. Discharge from the NHCU will be accomplished when the treatment goals have been reached and appropriate community resources are available to sustain the patient either at home or in an alternative level of care.

c. Discharge to home or a community agency or facility must be accomplished in an orderly fashion with ample time allowed to prepare the patient and family, to make appropriate referrals, and to assure that needed equipment and supplies have been procured and/or structural modifications to the home have been accomplished. Precipitous discharge with inadequate planning should always be avoided.

d. Additional policies on discharge planning are contained in M-1, part I, chapter 5.

**2.17 DUE PROCESS**

a. If, in the planning process for a community placement, it is discovered that the patient or family, or patient representative objects to outplacement, they should be made aware that they may present medical information relating to the patient's condition which would prevail against the discharge plan.

b. If the patient, family, or patient representative wishes to present new medical information, they will be given up to 1 week from receipt of notice of the discharge plan, to indicate their intent to present such information. The subsequent length of time allowed for the family to present the evidence should be reasonable, based on the nature and source of information to be provided, up to a maximum of 7 calendar days.

c. The medical information presented by the family should be reviewed by the attending physician who will decide whether or not to continue discharge planning to another setting, including a community nursing home. A decision to proceed with planning will be reviewed by the Chief of Staff. This review function may be delegated to another physician or to a medical review panel, if desired.

d. The family should be notified in writing of the decision. Beyond this point, the normal steps for either discharge planning or for continued VA nursing home care should be followed, depending on the decision.

e. Should continued VA nursing home care be planned, the case may be reviewed at any time there is new medical evidence that the veteran has reached maximum benefit of the VA Nursing Home Care Program.

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(4) Assure appropriate, timely followup of veterans placed in CNH.

(5) Develop working relationships with local regulatory and quality assurance agencies, ombudsman and/or complaints offices and assure regular exchange of information with these offices.

(6) Conduct, as needed, surveys of the nursing home market, to ensure that the supply of nursing homes under contract is adequate to meet the needs of patients.

(7) Provide overall guidance in the management of the CNH program.

d. The contracting officer is responsible for negotiating and consummating contracts with community nursing homes.

e. Followup of the veteran will normally be the responsibility of the placing facility and will be conducted primarily by Social Work and Nursing Services. Other services are expected to provide consultation to the nursing home in the followup process as needed. For example, patients with an identified nutritional problem will receive followup visits as determined necessary by the dietitian. A written referral will be made to another VA medical center or clinic when the distance to the nursing home or other circumstances make followup by the authorizing facility impractical. The medical district coordinator in consultation with the Social Work Council will determine facilities having followup responsibilities for specific nursing homes in the district.

f. Social Work Service will maintain an up-to-date list of all veterans outplaced under contract to community nursing homes which will be updated periodically and made available immediately in the event of disaster or other incidents. A copy will be provided to the Chief, MAS.

### 3.03 PROCEDURE FOR INITIATING A CONTRACT

a. Upon receipt of a request from the nursing home to be included in the contract nursing home program, the Chief, Supply Service or Contracting Officer, will mail SF 129, Solicitation Mailing List Application; VA Form 10-1170, Contract Award for Furnishing Nursing Home Services to Beneficiaries of the Veterans Administration, and a descriptive cover letter to the applying nursing home.

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b. Contracts should be negotiated at rates which reflect the current market value of nursing home care in the local community. Nursing homes shall receive a per diem rate commensurate with the care and services provided, not to exceed the approved maximum rate. Certain states or areas of the country have been approved for a higher maximum per diem rate and VA medical facilities in those areas are notified of the higher per diem rate. Medicaid (Title XIX) rates provide a general index to prevailing community rates. However, Medicaid rates are generally not all inclusive, and therefore, rates will be negotiated based on Medicaid rates plus a supplemental amount based on historical data of veterans' services and supplies, not normally to exceed 15 percent of Medicaid SNF rate. Where Medicaid rates are not a reliable indicator of actual cost, or where this amount exceeds 15 percent, nursing homes must provide documentation to justify special consideration for higher rates. Community nursing homes providing unusual care and/or services may be considered for higher rates, within the maximum rate, when justified.

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c. The per diem rates for intermediate care facilities must be commensurately less than those paid for skilled care, relative to the quality and intensity of services provided. When the nursing home has both skilled and intermediate levels of care, the ICF rate must be at least 10 percent less than the SNF rate for that CNH. When nursing homes do not provide skilled care, the ICF rate must be at least 10 percent less than the overall average rate paid by the VA medical center to local SNF facilities at the time of the contract award.

d. After return receipt of the application, an SF 98 and SF 98a, Notice of Intention to Make a Service Contract and Response to Notice, will be sent to the Department of Labor.

e. The contracting officer will notify the team coordinator of the nursing home's intent. An evaluation will be planned according to procedures outlined in paragraph 3.07. On initial inspections, the nursing home will be notified of the prospective time and date. The report of the evaluation, with recommendations, will be forwarded by the community nursing home team coordinator to the contracting officer. If appropriate, the contract will be completed by the contracting officer. The contracting officer will distribute copies of the contract to MAS and Social Work Service and any other concerned services. MAS will update information to be included in the Community Nursing Home Report, RCS 10-0168. (See app. B).

### 3.04 CONTRACT OBJECTIVES

a. Contracts will be sought with skilled and intermediate care nursing homes for the provision of care which meets VA standards. Every effort will be made to secure contracts to include within the per diem rate, the cost of a room, meals, nursing care, routine medical care, drugs, laboratory, x-ray, and other routine services. If this is not possible, the contract should specify those services and supplies which are not included in the per diem rate.

b. Contracts negotiated with exceptions will reflect a reduced per diem rate, calculated by decreasing the per diem rate by the estimated daily cost of the excepted items.

c. Contracts with nursing homes are meant to be shared among VA medical centers, as needed. A nursing home must have a contract with only one VA medical center.

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d. A supply of medications is often provided to the patient at the beginning of the placement period. This transitional supply of drugs should not exceed a 7 working day supply.

### **3.05 STANDARDS FOR SKILLED NURSING FACILITIES**

The facility shall be licensed or approved by the state in which it is located and it must comply with applicable state and local government regulations. VA standards for SNFs are the same as those used for the certification of nursing facilities for the Medicare or Medicaid programs except that, for the fire safety criteria, the facility shall meet the requirements of the latest edition of the Life Safety Code (NFPA 101).

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### **3.06 STANDARDS FOR INTERMEDIATE CARE FACILITIES**

The facility shall be licensed or approved by the state in which it is located and it must comply with applicable state and local government regulations. Minimal VA standards for ICFs are the same as the Federal Medicaid Standards contained in the 42 CFR, except for fire safety criteria, the facility shall meet the requirements of the latest edition of the Life Safety Code (NFPA 101). The following additional VA standards will also apply for nursing services:

(1) The Nursing Service is under the direct supervision of a full-time (40 hours) registered professional nurse, currently licensed to practice in the state.

(2) There is at least one registered professional nurse or licensed practical nurse or vocational nurse (a graduate of a state-approved school of practical nursing) on duty and in charge of nursing activities during each tour of duty.

(3) Provision is made for appropriately trained personnel to relieve during vacation, sick leave, and other periods of emergency to assure 24-hour coverage.

### **3.07 EVALUATION OF NURSING HOMES**

a. Nursing homes will be evaluated prior to consummation of a contract with the VA. A current accreditation as a long-term care facility by the JCAHO may be considered evidence of compliance with VA standards. If the medical center Director chooses to accept this method of evaluation, an onsite visit to the nursing home must be made by the social worker and nurse only, according to instructions outlined in subparagraph 3.07d. If the home is not JCAHO accredited or if the medical center Director chooses not to accept this method of evaluation, the home must be evaluated by one of the methods outlined.

b. If the nursing home has been certified under Title XVIII (Medicare) or Title XIX (Medicaid), it will have been inspected by the State agency according to the Federal standards. The community nursing home coordinator will obtain from the State agency, or the Regional Office of the Department of Health and Human Services, a copy of the most recent Form SSA 2567, Statement of Deficiencies and Plan of Correction, prior to evaluation. This document will note any deviation from standards, the nursing home's plan for correction, and any waivers. The community nursing home evaluation team members will review their appropriate sections of Form SSA 2567 prior to CNH evaluation.

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c. If a review of Form SSA 2567 raises questions as to the suitability of the home for the use of VA beneficiaries, appropriate members of the VA team, or the entire team, if indicated, will visit the home to resolve the questions, applying the cited 42 CFR standards and documenting the findings. VA team members are encouraged to discuss any particular areas of concern noted on Form SSA 2567, with the appropriate individuals at the agency which conducted the survey.

d. If the review of the Form SSA is satisfactory or if a current JCAHO accreditation is accepted, no full team inspection is required. A visit will be made to the home by the team social worker and nurse only. The purpose of this visit will be to describe and evaluate:

(1) The quality and level of care provided including staff, quality control programs, training, services, rehabilitation, care management, nutrition and corresponding documentation.

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(2) The quality of life in the facility including environment, safety, flexibility to accommodate lifestyle, participation of residents and families, system to assess satisfaction and response to concerns and complaints.

(3) Facility programs to meet the needs of veterans including medical, social and spiritual, and activities to promote self worth and a sense of well being.

(4) Special characteristics and unique programs of facilities.

e. Appendix A, CNHC Program: Quality of Care/Quality of Life Indicators, may be used in this evaluation.

f. The description and evaluation will be documented and will be used to determine how this facility might best be used to serve the needs of the target veteran population.

g. Based on the above evaluation processes, recommendations will be made by the community nursing home team coordinator to the contracting officer for disposition of the application. If problem areas are noted, the nursing home must be advised of the deficiencies in writing by the contracting officer and given a reasonable amount of time to take corrective action. A contract may be issued while corrective action is being pursued only if it is determined that the health and safety of the veteran will not be compromised in the meantime.

h. The same procedures outlined for the certified SNF facilities (above) will apply to certified ICFs except that the VA community nursing home team must determine that the home also meets the additional standards for nursing services outlined in paragraph 3.06 above. This can be determined by a review of VA Form 10-1170, Application for Furnishing Nursing Home Care to Beneficiaries of the Veterans Administration, and by the nurse/social work quality and program evaluation visit.

i. The evaluation process will be completed and documented every 12 months and no more than 45 days prior to expiration of the contract. The team coordinator will recommend to the contracting officer continuation of the contract, or continuation contingent on correction of deficiencies, or termination of the contract each year based on the evaluation process. If a contract is canceled and renegotiated during the year for the purpose of establishing a new per diem rate, it is not necessary to conduct another evaluation as long as the evaluation has been conducted within the required 12 month time limit.

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j. When serious deficiencies affect the health or safety of veterans, or in cases of continued uncorrected deficiencies, VA medical centers may consider the following action:

- (1) Suspend placement of veterans to the CNH.
- (2) Remove, transfer veterans under contract from the CNH.
- (3) Not renew the contract.
- (4) Terminate the contract.

*NOTE: In order to monitor the quality of inspections conducted by other agencies, VA medical centers may conduct onsite evaluations on a routine sampling basis as determined by the team coordinator. It is the clear intention of the VA to minimize unnecessary and redundant Federal*

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*inspections of nursing facilities through the processes outlined in this chapter. However, it is emphasized that the VA medical center retains the right and carries the responsibility to conduct an onsite VA evaluation by a full or a partial team at any time it is considered necessary to ensure that quality care is provided to veterans in a safe environment.*

k. Nursing homes not certified under Title XVIII (Medicare) or Title XIX (Medicaid) will be evaluated on site by the following community nursing home team members: social worker, nurse, dietitian, and fire safety officer, using the standards outlined in 42 CFR. The team physician and clinical pharmacist and any other discipline will be included in the inspection as appropriate. The social worker and nurse members of the team will, in addition to applying standards of 42 CFR, describe and evaluate the facility according to the principles outlined in subparagraph 3.07d.

l. Following completion of the evaluation, findings will be documented and a recommendation will be made by the community nursing home team coordinator to the Contracting Officer for disposition of the application.

m. The CNH program coordinator will assure maintenance of communication with regulatory agencies reviewing quality of care. VA medical centers will, on request, make information concerning contract nursing homes available to Federal, state, and local agencies charged with the responsibility of licensing, regulating or inspecting these homes. In addition, VA medical centers will, on their own initiative, make available to these agencies, information about facilities which are found to have significant deficiencies which may threaten the health or safety of residents.

### **3.08 SELECTION AND MOVEMENT OF PATIENTS**

a. Selection of patients for placement in community nursing homes will normally be made at the ward or section level by the patient's physician, nurse and social worker, subject to approval by the Chief of Staff or ACOS (Assistant Chief of Staff) of the placement, once eligibility has been determined by MAS.

b. Patients will be given the opportunity to choose a nursing home from facilities approved by and available to the VA. Listings of local nursing homes will be maintained by each VA facility. Information on other nursing home contracts is available at the appropriate medical district office. Admission to the nursing home will be accomplished promptly following completion of an episode of hospital, nursing home or domiciliary care.

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c. VA Form 10-1204, Referral for Community Nursing Home Care, will be prepared by the ward clerk or secretary. The responsibility for providing the necessary information rests with the physician, nurse, social worker, dietitian and other sources. The form will be filled out as completely as possible. If additional space is needed for any item, the "Remarks" space may be used or additional information may be furnished separately and attached to the form. When appropriate, forms required by local public assistance agencies will also be completed.

d. If the proposed placement is approved by the Chief of Staff or ACOS, after eligibility has been determined by MAS, the Chief, MAS, or designee, will contact a nursing home official to ascertain availability of a bed unless the social worker has already done so and it is so indicated on VA Form 10-1204. The medical facility will be responsible for complying with any requirements of local governments or regulatory bodies prior to movement of the patient to the nursing home.

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e. The original VA Form 10-1204, a copy of VA Form 10-1000, Discharge Summary, and other pertinent documents will be forwarded to the nursing home so that it is available when the patient arrives. A copy will be filed in the veteran's administrative records folder at the medical facility. An additional copy will be reproduced and forwarded to the facility which is to conduct the followup, if other than the authorizing facility.

f. Early planning will be initiated to assure that needed dental care, prosthetic appliances or assistive devices are furnished prior to discharge from the VA facility.

g. A nursing home retains the right to refuse to accept any patient when it is anticipated that the cost of the care and services required would exceed the scope of the contractor's ability to meet the medical needs of the veteran.

### 3.09 DUE PROCESS

These procedures are listed in M-5, part III, chapter 2, paragraph 2.17. The procedures apply to all CNH placements.

### 3.10 PLANNING AND FOLLOWUP

a. Prior to placement in a community nursing home, consideration will be given to post-contract planning. If there clearly is no viable post-contract plan and the veteran will most likely be returned to the VA medical center, the veteran should not be placed in a community nursing home. Social Work Service will actively assist the veteran and/or family in planning to assume responsibility for future needs following nursing home care at VA expense. Benefits and potential benefits, VA and other, will be fully explored and explained to the veteran and/or the family. Appropriate assistance is available from the veterans benefits counselor.

b. Each patient admitted to a community nursing home will be visited no less frequently than every 30 days by a VA staff member. Observations will be made as to the quality of professional care and need for continuation of nursing home care. Guidance may be provided to CNH staff in the provision of care for veterans under contract.

c. The social worker will make followup visits as often as necessary to:

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(1) Provide consultation and liaison related to care management and provide patient advocacy.

(2) Assist the patient and/or family with the social and emotional aspects of the transition to long-term care.

(3) Address unresolved patient/family concerns/complaints with CNH staff.

(4) Assist the patient/family in planning for continued care in the nursing home or transition to another level of care in the community, if indicated, and coordinate the application for maximum VA benefits post contract.

(5) Provide consultation to CNH staff related to discharge planning and coordinate referrals to VA medical center services.

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d. A nurse will make followup visits at least once every 60 days and more often if necessary to ensure that adequate and safe care is being provided. At time of discharge, patients whose clinical status and nursing requirements put them at risk of frequent readmission to the medical center should be identified and a specific plan be developed for nursing follow-up. The nurse will make visits to:

- (1) Provide consultation and liaison to CNH staff.
- (2) Monitor appropriateness of care.

e. A dietitian will make followup visits as determined necessary to:

- (1) Evaluate the care provided to patients with an identified nutritional problem.
- (2) Provide education and consultation to CNH staff for the purpose of enhancing nutritional care services.

*NOTE: It is VA policy to provide followup visits to veterans in CNHs once every 30 days by a VA staff member. A VA nurse will provide a followup visit at least once every 60 days. Depending on the need of the patient, a nurse and social worker may be able to alternate visits on a 30-day interval, with the social worker visiting the patient during one 30-day period and the nurse visiting the patient during the next 30-day period. In other cases, as a function of patient needs, the social worker may need to provide followup services every 30 days, notwithstanding the nurse's visits as outlined in subparagraph 3.10d.*

f. If plans for continued nursing care at non-VA expense cannot be completed prior to the expiration of the VA authorization, the social worker will continue to offer assistance in planning. If there are valid reasons for continued care at VA expense and the veteran meets the requirements in paragraph 3.11, consideration will be given to extending the period of VA authorized care at the community nursing home.

g. If plans for continued nursing care at non-VA expense for a veteran whose hospitalization or need for nursing home care was primarily for treatment of nonservice-connected disabilities is feasible, but the veteran and/or family decline to cooperate, the VA authorization will be terminated. Written notification of the pending termination will be made to the veteran and/or family, the community nursing home and any other interested parties. Termination will be effective 30 days following written notification or at the expiration of the current authorization, whichever comes first.

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h. Placement from a VA medical center to a contract nursing home at VA expense may be denied to a veteran seeking care for a nonservice-connected condition if it is objectively and realistically determined that an alternative to VA contract care is feasible but the veteran or the veteran's family declines to utilize the alternative. If an alternative arrangement is available to VA care, such as public assistance, and the veteran declines to use this potential benefit, the VA may deny placement at VA expense.

i. Patients remaining in the community nursing home for an extended period of time (more than 1 year) will be given a comprehensive physical examination no less often than once a year to determine the need for continued nursing home care. Such examinations will be done, to the extent practicable, on a staff basis at the VA medical facility nearest the community nursing home. If this is not feasible, the examination will be done at the nursing home on a fee basis or

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by a VA physician. The report of examination will be reviewed by the community nursing home team to determine the need for continued care. A copy of the report of examination will be furnished to the community nursing home for inclusion in the patient's record.

### 3.11 EXTENSIONS BEYOND 6 MONTHS

a. Extensions beyond 6 months for veterans whose hospital, nursing home, or domiciliary care was primarily for treatment of nonservice-connected disabilities will be held to a minimum and must meet one of the following conditions when the need for nursing home care continues to exist:

(1) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility problems which can reasonably be expected to be resolved within the extension period, or

(2) The veteran has made specific arrangements for private payment for such care, and

(a) Such arrangements cannot be put into effect as planned because of unforeseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and

(b) Such difficulties can reasonably be expected to be resolved within the extension period; or

(3) The veteran is terminally ill and life expectancy has been medically determined to be less than 6 months.

b. Extensions must be for a specific period of time, not to exceed 45 days.

c. Cases which meet the requirements of subparagraph a. (1), (2), or (3) will be fully developed and documented, including recommendations of the physician, nurse and social worker. Cases will be forwarded to the medical center Director for a decision on the requested extension at least 5 days prior to expiration of the current authorization.

### 3.12 OTHER RELATED TOPICS--COMMUNITY NURSING HOME CARE

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The policy on the following issues is found in M-1, part I, chapter 12:  
Eligibility; Active Military Duty; Procedures in AK and HI; Readmission to a Medical  
Center; Additional Care; Billing and Reporting Procedures; Deaths and Notification  
of Adjudication.

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b. Staff Training

- (1) Orientation/training of new employees
- (2) Inservice education matched to identified needs
- (3) Staff training in CPR
- (4) Affiliation with student programs
- (5) Opportunities for continuing education

c. Quality Assurance

- (1) Representation by all departments at regular quality assurance meetings
- (2) Staff input to development/revision of policy procedures

### CHAPTER 3. COMMUNITY NURSING HOME CARE

#### 3.01 GENERAL

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#### 3.02 RESPONSIBILITIES

a. Medical center Directors are responsible for designating members of a community nursing home evaluation team and ensuring that transportation is available for evaluation and patient followup. At a minimum, the team will consist of a professional nurse, social worker, physician, dietitian, pharmacist, fire safety officer, contracting officer and a representative from MAS. The medical center Director will designate one team member as the coordinator. The function of the team will be to:

- (1) Review inspection findings of other agencies.

(3) Federal/State deficiencies corrected timely and appropriately

**3. Compliance with Life Safety Code Regulations (NFPA 101)**

**4. Safety Practices and Procedures**

- a. Resident care equipment availability, utilization, maintenance
- b. System for resident identification
- c. Accessibility of call system in bedroom/bathroom
- d. Safety of bathtubs/showers/hallways
- e. Storage of potentially hazardous solution (ingestibles)
- f. Acceptable practice in cleaning premises

**5. Staffing Patterns/Bed Capacity**

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- (1) Review inspection findings of other agencies.

- a. Sufficiency of staff/resident ratio
- b. Continuity of staff
- c. Use of temporary staff
- d. Staff grooming/clothing

**6. Patient Care Services**

- a. Personal Care/Hygiene
  - (1) Evidence of appropriate personal hygiene
  - (2) Privacy in toileting/bathing areas

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- (1) Review inspection findings of other agencies.

- (3) Accessibility of toilets/baths
- (4) Flexibility of routine to allow resident control in bathing, eating, etc.
- (5) Appropriateness of resident clothing
- (6) Frequency of access to beautician or barber
- (7) Appropriate informed consent for care procedures

b. Rehabilitation/Specialty Programs

- (1) Weight monitoring system
- (2) Foley catheter care
- (3) Decubitus ulcer care

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- (1) Review inspection findings of other agencies.

- (4) Bowel training program
  - (5) Bladder training program
  - (6) Staff skill in care of gastrostomy/trach/NG/O<sub>2</sub>/IV
  - (7) Staff skill in care of bedfast residents
  - (8) Nursing rehabilitation programs for enhancement of independence
  - (9) Appropriate use of mirrors, clocks, calendars, orientation cues
  - (10) Facility sponsored programs/hospice/respite/adult day health care/other
- c. Policy and Procedure Manuals
- (1) Development by facility staff
  - (2) Documentation of annual update

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- (1) Review inspection findings of other agencies.

- (3) Accessibility to staff
- (4) Restraint policy/procedure (chemical/physical)
- (5) Medical emergencies
- (6) Functions of Medical Director
- d. Infection Control Measures
  - (1) Handwashing accessibility
  - (2) Linen-storage and management

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- (1) Review inspection findings of other agencies.

- (3) Utility room-use and storage
- (4) Isolation procedures/policies

**7. Medication Management**

- a. Storage of medications
- b. System for dispensing
- c. Documentation of medication administration
- d. Notation of reason given/results obtained
- e. Review for side effects
- f. Documentation of reason for PRN meds and results

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- (1) Review inspection findings of other agencies.

- g. Medication orders checked by consultant pharmacist
- h. Appropriate monitoring of emergency medications

**8. Medical Care**

- a. Frequency of physician visits to residents
- b. Physician availability as needed with appropriate consultation/care planning response
- c. Physician orders signed within 48 hours with follow-up system
- d. DNR policy/DNI/Supportive Care Guidelines

**9. Consultants**

- a. Dietitian
- b. Physical Therapy

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- (1) Review inspection findings of other agencies.

- c. Speech Therapy
- d. Podiatry
- e. Occupational Therapy
- f. Psychiatry
- g. Pharmacist
- h. Dental
- i. Other

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- (1) Review inspection findings of other agencies.

10. **Clinical Records**

- a. Initial assessment by physician/nurse/social worker
- b. Resident care plans reflect current needs/goals/actions
- c. Documentation reflects implementation of care plan
- d. Care plans evaluated and revised appropriately
- e. Appropriate rehabilitation/discharge plans
- f. Records/charts are well organized

11. **Policies and Practices Affecting Resident Satisfaction**

- a. Facility's recognition of residents' religious/ethnic autonomy

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- (1) Review inspection findings of other agencies.

- b. Encouragement by facility of family and resident in care planning
- c. Flexibility of resident bedtime/waking hours
- d. Encouragement of family and resident to participate in decisions of daily life
- e. Effectiveness of resident/family council to influence home policy
- f. System for assessing resident satisfaction
- g. Programs for orienting new residents and their families
- h. Response system to resident and family complaints
- i. Residents' freedom to personalize own room/adequate space/access to funds/possessions
- j. Openness and flexibility of visiting hours

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- (1) Review inspection findings of other agencies.

- k. Practices to accommodate lifestyle of residents
- l. Resident participation in selection of roommate
- m. System to accommodate resident sexuality issues/practices
- n. Programs to enhance self worth/self esteem

12. **Activities**

- a. Opportunities for productive activities
- b. Facility system for assessing resident interests
- c. Balance between sedentary and physical activities

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- (1) Review inspection findings of other agencies.

- d. Opportunities for activities in community
- e. Balance of activities for male/female residents
- f. Activity opportunities for bedfast residents
- g. Availability of current/appropriate reading material
- h. Opportunities for community activities in nursing home
- i. Use of sensory stimulation programs/orientation cues
- j. Availability of community transportation
- k. Availability of evening/weekend activities
- l. Facility's ability to recruit volunteers from varied sources

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- (1) Review inspection findings of other agencies.

- m. Utilization of volunteers in various programs

13. **Unique Features/Programs**

Unique programs

14. **Interaction with VA Follow-up Staff Since Last Evaluation**

- a. Openness to suggestion/constructive criticism
- b. Responsiveness to criticism/complaints
- c. Timeliness of response

15. **Nutrition**

- a. Establishment and periodic update of nutritional care plans
- b. Maintenance record of feeding hydration of residents

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- (1) Review inspection findings of other agencies.

- c. Maintenance of height and weight records
- d. Visitation by dietitian or food service supervisor or consultant with resident
- e. Practices for responding to residents' food likes/dislikes
- f. Provision for selective menus
- g. Provision for food substitutes
- h. Provision made to help resident and family understand diet

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- (1) Review inspection findings of other agencies.

- i. Provisions of in-between meal and bedtime snacks for residents
- j. Timeliness of meal service
- k. Flexibility of meal schedule
- l. Appeal and appearance of food
- m. Level of sanitation
- n. Encouragement of congregate eating
- o. Residents' satisfaction of foods served
- p. Suitability of dining facilities
- q. Provisions for special occasions: e.g.,birthdays, holidays

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- (1) Review inspection findings of other agencies.

- r. Established monitoring of food intake and identification of patients with inadequate intake
- s. Provision of adaptive feeding devices
- t. Provision of assistance for patients requiring help during meals.

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- (1) Review inspection findings of other agencies.

(3) Checking the forms and report for inclusion of all community nursing care homes in which your facility has placed veterans, and homes approved for placement of veterans,

(4) Training appropriate personnel to correctly complete the forms.

(h) The coordinator will determine that the correct information is filled in each block of the form and that those blocks which do not require information are left blank. All zeros should be slashed. The address of the community nursing home should be filled in if the home is an addition during the reporting period. After the forms have been keypunched, the cards should be verified.

(i) Once the DPC receives the cards, they will be edited. All cards which contain errors will be rejected by the system and will be listed in a separate report to be sent to each facility. The report will show the entire card. Asterisks will be used to indicate an erroneous field(s). All positions below the fields in error will contain asterisks.

#### **CNHC PROGRAM: QUALITY OF CARE/QUALITY OF LIFE INDICATORS**

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##### **1. Physical Environment**

- a. Attractiveness of building
- b. Maintenance of building
- c. Maintenance of grounds
- d. Lighting of interior
- e. Adequacy of privacy/personal living space
- f. Privacy for resident/family counseling/visitation
- g. Absence of offensive odors
- h. Absence of excessive noise
- i. Condition of furnishings
- j. Suitability of furnishings
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(j) If an error listing is received at the facility, it will be the coordinator's responsibility to correct all errors, have new cards keypunched, and send the new cards to the Austin DPC. The error corrections should reach the DPC no later than the end of the month following the end of the quarter; i.e., January 30, April 30, July 31, and October 30.

(k) If there are still errors after these dates, those cards with errors will be rejected and will not be included in the CNH reports. A second listing of errors will be produced at this time and sent to the appropriate facilities with their other CNH reports. Errors on the second listing should be noted and corrected on the next report. If the facility has a number of cards listed in error for several reporting periods, procedures for coding and keypunching the forms should be reviewed and problems eliminated.

(l) Each health facility will receive a report of the CNH where the facility has veterans placed, the location, bed capacity, one day census, per diem rate, date of last assessment, licensing and accreditation status, with medical district and system-wide totals. Medical District Directors will receive a listing for each

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facility in the District, as well as a report of district totals and system-wide totals.

3. CODING INSTRUCTIONS FOR VA FORM 10-1204d, COMMUNITY NURSING HOME REPORT CODE SHEET

<u>Number</u>	<u>Item</u>	<u>Coding Instructions</u>
1.	Three Digit Station Number	Columns 1-3. Enter in the blocks the three digit number for the VA medical center reporting the patient. (Refer to current Consolidated Address Bulletin). Slash all zeros.
2.	Addition or Reestablishment	Column 4. If the nursing home has never been under VA contract before, enter an "A" in the block. If the nursing home has a terminated contract which has been reestablished, enter

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<u>Number</u>	<u>Item</u>	<u>Coding Instructions</u>
		an "R" in the block. If a contract has been renewed or renegotiated during the reporting period, it is not considered a reestablishment. If the nursing home is not an addition or reestablishment, leave the block blank.
3.	Alpha Code Within Medical Center for Item 2	Column 5. If this is a new or reestablished community nursing home (an "A" or an "R" was entered for item 2), then enter a letter in this block, starting with "A" and using a different alphabetic character for each addition or reestablished home during this reporting period. If item 2 was left blank (the home was not an addition or reestablishment during this period), leave

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item 3 blank also.

- |                                   |   |
|-----------------------------------|---|
| 4. Card Number                    | Column 6. The number "1" has been reprinted in this block. A second card will be necessary only if this home is an addition or reestablishment.   |
| 5. Medical District               | Columns 7-8. Enter the medical district number of the reporting medical center. If the number contains only one digit, enter a zero in the first block. Slash any zeros.  |
| 6. Name of Community Nursing Home | Columns 9-31. Enter the complete name of the nursing home starting with the left-most block. If the name is composed of two or more words, skip a block between each word. Abbreviations will be necessary for many of the names, (see list below) however, proper names should not be abbreviated. Where |

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abbreviations are used, it is not necessary to skip blocks between each word. The following standardized abbreviations will be used:

N - Nursing  
H - Home or Hospital  
C - Convalescent or Center  
R - Rest, Rehabilitation or Restorium  
S - Sanitarium  
G - Geriatric  
I - Incorporated  
SC - Senior Citizen  
HA - Home for the Aged

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Number                      Item                                      Coding Instructions

Examples:

New Haven Rest Home

```
+-----+  
|N|E|W| |H|A|V|E|N| |R|E|S|T| |H|O|M|E|  
+-----+
```

Two Rivers Extended Care Facility

```
+-----+  
|2| |R|I|V|E|R|S| |E|C|F|  
+-----+
```

Clearwater Nursing and Convalescent Center

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+-----+  
|B|O|O|N|E|V|I|L|L|E|  
+-----+

Pass Christian

+-----+  
|P|A|S|S| |C|H|R|I|S|T|I|A|N|  
+-----+

8. State Code Where  
Nursing Home is  
Located

Columns 47-48. Enter the two digit code for  
the State in which the nursing home is  
located. The codes to be used will be found  
in M-1, part I, appendix B.

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<u>Number</u>	<u>Item</u>	<u>Coding Instructions</u>
9.	County Where Nursing Home is located	Columns 49-51. Enter the three digit code for the county in which the nursing home is located. The codes to be used will be found in M-1, part I, appendix B.
10.	Level of Care	Column 52. This item refers to the level(s) of care provided by the nursing home, not to the level(s) of care for which the VA contracts. The letter "S" should be entered in this block if the nursing home provides only skilled nursing care. Enter the letter "I" if the home provides only intermediate level care. If the home provides both skilled and intermediate care, enter the letter "B."

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11. Number of Beds in Nursing Home
- Columns 53-58. Enter the number of beds in the nursing home designated for skilled nursing care (columns 53-55). Enter the number of beds designated for intermediate care (columns 56-58). If either number is less than three digits, prefix the number with a zero or zeros. If a home does not have any beds in one category, enter all zeros in the blocks for the category. If a home has both skilled and intermediate care beds but does not specifically designate the number of each, i.e., the beds are used interchangeably, then count all beds as skilled and enter slashed zeros under the number of intermediate beds (columns 56-58). However, the number of beds for each care category should at least equal the number of patients shown in that category

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(item 15). Slash all zeros.

Examples:

	+--+--+
96 beds	0 9 6
	+--+--+
8 beds	0 0 8
	+--+--+
135 beds	1 3 5
	+--+--+

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<u>Number</u>	<u>Item</u>	<u>Coding Instructions</u>
12.	Nursing Home Inspected or Accredited	Column 59. Enter the letter "I" in the block if the nursing home has been inspected by VA personnel. Enter the letter "A" in the block if the nursing home is accredited by the JCAHO. If the nursing home is accredited by the JCAHO, but also inspected by VA personnel, enter the letter "B."
13.	Per Diem Rate	Columns 60-65. Enter the per diem rate charged by the home for skilled care per the contract (columns 60-62). If the home does not provide skilled care or if the VA has no contract for theskilled level, enter zeros in the blocks. Enter the per diem rate charged by the nursing home for intermediate

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care per the contract (columns 63-65). If the home does not provide intermediate level of care, enter zeros in the blocks. Slash all zeros. The per diem rate should be rounded off to the nearest dollar.

Examples:

Rate:	\$45.50	+---+---+---+
		0   4   6
		+---+---+---+
Rate:	\$59.00	0   5   9
		+---+---+---+

14. Certified for  
Medicare/Medicaid

Column 66. Reference is made to certification for Medicare under Title XVIII and for Medicaid under Title XIX of the Social Security Act. The codes 1, 2, 3, and 4 will be used as follows:

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- 1 - Not certified for either Medicare or Medicaid
- 2 - Certified for Medicare only
- 3 - Certified for Medicaid only
- 4 - Certified for both Medicare and Medicaid

15. Number of Veterans

Columns 67-72. Enter the number of veterans in the Home Under VA in the contract home receiving skilled (columns 67-69) and/or intermediate care (columns 70-72) at VA expense on the last day of the reporting period. Precede number of less than three digits with zeros. If no veterans are receiving care at VA expense, enter zeros. Slash all zeros.

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Number

Item

Coding Instructions

Since the purpose of this entry is to indicate the actual usage of a given contract home for the care of veterans at VA expense, the contracting medical center should include all veterans in the home whose care is purchased by the VA, regardless of the source of VA payment, that is, which medical center is paying for it. This data should be available from the Social Work Service which provides follow-up to veterans in the home. Veterans in the home at their own or other non-VA expense are not to be included.

15a. Date of Last Columns 73-76. Enter the month (columns

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Assessment

73-74) and the year (columns 75-76) that the nursing home was last evaluated by either a partial or full VA team. Slash all zeros.

*NOTE: The second card will be necessary only if this home is an addition or reestablishment. If this is not an addition or reestablishment, items 16 through 18 can be left blank.*

- |     |                                |   |
|-----|--------------------------------|---|
| 16. | Identification Code            | If a second card is needed, the keypuncher will duplicate columns 1-5 from card 1.  |
| 17. | Card Number                    | The number 2 has been preprinted.   |
| 18. | Street Address of Nursing Home | Enter the street address of the nursing home in the blocks provided, starting with the left-most block. Leave an empty block between the numbers and the name. If the name consists of more than one word, leave an empty block between the words. Abbreviations may be used where appropriate. |

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Examples:

123 Old Church Road

```
+---+---+---+---+---+---+---+---+---+---+
|1|2|3| |O|L|D| |C|H|U|R|C|H| |R|D|
+---+---+---+---+---+---+---+---+---+---+
```

426 E. Main St.

```
+---+---+---+---+---+---+---+---+---+---+
|4|2|6| |E| |M|A|I|N| |S|T|
+---+---+---+---+---+---+---+---+---+---+
```

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