

1. Transmitted is a new part to the Department of Veterans Affairs, Veterans Health Administration Manual M-5, "Geriatrics and Extended Care," Part VIII, "State Veterans Homes," chapters 1 through 5.
2. Principal purposes are:
 - a. Chapter 1: General. Cites statutory authority, specifies responsibilities of VA Central Office and VA Health Care Facilities, and provides key program-definitions.
 - b. Chapter 2: Procedures and Standards. Provides procedures for obtaining recognition of a State home and establishes quality of care standards for hospital, nursing home, and domiciliary care.
 - c. Chapter 3: Inspection, Recognition, Muster, and Reports. Describes the composition of the inspection team and various requirements to be reviewed and reported on during the annual inspection cycle.
 - d. Chapter 4: Procedure for Approval of Beds Within A Recognized Home. Describes the procedure for obtaining approval of hospital, nursing home, or domiciliary care beds within a recognized home.
 - e. Chapter 5: Civil Rights. Describes procedure for assuring compliance with equal opportunity laws.
3. Filing Instructions

Remove Pages

Insert Pages

i through v
1-i through 1-4
2-i through 2-22
3-i through 3-4
4-i through 4-1
5-i through 5-1

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Department of
Veterans Affairs

STATE VETERANS HOMES

M-5, Part VIII

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

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The Department of Veterans Affairs, Veterans Health Administration Manual M-5, "Geriatrics and Extended Care," Part VIII, "State Veterans Homes," is published for the compliance of all concerned.

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FOREWORD

Following the Civil War, a number of the States established homes for the domiciliation of disabled soldiers and sailors. These were originally erected or acquired and operated entirely at State expense. The first enactment to provide for payment of Federal aid to States which maintained homes in which certain disabled soldiers and sailors in the United States received care was the Act of August 27, 1888.

Since that date, several major revisions in the State Home Program have resulted in passage of public laws to expand the base of payments to include hospital and nursing home care, and matching grants to States for the construction of new State homes and the remodeling and alteration of existing buildings for the provision of domiciliary, nursing home, or hospital care in State homes.

Currently, a State home is a home approved by the United States Department of Veterans Affairs which was established by a State primarily for veterans disabled by age, disease or otherwise, who by reason of such disability are incapable of earning a living. State homes include facilities for domiciliary and/or nursing home care. Hospital care may be included when provided in conjunction with domiciliary or nursing home care. A State home may also provide care to veteran related family members.

A State home is owned and operated by a State.

CONTENTS

CHAPTERS

1. GENERAL
2. PROCEDURE FOR OBTAINING RECOGNITION OF A STATE HOME AND APPLICABLE STANDARDS
3. INSPECTION, RECONCILIATION, MUSTER AND REPORTS
4. PROCEDURES FOR OBTAINING APPROVAL OF HOSPITAL, NURSING HOME, OR DOMICILIARY CARE BEDS WITHIN A RECOGNIZED HOME
5. CIVIL RIGHTS

CONTENTS

CHAPTER 1. GENERAL

PARAGRAPH	PAGE
1.01 Purpose	1-1
1.02 Authority	1-1
1.03 Responsibilities of VA Central Office	1-1
1.04 Responsibilities of Health Care Facilities	1-1
1.05 Definitions	1-2
1.06 Health Records	1-3

CHAPTER 1. GENERAL

1.01 PURPOSE

This contains standards of care, policies and procedures for recognition, inspection, reconciliation, muster, reports and civil rights.

1.02 AUTHORITY

Title 38 CFR (Code of Federal Regulations) 17.165 through 17.168 authorize VA (Department of Veterans Affairs) to make aid payments to States maintaining State Veterans' Home subject to the provisions of 38 CFR 18.1 through 18.13.

1.03 RESPONSIBILITIES OF VA CENTRAL OFFICE

a. The ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care (114B), VA Central Office, is responsible for all professional aspects and overall coordination of the State Veterans' Home Program including the processing of grants for construction of State home facilities.

b. Regional Directors are responsible for the overall operation of the program and work in collaboration with the ACMD for Geriatrics and Extended Care.

1.04 RESPONSIBILITIES OF VA HEALTH CARE FACILITIES

a. The VA health care facilities responsible for administering the State home program in their area of jurisdiction are shown in VHA (Veterans Health Administration) Manual, M-1, part I, chapter 3, appendix A.

b. The Chief, MAS (Medical Administration Service), at health care facilities is responsible for administrative aspects including:

- (1) Determination of eligibility,
- (2) Maintenance and reconciliation of records,
- (3) Review of claims for payment,
- (4) Compliance with VA Regulations, and
- (5) General coordination of the program.

c. A physician, designated by the VA medical center Director and/or Chief of Staff, is responsible for verifying levels of care and overseeing all clinical aspects of the annual inspection.

d. The Fiscal Service at health care facilities is responsible for accounting, auditing and certifying vouchers for payment. NOTE: For the purpose of verifying the computation of per diem rates used, a representative

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

of this service will be one of the members of the group making the annual inspection.

e. Directors of health care facilities having responsibility for State homes are responsible for developing close relationships with these facilities.

M-5, Part VIII
Chapter 1

November 4, 1992

1.05 DEFINITIONS

a. Veteran. The term "veteran" means a person who served in the active military, naval or air service, and who has been discharged or released from the service under conditions other than dishonorable.

b. State Home. "State home" means a home approved by VA which was established by a State primarily for veterans disabled by age, disease or otherwise, who by reason of such disability are incapable of earning a living.

(1) The term State home includes facilities for domiciliary and/or nursing home care. Hospital care may be included when provided in conjunction with domiciliary or nursing home care.

(2) For the purposes of this part, a home which furnishes different levels of care must provide care in clearly designated areas within the home so that patients receiving separate levels of care are not intermingled.

(3) A State home may also provide care to veteran related family members, i.e., spouses, surviving spouses and/or gold star parents who are not entitled to payment of VA aid. A State home will hereafter be referred to as a home or facility in this part.

c. Hospital Care. Hospital care means providing diagnosis and curative treatment and other medical care and services (as opposed to maintenance only) to inpatients suffering from a particular disability. These inpatients require the continuous services of a physician, with attendant diagnostic, therapeutic, and rehabilitative services. A hospital facility providing such care will be operated by or under the direct supervision of a physician.

d. Nursing Home Care. Nursing home care means the accommodations of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled or intermediate nursing care and related medical services. Such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care.

e. Domiciliary Care. Domiciliary care means providing shelter, food, and necessary medical care on an ambulatory self-care basis.

(1) It assists eligible veterans who are suffering from a disability, disease, or defect of such a degree that incapacitates the veterans from earning a living, but who are not in need of hospitalization or nursing care services.

(2) It assists in attaining physical, mental, and social well-being through special rehabilitative programs to restore patients to their highest level of functioning.

f. Administrator. Administrator means the officer (Superintendent or Commandant) in charge of the home.

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

g. Secretary. Secretary means the Secretary of the Department of Veterans Affairs.

h. VA Aid. VA aid means Federal aid payments made to a State for care of veterans in State homes under the provisions of VA Regulations 17.165 through 17.168.

M-5, Part VIII
Chapter 1

November 4, 1992

i. Income Limitations. Income limitations means the limitations on a State's eligibility to receive per diem payments for State domiciliary care. States may receive per diem payments for domiciliary care to a veteran only if a veterans's annual income does not exceed the maximum annual rate of pension payable to a veteran in need of aid and attendance or to any veteran whom the Secretary determines has no adequate means of support.

j. No Adequate means of support. In accordance with 38 CFR 17.48 (b)(2) no adequate means of support refers to an applicant:

(1) Who is receiving income above the annual rate of pension for a veteran in receipt of regular aid and attendance, as defined in 38 U.S.C. (United States Code) Section 1503.

(2) Who is able to demonstrate to the satisfaction of the VA medical center Chief of Staff, on the basis of objective evidence, that deficits in health and/or functional status render the veteran incapable of pursuing substantially gainful employment.

(3) Who is otherwise without the means to provide adequately for self, or to be provided for in the community.

1.06 HEALTH RECORDS

a. Hospital and Nursing Home Care

(1) Health records shall be maintained for hospital and nursing home levels of care. They will contain, at least:

(a) An admission-identification sheet,

(b) Admitting evaluation (including history, physical examination, diagnosis),

(c) Physician orders,

(d) Progress notes,

(e) Special reports (such as laboratory, X-ray, consultation), and

(f) A record of medications and treatments given.

(2) All information in the health record is confidential and will be disclosed in accordance with applicable law to authorized persons only.

(3) Health records shall be kept current, and on discharge or death of a veteran the attending physician will record a summary (progress note or formal summary form) of the patient's medical experience.

(4) Filing and retention of health records shall be in accordance with the State Law.

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

b. Domiciliary Care

(1) A health record for each patient shall be maintained and will contain:

(a) An identification sheet,

- (b) A medical history,
- (c) A report of an initial physical examination, and
- (d) Subsequent records of treatment and progress, including:

- 1. Medications,
- 2. Diets, and
- 3. Consultations.

(2) An annual reevaluation of the patient's health status should be conducted and recorded.

(3) These records will be kept confidential and preserved for a period of time not less than that determined by the statute of limitations of the State.

c. State Home Program - Patient Information Card

(1) VA medical centers of jurisdiction are required to maintain VA Form 10-3563, State Home Program - Patient Information Card, on each veteran in the program showing:

- (a) Patients' names,
- (b) Social Security Numbers,
- (c) Levels of care, and
- (d) Dates the patients entered the program and were discharged.

(2) Patients admitted for inpatient care to a VA medical center will have their patient information card properly annotated for their change of status. This shall include any veterans absent from the State home over 96 hours.

CONTENTS

CHAPTER 2. PROCEDURE FOR OBTAINING RECOGNITION OF A STATE
HOME AND APPLICABLE STANDARDS

PARAGRAPH	PAGE
2.01 Application	2-1
2.02 Recognition Inspection	2-1
2.03 Notice of Recognition	2-3
2.04 Additions or Enlargements	2-3
2.05 VA Form 10-3567, State Home Inspection Staffing Profile	2-3
2.06 VA Form 10-3567a, Standards for Hospital	2-4
2.07 VA Form 10-3567b, Standards for Nursing Home	2-11
2.08 VA Form 10-3567c, Standards for Domiciliary Care	2-18

CHAPTER 2. PROCEDURES FOR OBTAINING RECOGNITION OF A STATE
HOME AND APPLICABLE STANDARDS

2.01 APPLICATION

An authorized State official must write a letter to the CMD (Chief Medical Director) (114B), Department of Veterans Affairs, 810 Vermont Avenue, N.W., Washington, DC 20420, requesting an inspection for purposes of obtaining recognition of the home by the Secretary of Veterans Affairs. The letter of application will include the:

- a. Name;
- b. Location (address);
- c. Level of care for which approval is requested (nursing home and/or domiciliary care);
- d. Specific bed capacity of such care; and
- e. Title and address of the State agency designated to receive VA (Department of Veterans Affairs) payments.

2.02 RECOGNITION INSPECTION

a. Once the State official has requested recognition of a facility as a State veterans home, an inspection team will be appointed by the CMD to visit the facility and report on its acceptability as a home within the framework of the definition found in 38 CFR (Code of Federal Regulations) 17.165 through 17.168.

(1) The team will determine whether necessary requirements and standards are met for approval of nursing home and/or domiciliary care.

(2) Frequently, the State will have just completed construction of the facility and will not have admitted patients. In this case, the team will:

(a) Look at:

1. Operational plans,
2. Staffing patterns, and
3. Physical characteristics of the facility.

(b) Make a determination and recommendation whether or not the standards of care prescribed by VA can be met.

M-5, Part VIII
Chapter 1

November 4, 1992

(3) The team may wish to consider recommending a follow-up inspection within 6 months after patients have been admitted.

b. Accreditation by the JCAHO (Joint Commission on Accreditation of Healthcare Organizations) can be considered satisfactory evidence of compliance with VA standards for nursing home.

(1) At the discretion of the VA health care facility Director, the State nursing home may be exempted from the recognition inspection if:

M-5, Part VIII
Chapter 1

November 4, 1992

(a) The home provides satisfactory evidence of current accreditation by JCAHO, or

(b) Certification by Medicare/Medicaid, and

(c) All VA inspectors agree the home is in compliance with VA standards.

(2) If accepted, a copy of the JCAHO report or the Medicare/Medicaid reports will be sent to the Office of Geriatrics and Extended Care (114B), and the inspection team will mark and sign the appropriate VA inspection form for nursing home (VA Form 10-3567, State Home Inspection Staffing Profile, and VA Form 10-3567b, Standards for Nursing Homes) to indicate that the State is in compliance with VA standards.

(3) The domiciliary must be inspected using VA Form 10-3567 and VA Form 10-3567c, Standards for Domiciliary Care.

c. The following information will be requested from the State officials by the ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care (114B):

(1) A copy of legal and administrative action to establish the State operated facility.

(2) An executive summary of the plan of operation for the facility, including organizational charts.

(3) Certification from the responsible State agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) as incorporated in 38 CFR 18.400 series.

(4) Certification of compliance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352) as incorporated in 38 CFR 18.1 through 18.13. This includes:

(a) A list of the number of patients in each level of care indicating the minority designation as well as veteran or nonveteran status.

(b) A list of the staff by category indicating full-time, part-time, and minority designation.

(5) Certification of compliance with the Drug-Free Workplace Act of 1988 as defined incorporated in 38 CFR Part 44, Subpart F.

(6) Certification regarding lobbying in compliance with Public Law 101-121.

(7) A plot plan showing the location of the new home.

M-5, Part VIII
Chapter 1

November 4, 1992

d. Reinspection of the home will be conducted annually for compliance with VA standards of care.

(1) The VA health care facility Director will appoint an inspection team consisting of, at minimum, a physician, nurse, pharmacist, dietician, rehabilitation therapist, social worker, and one representative each from Medical Administration, Fiscal, Engineering, and Environmental Management Service.

(2) At the discretion of the VA health care facility Director, the State nursing home and/or hospital may be exempted from the annual inspection if:

(a) The home provides satisfactory evidence of current accreditation by JCAHO, or

M-5, Part VIII
Chapter 1

November 4, 1992

(b) Certification by Medicare/Medicaid, and

(c) All VA inspectors agree the home is in compliance with VA standards.

(3) If accepted, a copy of the JCAHO report or the Medicare/Medicaid reports will be sent to the Office of Geriatrics and Extended Care, and the inspection team will mark and sign the appropriate VA inspection form to indicate that the State is in compliance with VA standards.:

(a) For a hospital, VA Form 10-3567 and VA Form 10-3567a

(b) For a nursing home, VA Form 10-3567 and VA Form 3567b, and

(c) For a domiciliary, VA Form 10-3567 and VA Form 10-3567c.

(4) Reinspections must be accomplished annually.

2.03 NOTICE OF RECOGNITION

After completion of the initial inspection, the CMD will recommend appropriate action by the Secretary of Veterans Affairs by drafting a letter for the Secretary to send to the appropriate State official.

a. A copy of the letter of approval will be sent to the appropriate VA health care facility.

b. The Administrator of the home will be promptly contacted by an official of the VA health care facility to:

(1) Assist in establishing the eligibility of veterans in the home, and

(2) Provide instructions related to records, reports and procedures required for payment of VA aid.

c. VA may not pay claims for VA aid for care furnished prior to the date of the Secretary's notification of recognition of the facility as a State home. Payments may then be provided retroactively to the date of the initial inspection that resulted in a recommendation for approval, if concurred in by the Office of Geriatrics and Extended Care.

2.04 ADDITIONS OR ENLARGEMENTS

a. The procedures described in paragraph 2.02 will be followed by the State and VA in approving an annex, branch, enlargement, consolidation, merger, or expansion of an existing home if the buildings to be occupied by the veteran-patients are not a part of, nor on the immediate grounds of, the parent facility.

M-5, Part VIII
Chapter 1

November 4, 1992

b. The procedures described in paragraphs 4.01 through 4.03 will be followed if additions or enlargements are a part, or on the immediate grounds of the parent facility.

2.05 VA FORM 10-3567, STATE HOME INSPECTION STAFFING PROFILE

The staffing profile will be completed for hospital, nursing home, and/or domiciliary care as a component of the recognition inspection and annual reinspection. All parts of the staffing profile must be completed according to the instructions by the State home and reviewed by the inspection team at the time of the inspection.

M-5, Part VIII
Chapter 1

November 4, 1992

2.06 STANDARDS FOR HOSPITAL CARE

a. Governance and Operation. The hospital is governed and managed effectively.

(1) The hospital facility shall be licensed as a long-term or acute care hospital by the State, and shall comply with Federal, State, and local laws, rules and regulations for hospital care.

(2) The hospital has a governing body, or designated person so functioning, with full legal authority and responsibility for the operation of the facility.

(3) The hospital provides diagnosis and treatment for inpatients with medical, surgical, or psychiatric illnesses.

(4) Written administrative policies, procedures, and controls are established, implemented, and reviewed at least annually to promote the orderly and efficient management of the facility.

(5) Written personnel policies and procedures are established and implemented to facilitate sound patient care and personnel practices.

(6) Hospital and professional staff credentials and privileges are current, and a yearly review of these certificates is performed.

(7) There is evidence of input from all services to management by regular meetings and systematic reviews.

b. Safety and Environment. The hospital provides a safe and sanitary environment.

(1) There is a current State Fire Marshall's inspection certificate.

(2) There is a report by a qualified VA Safety Officer/Engineer certifying that the hospital is in compliance with the provisions of the Life Safety Code currently in force.

(3) There is evidence that any reported deficiencies are being or have been corrected.

(4) The hospital has available an emergency source of electrical power to provide essential service when the normal electrical supply is interrupted.

(5) Acceptable practices are employed in:

(a) Cleaning of the premises;

(b) Processing of clean and used supplies;

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

(c) Storage of chemicals, pesticides and soaps; and

(d) Handling and disposal of refuse.

(6) There is evidence of preventive maintenance of mechanical aids such as wheelchairs, litters, lifts, oxygen, suction, sterilizing and X-ray equipment used for patient care.

M-5, Part VIII
Chapter 1

November 4, 1992

(7) There is adequate space in the patient rooms and other treatment areas for unimpeded movement of patients and staff.

c. Infection Control. The hospital has a program for prevention of transmission of infection.

(1) There is an infection control committee which meets on a regular schedule established by the facility.

(2) Written policies and procedures are established for investigation, control, and prevention of infections.

(3) Procedures in isolation techniques are reviewed and revised annually.

(4) Regular review of the infection rate is documented.

(5) Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(6) The facility has an ongoing integrated program for pest management.

d. Medical Care. The hospital provides each patient with medical care which meets the standards of care in the community.

(1) A Medical Director, physician employed by the State home, is responsible for the overall patient care in the hospital.

(2) A specific physician is responsible for the overall medical care and coordination of the treatment of the patient. Adequate coverage is available in the planned or emergency absence of the primary physician. The treating physician is identified:

(a) On the patient's:

1. Medical chart,

2. Care plan,

3. Identification bracelet, and

4. Bed; and

(b) To the patient and family.

(3) There is evidence of input from the medical, surgical, and/or psychiatric professional services to management by regular meetings and systematic review.

(4) Patients are properly classified and in need of hospital care.

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

(5) The initial evaluation of each patient by a physician is recorded on the chart within 24 hours of admission, signed and dated.

(6) Rounds are made at least daily.

(7) Physician progress notes are made when there are significant changes in the patient, laboratory or treatment and periodically if the status is stable. All entries will have a legible signature.

M-5, Part VIII
Chapter 1

November 4, 1992

(8) Orders are timed and dated; verbal orders are signed by the physician within 48 hours.

(9) There are written agreements with one or more hospitals to provide specialty or complex care that is beyond the capability of the State home. Appropriate procedures for transfer include release of information and arrangement for transportation.

(10) Quality of care is evaluated by chart audit using outcomes as well as process audit. Continuing medical education is documented for all physicians.

e. Laboratory and Radiology Services. Laboratory and radiology services are available at all times for routine and emergency diagnostic procedures.

(1) The laboratory meets State and local standards and quality control of laboratory procedures is routine. Laboratory results are made available to the physician promptly.

(2) Radiology equipment is checked routinely for safety and necessary maintenance is performed. Radiographs are interpreted by a radiologist.

(3) Electrocardiograms are available, including provision for interpretations by a properly trained specialist.

f. Nursing Services. The hospital has an organized nursing staff under the direction of a licensed registered nurse, with adequate staffing to provide for the total nursing needs of all the patients 24 hours a day.

(1) The Director of Nursing Services is employed full-time and is responsible for:

(a) The development and maintenance of:

1. Nursing service objectives,
2. Standards of nursing practice,
3. Nursing policy and procedure manual,
4. Written job descriptions for all levels of nursing personnel, and
5. Nursing staff development.

(b) Recommending the number and levels of nursing personnel to be employed.

(2) There is at least one registered nurse on each tour of duty to plan, direct and supervise patient care, and other nursing personnel to assure adequate care to patients on all tours of duty.

M-5, Part VIII
Chapter 1

November 4, 1992

(3) There is a formal program for orientation, inservice education and training. Records are reviewed annually and maintained to reflect the:

- (a) Content,
- (b) Time,
- (c) Instructor(s),
- (d) Attendees, and

M-5, Part VIII
Chapter 1

November 4, 1992

- (e) Applicable pre-and post-test for each inservice activity.
- (4) A written care plan is maintained for each patient. The plans reflect:
 - (a) Patient goals,
 - (b) Functional abilities,
 - (c) Special nursing problems,
 - (d) Observable signs and symptoms in regard to medical treatment,
 - (e) Medication(s),
 - (f) Diet,
 - (g) Disease process,
 - (h) Possible complications, and
 - (i) Teaching and other instructions given to the patient and/or family member about the patient's program for health maintenance.
- (5) Rehabilitation nursing procedures are applied to help patients reach maximum potential. These include:
 - (a) Special demonstrations,
 - (b) Instruction,
 - (c) Supervision and evaluation of proper positioning and body alignment,
 - (d) Splinting,
 - (e) Ambulation,
 - (f) Transfers,
 - (g) Reality orientation,
 - (h) Remotivation, and
 - (i) Retraining in daily living activities.
- (6) Restraints and safety devices are used only on written approval by a physician. Procedures are in writing with reference to the types of restraints permitted as well as instructions for application and observation of patients in restraints.

M-5, Part VIII
Chapter 1

November 4, 1992

g. Rehabilitation Services. Rehabilitation services are provided to restore patients to their maximum function.

(1) Each patient has access to the necessary rehabilitation services, when indicated.

(2) Therapy is initiated by order of a physician. The prescribed mode of treatment, expected outcomes and goal achievement dates are reflected in the patient's treatment plan. A progress report is entered into the patients's medical record at least monthly by the person(s) providing the treatment.

M-5, Part VIII
Chapter 1

November 4, 1992

(3) Arrangements are made to provide the necessary services if they are not available in the hospital.

h. Social Services. Social Work Services are provided to assist in the adjustment of patients to the social and emotional aspects of illness.

(1) A qualified professional social worker is on the facility staff, or there is a written agreement with a qualified social worker consultant to provide routine and emergency social services.

(2) A social history is obtained on admission to the hospital and maintained in the patient's medical records. Discharge planning is initiated as soon as possible after admission to the hospital.

(3) The emotional and social needs of patients are identified. Treatment is provided in relation to medical, nursing and other health care needs during the period of hospitalization.

i. Dietetic Services. The hospital provides a hygienic dietary service that meets the daily nutritional needs of patients and ensures that special dietary needs are met.

(1) There is written evidence that a qualified dietitian who meets the requirements of the American Dietetic Association supervises the total food operation. Hospitals using a contract food management service must meet this requirement.

(2) Menus are planned in accordance with the RDA (recommended dietary allowances) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(3) Therapeutic diets are prescribed by a physician, are planned in writing and supervised by the dietitian.

(4) A current approved dietetic manual is available to physicians, nursing and dietetic service personnel.

(5) At least three meals or their equivalent are served at regular intervals, with no more than 14 hours between the evening meal and breakfast on the following day. Meals are attractive and appetizing.

(6) Records of planned meals are retained for no less than 6 months.

(7) There is evidence that food is prepared, served and stored under sanitary conditions.

(8) A 2-day perishable food supply and a 7-day nonperishable food supply are on hand for emergencies.

M-5, Part VIII
Chapter 1

November 4, 1992

(9) There is evidence of compliance with Federal, State and local regulations regarding safe and sanitary management of food services and food handlers. Required permits are current and posted.

(10) There are written procedures for:

(a) Sanitary maintenance of work areas,

(b) Dishwashing,

M-5, Part VIII
Chapter 1

November 4, 1992

(c) Cleaning of equipment, and

(d) Proper waste disposal.

(11) Complaints about foods are documented and remedial action is taken if appropriate.

j. Medical Records. The medical records are maintained in accordance with professional standards. These will be organized, legible and sufficiently current for routine use.

(1) The medical record includes:

(a) Patient identification,

(b) The physician's name,

(c) Medical history and physical examination,

(d) Diagnosis,

(e) Treatment goal and plan,

(f) Physician orders,

(g) Progress notes,

(h) Nursing notes,

(i) Medication and treatment record,

(j) Laboratory and X-ray reports,

(k) Consultation reports,

(l) Report of auxiliary or allied health personnel,

(m) Social service summaries,

(n) Final diagnosis,

(o) Discharge plan, and

(p) Follow-up summary.

(2) Originals of laboratory and X-ray reports are filed in the medical record.

M-5, Part VIII
Chapter 1

November 4, 1992

(3) Summaries are prepared at the time of discharge and are filed in the medical record within 15 days.

(4) Storage and disposal of inactive records are in compliance with State law.

k. Pharmaceutical Services. Pharmaceutical services are provided in accordance with professional standards.

(1) A registered pharmacist, who either is employed by the facility or provides consultation services under written agreement with the facility, is responsible for pharmacy service.

(2) Written policies and procedures are established for procuring, storing, dispensing and administering drugs and for disposal of outdated and discontinued drugs.

(3) There is controlled access to all drugs and substances used for treatment. Controlled substances are secured, stored and accounted for in compliance with Drug Enforcement Administration regulations.

(4) Written procedures are established for direct administration of drugs to patients. The person who prepares the medication administers it and records it in the patient's medical record. Errors are reported and recorded, and treatment initiated in accordance with procedures.

(5) Emergency medication kits are approved by the medical staff, are replaced immediately after use, and checked at reasonable intervals.

1. Utilization Review. The hospital provides an effective utilization review program.

(1) The facility has a written, currently applicable utilization review plan approved by the governing body, medical director, and organized medical staff.

(2) Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(3) The administrative staff is kept directly and fully informed of utilization review committee activities to facilitate support and assistance.

(4) Written records of utilization review activities are maintained at the facility.

(5) The facility maintains a centralized, coordinated program to ensure that each patient has a planned program of continuing care which meets post discharge needs.

m. Quality Assurance Program. The hospital has a quality assurance program to ensure the effective delivery of patient care within available resources and consistent with achievable goals.

(1) A committee, group, or individual is responsible for administering or coordinating the quality assurance program.

(2) There is a planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality of care in the hospital.

(3) Clinically valid criteria are used in assessment of problems which may address the structure, process, or outcome of care.

(4) When problems are identified, appropriate action is taken to correct them.

(5) Results of quality assurance activities are routinely reported to the professional staff, chief executive officer, and the governing body.

(6) The quality assurance program is reevaluated at least annually.

n. Patient Rights. The management of the hospital assures that the rights of patients are protected.

(1) There is compliance with the Federal Privacy Act of 1974 (Public Law 93-579).

(2) Patients are accorded privacy in their rooms and personal care areas.

(3) Patients are permitted to voice grievances with impunity.

(4) The hospital policies and procedures describe the mechanisms by which patient rights are protected and exercised. (Patient Self Determination Act of 1991).

2.07 VA FORM 10-3567b, STANDARDS FOR NURSING HOME CARE

a. Governance and Administration. The facility shall be governed and managed effectively.

(1) The facility shall have a governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility.

(2) The facility shall be in compliance with applicable Federal, State, and local laws and regulations. The facility shall be licensed as a nursing home by the State and shall, at least, fully meet the same standards established for licensing all nursing homes in the State. Nursing home and professional staff licenses are current, and a yearly review of these certificates is performed.

(3) There is a full-time administrator qualified by training and experience for the proper discharge of delegated responsibilities. If required by State or local law, the administrator is to be currently licensed as a nursing home administrator by the State in which the administrator is practicing.

(4) Written administrative policies, procedures, and controls are established, implemented, and reviewed at least annually to promote the orderly and efficient management of the facility.

(5) Written personnel policies and procedures are established and implemented to facilitate sound patient care personnel practices.

(6) There is evidence of input from all services to management by regular meetings and systematic reviews.

b. Safety. The home shall be structurally safe, equipped, and maintained to protect the health and safety of patients, personnel, and visitors.

(1) The facility has a current State Fire Marshall's certificate.

(2) The home has a current report by a qualified VA Life Safety engineer that the facility is in compliance with the provisions of the Life Safety Code currently in force, applicable to nursing homes.

(3) There is evidence that reported life safety deficiencies have been or are being corrected in an appropriate time frame.

(4) The home has available an emergency source of electrical power to provide essential service when the normal electrical supply is interrupted.

(5) The home has a functioning nurse-call system which is easily accessible to immobilized patients.

(6) Space is adequate for the particular function or service activity performed.

(7) Essential mechanical, electrical, and patient care equipment is checked routinely and replaced as necessary for patient safety.

(8) Corridors in patient areas are equipped with firmly secured handrails on each side.

c. Environment. The home provides a functional, aesthetically pleasing, sanitary, and comfortable environment for patients, personnel and visitors.

(1) The facility employs a full-time supervisor of sanitation with sufficiently trained personnel to maintain a safe, clean, and orderly environment.

(2) Acceptable practices are employed by the home for proper maintenance and repair of equipment, building, and grounds.

(3) Lighting levels are appropriate and comfortable in all areas of the home.

(4) Ventilation is provided through windows or mechanical means or a combination of both.

(5) There is a directional/information signage system in the home.

d. Infection Control. The facility has a program for prevention of transmission of infection.

(1) There is an Infection Control Committee which meets on a regular schedule established by the facility.

(2) Written policies and procedures are established for investigation, control, and prevention of infections.

(3) Procedures in isolation techniques are reviewed and revised annually.

(4) Regular review of the infection rate is documented.

(5) Linens are handled, stored, processed and transported in such a manner as to prevent the spread of infection.

(6) The facility has an ongoing integrated program for pest management.

e. Medical Care. The home assures the availability of regular and emergency medical care.

(1) A Medical Director, physician employed by the State home, is responsible for medical care in the home to ensure the adequacy and appropriateness of the medical services provided to patients.

(2) Each patient is designated to a primary physician who is responsible for overall medical care.

(3) There are written agreements with one or more hospitals to provide routine and emergency treatment and/or diagnostic services that the home does not provide.

(4) Procedures for transfer of patients to community facilities are in writing.

(5) The facility provides allied health services as needed.

f. Nursing Service. The facility maintains an organized Nursing Service with a sufficient number of qualified nursing personnel to meet the total nursing care needs of all patients within the facility 24 hours a day.

(1) The nursing service is under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the Nursing Service staff.

(2) A registered nurse is designated as supervising nurse by the Director of Nursing Service for each tour of duty.

(3) The facility provides 24-hour nursing services which are sufficient to meet total nursing care needs of all patients.

(4) Patients are classified according to nursing care required.

(5) In coordination with the other patient care services to be provided, a written care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care.

(6) The home has ongoing staff development program for all levels of nursing personnel.

(7) The facility has an active program of rehabilitation nursing care which is an integral part of Nursing Service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence.

(8) Nursing personnel are aware of the nutritional needs of the patients and observe the food and fluid intake to ensure it is consistent with diets prescribed by the physician.

(9) State certified medication technicians are under the supervision of a registered nurse.

g. Rehabilitation. Specialized rehabilitation services are provided as needed to patients to improve and maintain maximum functioning.

(1) The facility provides, or arranges for, under a written agreement, specialized rehabilitation services by qualified personnel.

(2) Rehabilitation services are provided under a written plan of care for each patient.

(3) Information recorded in the patient's record include:

- (a) The physician's order,
- (b) The plan of rehabilitation care,
- (c) The services rendered,
- (d) The evaluations of progress, and
- (e) Other pertinent information.

h. Social Services. The facility assures the availability of social services to identify and meet the social and emotional needs of all patients.

(1) The facility assures the provision of social services.

(2) A qualified social worker is on the staff or the home has a written agreement with a qualified social worker or recognized social agency for consultation on a regular scheduled basis.

(3) A written psychosocial assessment is maintained in each patient's medical record.

(4) Results of social services rendered are documented in the patient's medical record.

(5) The facility has an organized discharge planning program in operation.

(6) Policies and procedures are established to protect the confidentiality of social service records.

i. Patient Activities. The facility provides for a patient activities program, appropriate to the needs and interests of each patient to encourage self-care, resumption of normal activities, and maintenance of optimal level of psychosocial functioning and contact with the environment.

(1) A member of the facility's staff is designated as responsible for the patient activities program.

(2) Space designated for the activities program is adequate for individual and/or group activities.

(3) Each patient's activity plan is a part of the overall plan of care.

M-5, Part VIII
Chapter 1

November 4, 1992

(4) There is provision for spiritual counseling by clergy of various denominations. Space is provided on the premises for religious services and patients are permitted to attend religious activities in the community.

j. Dietetics. The facility provides a Dietetic Service that meets the daily nutritional needs of patients and ensures that special dietary needs are met.

(1) The Dietetic Service is under the direction of a qualified dietitian.

M-5, Part VIII
Chapter 1

November 4, 1992

(2) The treatment plan reflects an ongoing nutritional assessment and care plan for each patient.

(3) Menus, to the extent medically possible, are planned in accordance with the RDA (Recommended Dietary Allowances) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(4) Diets are prescribed by the attending physician.

(5) At least three or more regular meals are served daily, with not more than a 14-hour span between substantial evening meal and breakfast.

(6) Dietetic Service personnel practice safe and sanitary food-handling techniques.

(7) Food processing and distribution meet sanitation and safety requirements of Federal, State, and local authorities.

(8) Dining areas are large enough to accommodate patients who are able to eat outside their rooms.

k. Medical Records. The facility maintains medical records on all patients in accordance with accepted professional standards and practices.

(1) The Medical Record Service has sufficient staff, facilities, and equipment to provide medical records that are:

(a) Completely and accurately documented,

(b) Readily accessible, and

(c) Systematically organized to facilitate retrieving and compiling information.

(2) The facility safeguards medical record information against loss, destruction, or unauthorized use.

(3) The medical record contains sufficient information to clearly identify the patient.

(4) Only physicians enter or authenticate in medical records opinions that require medical judgment in accordance with medical staff by laws, rules, and regulations, if applicable.

(5) Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient's stay is centralized in the patient's medical record.

M-5, Part VIII
Chapter 1

November 4, 1992

(6) The facility has written procedures for the filing, retention, and disposal of medical records which, when applicable, complies with State laws and regulations.

(7) Patient's medical records are indexed according to name of patient and final diagnosis to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(8) The facility maintains storage space and equipment, conveniently located, to provide efficient processing of medical records, such as:

M-5, Part VIII
Chapter 1

November 4, 1992

- (a) Reviewing,
- (b) Indexing,
- (c) Filing, and
- (d) Prompt retrieval.

1. Pharmaceutical Services. Pharmaceutical services meet the needs of patients and are provided in accordance with ethical and professional practices and legal requirements.

(1) A registered pharmacist, who either is employed by the facility or provides consultation services under written agreement with the facility, is responsible for pharmacy services.

(2) Written policies and procedures are established for pharmaceutical services.

(3) Written procedures are established for direct administration of drugs to patients.

(4) There is controlled access to all drugs and substances used for treatment.

(5) The facility provides an emergency medication kit.

(6) The labeling of drugs and biologicals is based on currently accepted professional principles.

(7) A Pharmaceutical Services Committee, or its equivalent, develops written policies and procedures for safe and effective drug therapy, distribution, control, and use.

(8) There is an established schedule for Pharmaceutical Service to make rounds and review charts for drug utilization.

(9) There is an established system for disseminating drug information to medical and nursing staff.

(10) There is an established system for monitoring the outcome of drug therapy or treatment.

m. Utilization Review. The facility conducts an utilization review to maintain high quality patient care and assure the appropriate and efficient use of facility services.

M-5, Part VIII
Chapter 1

November 4, 1992

(1) The facility has a written, currently applicable utilization review plan approved by the governing body, Medical Director, and organized medical staff.

(2) Medical care evaluation studies are performed to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(3) Periodic reviews is made of each current inpatient to determine if further inpatient stay is necessary.

(4) The administrative staff is kept directly and fully informed of Utilization Review Committee activities to facilitate support and assistance.

(5) Written records of utilization review activities are maintained at the facility.

(6) The facility maintains a centralized, coordinated program to ensure that each patient has a planned program of continuing care which meets his/her post discharge needs.

n. Quality Assurance. The facility has a Quality Assurance Program to ensure the effective delivery of patient care within available resources and consistent with achievable goals.

(1) A committee, group, or individual is responsible for administering or coordinating the Quality Assurance Program.

(2) Clinically valid criteria are used in assessment of problems which may address the structure, process, or outcome of care.

(3) When problems are identified, appropriate action is taken to correct them.

(4) Results of quality assurance activities are routinely reported to the:

(a) Professional staff,

(b) Chief executive officer, and

(c) the governing body.

(5) The Quality Assurance Program is reevaluated at least annually.

o. Quality of Life. The patient's quality of life is enhanced by the nursing home environment.

(1) Patients are fully informed of their medical condition and may participate in planning the treatment program.

(2) Procedures are established to allow patients to voice grievances and recommend changes in policies and services to the staff or outside representatives.

(3) Patients may manage personal financial affairs, or are given an accounting as required by State law, of financial transactions made in their behalf.

(4) Patients are treated with respect and dignity.

November 4, 1992

M-5, Part VIII
Chapter 1

M-5, Part VIII
Chapter 1

November 4, 1992

(5) There is an active resident council with elected officers. The council regularly communicates with management concerning patient needs and concerns.

(6) Architectural barriers to patient activities have been minimized.

(7) There is adaptive equipment and special furniture which facilitates independent functioning by the patients as required.

2.08 VA FORM 10-3567c, STANDARDS FOR DOMICILIARY CARE

a. Governance and Administration. The facility is governed and managed effectively.

(1) The facility has a governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility.

(2) Written administrative policies, procedures, and controls are established, implemented and reviewed at least annually to promote the orderly and efficient management of the facility.

(3) There are sufficient, knowledgeable administrative and clinical staff assigned to provide quality care within the domiciliary.

(4) Written personnel policies and procedures are established and implemented to facilitate sound patient care and personnel policies.

(5) The facility has an ongoing staff development program including orientation of new employees and inservice education related to the needs and care of domiciliary patients.

(6) There is evidence of input from all services to management by regular meetings and systematic review of the domiciliary program.

b. Safety. The facility shall be structurally safe and maintained to protect the health and safety of patients, personnel, and visitors.

(1) The facility has a current State Fire Marshall's certificate.

(2) The facility has a current report by a qualified VA Life Safety engineer or specialist that the facility is in compliance with the provisions of the Life Safety Code currently in force, applicable to domiciliaries.

(3) There is evidence that reported life safety deficiencies have been or are being corrected in an appropriate time frame.

(4) The facility has available an emergency service of electrical power to provide essential service when the normal electrical supply is interrupted.

(5) The buildings are accessible to and safe for persons with handicaps.

(6) The facility has a program for prevention and control of infection.

(7) Linens are handled, stored, processed, and transported in such a manner as to maintain a clean environment and prevent infection.

(8) The facility has an ongoing program of integrated pest management.

(9) Cleaning agents, maintenance supplies, and pesticides are stored under safe and sanitary conditions.

c. Physical Environment. The facility provides a functional, aesthetically pleasing, sanitary, and comfortable environment for patients, personnel, and visitors.

(1) The facility employs a supervisor of sanitation and sufficiently trained personnel to maintain a safe, clean, and orderly environment.

(2) The buildings are maintained in a clean, attractive, and comfortable manner.

(3) Acceptable practices are employed for maintenance and repair of equipment, buildings, and grounds.

d. Medical care. There is comprehensive ambulatory medical care program designed to meet the needs of domiciliary patients.

(1) The facility ensures the provision of professional medical services for the patients.

(2) Each patient has a primary physician responsible for medical care.

(3) Patients are classified in the domiciliary according to the level of supervision required.

(4) A patient treatment plan is established and maintained for each domiciliary patient.

(5) Primary care medical services are provided for domiciliary patients as needed.

(6) Each patient has a complete medical reevaluation annually and as needed.

(7) There is provision made for preventive and maintenance dental and other health services.

(8) Transportation is available for patients needing medical, dental, and other health services.

(9) Domiciliary patients are admitted to an infirmary when necessary.

(10) There is a written agreement with one or more hospitals to accept a patient requiring hospitalization.

(11) Domiciliary patients are admitted to nursing home care or hospital care if medically necessary.

e. Nursing Care. The facility maintains an organized nursing service with nursing personnel qualified to meet the nursing care needs of the domiciliary patient.

M-5, Part VIII
Chapter 1

November 4, 1992

(1) A full-time qualified registered nurse is responsible for the nursing service provided the patients.

(2) Primary care nursing services are provided for domiciliary patients.

(3) Nursing services rendered are documented in the patient's medical record.

(4) Nursing service participates in the establishment and maintenance of a treatment plan for each domiciliary patient.

(5) The facility provides for 24-hour nursing services as required to meet the nursing care needs of the domiciliary patients.

f. Rehabilitation. Rehabilitation services are provided, as needed, to improve and maintain maximum functioning of each domiciliary patient.

(1) The facility provides, or arranges for under a written agreement, rehabilitation services for patients, as needed.

(2) Rehabilitation services are provided under a written plan of care for each patient.

(3) Specialized rehabilitation therapy rendered, progress notes, and evaluation of treatment plan are recorded in the patient's medical record.

g. Social Services. The facility provides professional social work services to identify and meet the social and emotional needs of patients.

(1) A qualified social worker is on the staff, or the facility has a written agreement with a qualified social worker or recognized social agency, for consultation on a regularly scheduled basis.

(2) A written psychosocial assessment is maintained in each patient's medical record.

(3) Results of social services rendered are documented in the patient's medical record.

(4) The facility has an organized procedure for discharge and transfers.

h. Dietetics. The facility provides a Dietetic Service that meets the daily nutritional needs of patients and ensures that special dietary needs are met.

(1) The Dietetic Service is under the direction of a qualified dietitian or a full-time dietetic service supervisor with consultation from a qualified dietitian.

(2) Menus, to the extent medically possible, are planned in accordance with the RDA (Recommended Daily Allowance) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(3) Special diets are available as needed.

(4) At least three or more regular meals are served daily, with not more than a 14-hour span between substantial evening meal and breakfast.

(5) Dietetic service personnel practice safe and sanitary food-handling techniques.

(6) Dining areas are large enough to accommodate all domiciliary patients.

(7) The nutritional status of each patient is monitored on a regular basis.

i. Patient Activities. An activities program is available to the domiciliary patients and designed to enhance each patient's sense of physical, psychosocial, and spiritual well-being.

M-5, Part VIII
Chapter 1

November 4, 1992

(1) A member of the facility's staff is designated as responsible for the patient activities program.

(2) Space, equipment, and supplies for the activities program are adequate for individual and/or group activities.

(3) There are regularly scheduled activities during weekdays, evenings, and weekends.

(4) Each patient's activity plan is a part of the overall treatment plan.

(5) Religious services and spiritual activities are provided for patients.

(6) Domiciliary patients are encouraged to participate in supervised community activities.

j. Pharmacy. Pharmaceutical services meet the needs of patients, and are provided in accordance with ethical and professional practices and legal requirements.

(1) A registered pharmacist, who either is employed by the facility or provides consultation services under written agreement with the facility, is responsible for pharmacy services.

(2) A program is established for the safe procurement, control, and distribution of drugs.

(3) There is controlled access to all drugs and substances used for treatment.

(4) Patients on self-medication are instructed by qualified personnel on the proper use of drugs.

(5) Provision is made for qualified nursing personnel to administer medication to patients who are not in a self-medication program.

(6) There is an established system for monitoring the outcome of drug therapy or treatment.

k. Medical Records. The patient's health status is documented regularly in the medical record in accordance with the treatment plan.

(1) Medical records are completely legible and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(2) The facility safeguards medical record information against loss, destruction, or unauthorized use.

(3) The medical record contains sufficient information to clearly identify the patient.

1. Quality Assurance. The facility has an active quality assurance program in the domiciliary to ensure effective utilization and delivery of patient care services.

(1) A member of the facility's staff or facility committee is designated as responsible for coordinating the quality assurance program.

(2) The quality assurance program encompasses reviews of all services and programs provided for the domiciliary patients.

(3) The quality assurance program encompasses ongoing utilization review.

(4) The quality assurance program is reevaluated at least annually.

m. Quality of Life. The domiciliary level of care fosters a quality of life conducive to self esteem, security, and personal growth.

(1) Patients are treated with respect and dignity.

(2) There is input to the domiciliary program through a patient advisory council.

(3) A homelike environment is provided.

(4) The facility has written policies and procedures concerning the rights and responsibilities of the domiciliary patient.

(5) Patients are oriented to the policies and procedures concerning the rights and responsibilities of the domiciliary patient.

(6) Patients may manage personal financial affairs or are given an accounting as required by State law, of financial transactions made on the patient's behalf.

CONTENTS

CHAPTER 3. INSPECTION, RECONCILIATION, MUSTER AND REPORTS

PARAGRAPH	PAGE
3.01 Inspection	3-1
3.02 Reconciliation of Records	3-2
3.03 Muster	3-3
3.04 Corrective Action	3-3
3.05 Recurring Report	3-4

CHAPTER 3. INSPECTION, RECONCILIATION, MUSTER AND REPORTS

3.01 INSPECTION

a. In accordance with the provisions of 38 U.S.C. (United States Code) 1742 and 38 CFR (Code of Federal Regulations) 17.167, an annual inspection, audit and reconciliation of records will be conducted to assure that the minimum standards of care as prescribed by the VA (Department of Veterans Affairs) are met.

(1) The annual inspection and audit of each home will be conducted by appropriate VA personnel on a mutually agreeable date arranged by the Chief, MAS (Medical Administration Service) with the Administrator of the State Veterans' Home.

(2) As a minimum, the team appointed by the VA health care facility Director, will consist of:

(a) A physician, who will be responsible for verifying levels of care and overseeing all clinical aspects of the annual inspection;

(b) A nurse;

(c) A pharmacist;

(d) A dietitian;

(e) A rehabilitation therapist;

(f) A social worker, and

(g) Representatives from:

1. MAS,

2. Fiscal Service,

3. Engineering Service, and

4. Environmental Management Service.

(3) The inspection will include:

(a) The physical plant,

(b) Admissions,

(c) Discharges,

(d) A reconciliation of records,

(e) A muster,

November 4, 1992

M-5, Part VIII
Chapter 3

M-5, Part VIII
Chapter 3

November 4, 1992

(f) Fiscal records, and

(g) A review of evidence of compliance with standards of care and applicable laws and regulation, e.g., 38 CFR 17.165-17.168, and 38 CFR 18.1-18.13.

M-5, Part VIII
Chapter 3

November 4, 1992

(4) Additional musters and inspections will be made whenever considered necessary by the Director of the VA health care facility or ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care.

b. The VA health care facility Director will designate a coordinator for the State home inspection.

(1) The coordinator's responsibility is to:

(a) Meet with all members of the inspection team;

(b) Review the inspection process;

(c) Review previous years inspection reports, and inform the team of any changes that have been made since the last inspection;

(d) Assemble the final inspection report;

(e) Resolve any inconsistencies, and

(f) Obtain signed concurrences for the completed report from all inspection team members before the VA health care facility Director signs and transmits the report to the State veterans' home.

(2) All inspection team members should review the video on the inspection process prior to the inspection.

c. In reviewing State homes under the provisions of this paragraph, VA personnel are instructed to observe the quality of care provided and measure it against the standards of care as prescribed in M-5, part VIII, paragraphs 2.05 through 2.08.

(1) The VA Form 10-3567, State Home Inspection Staffing Profile, with applicable attachments (i.e., domiciliary, nursing home, and/or hospital) will be prepared to record the results of the inspection and compliance with applicable standards and regulations.

(2) Any deficiencies should be clearly indicated, with explanatory statements indicating any adverse impact upon patient care and recommendations for corrective action to achieve compliance.

d. The authority to inspect carries with it no authority over the management or control of any home.

3.02 RECONCILIATION OF RECORDS

a. The control cards in the active file of the VA facility will be checked against the home's records.

(1) The computation of days of care for at least a 12-month period, as reported on line 10 of VA Form 10-5588, State Home Report and Statement of Federal Aid Claimed, will be verified.

November 4, 1992

M-5, Part VIII
Chapter 3

M-5, Part VIII
Chapter 3

November 4, 1992

(2) A complete review of the records since the last reconciliation will be made if significant discrepancies are found. NOTE: The VA facility staff responsible for verification of records should be trained in and knowledgeable of State home operations.

M-5, Part VIII
Chapter 3

November 4, 1992

b. The fiscal representative will verify, at least annually, the computation of per diem rates and authorized expense items.

(1) Records of collections by the State from patients or other sources on their behalf, will be audited to assure compliance with M-1, part I, paragraph 3.10c.

(2) The fiscal representative will also obtain annually the signed verification from the Administrator, if there is a fund as described in M-1, part I, paragraph 3.10d.

3.03 MUSTER

a. To assure that veterans for whom the State is receiving VA aid are actually present, a muster will be conducted of a 10 percent sample but not fewer than 20 patients.

b. The sample will be made by random selection of one card from among the first 10 in the active file and every 10th card thereafter. The selection process will be repeated until a minimum of 20 cards has been selected. All patients will be mustered in homes with an average load of fewer than 20.

c. No substitutions will be made for names selected nor will names be revealed to State officials prior to muster.

(1) A positive accounting must be made of each patient on the list.

(2) Authorized absences will be accounted for by home's absence records.

3.04 CORRECTIVE ACTION

a. After approval by the VA health care facility director, the inspection report should be sent to the State home and to the Office of Geriatrics and Extended Care (114B) no later than 15 workdays after the inspection has been performed.

(1) A plan of correction for the home shall be requested for any cited deficiencies that cannot be corrected within 30 days from the date of the annual inspection. The plan for corrective action shall be submitted to the VA facility of jurisdiction 10 workdays after the inspection report is received by the State home.

(2) The Director of the VA facility of jurisdiction, on review of the plan, will assure that the standards prescribed by the VA are met within a reasonable period of time. A follow-up inspection may be required.

(3) The facility of jurisdiction will forward one copy of the home's plan of corrective action to the Office of Geriatrics and Extended Care (114B) within 30 workdays from the date of the inspection.

November 4, 1992

M-5, Part VIII
Chapter 3

M-5, Part VIII
Chapter 3

November 4, 1992

(4) Six months from the date of inspection visit, the facility of jurisdiction will provide a status report related to any cited deficiency and a follow-up plan for any deficiency not corrected by that date to the Office of Geriatrics and Extended Care (114B).

(5) The facility of jurisdiction will provide regular reviews of partially met and/or not met standards until the deficiency is corrected.

b. If there is no evidence of satisfactory progress toward correction, appropriate action by the Director of the VA health care facility will be initiated with concurrence of the ACMD for Geriatrics and Extended Care. The Secretary of Veterans Affairs may approve action which includes withholding of funds or withdrawal of recognition, pending compliance.

3.05 RECURRING REPORT (RCS exempt)

After approval by the Director, the original VA Form 10-3567 with applicable attachments will be filed at the VA facility of jurisdiction.

a. One copy will be furnished to the Administrator of the State home and a copy forwarded to the ACMD for Geriatrics and Extended Care (114B).

b. If the results of the fiscal audit, muster, and reconciliation of records meet VA requirements, a certification to that effect should be forwarded to the ACMD for Geriatrics and Extended Care in lieu of the complete reports. NOTE: Only unusual findings should be reported to VA Central Office; however, necessary records and evidence to support the certification will be retained at the facility of jurisdiction.

CONTENTS

CHAPTER 4. PROCEDURES FOR OBTAINING APPROVAL OF HOSPITAL, NURSING
HOME, OR DOMICILIARY CARE BEDS WITHIN A RECOGNIZED HOME

PARAGRAPH	PAGE
4.01 Application and Inspection	4-1
4.02 Notice of Approval	4-1
4.03 Notice of Disapproval	4-1

CHAPTER 4. PROCEDURES FOR OBTAINING APPROVAL OF HOSPITAL, NURSING
HOME, OR DOMICILIARY CARE BEDS WITHIN A RECOGNIZED HOME

4.01 APPLICATION AND INSPECTION

Homes furnishing care to veterans and desiring to receive VA (Department of Veterans Affairs) aid for levels of care not previously authorized, or for changes in current operating and/or authorized bed capacities will notify the VA health care facility of jurisdiction. The Director of the VA health care facility will arrange for an inspection of the home by appropriate personnel at the earliest mutually agreeable date, to determine whether the levels of care fall within the definition of domiciliary, nursing home, or hospital care and whether the VA standards of care for that level are met.

4.02 NOTICE OF APPROVAL

a. If it is determined that all VA standards and requirements are met and the request for a change in the number of authorized beds will involve an increase and/or decrease in census for specific levels of care, but does not require additional funding, the VA health care facility will forward a letter of approval to the home containing the number of beds authorized for per diem payment for each level of care and the effective date of approval with a copy to the ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care.

b. If the request for changes in the number of authorized beds involves an increase and/or decrease in census for the levels of care provided, and requires additional funds, and requirements and standards are met, the VA facility will send a written recommendation through the Regional Director for approval by the ACMD for the Office of Geriatrics and Extended Care. When approval is received, the VA facility will then forward a letter of approval to the home as indicated. Requests for changes that require additional funds should be made in the Federal Fiscal Year prior to activating beds which result in an increase in census.

4.03 NOTICE OF DISAPPROVAL

Homes which fail to meet the necessary requirements and standards of care will be advised by letter of reasons for disapproval. Copies of the letter and related correspondence will be forwarded to the ACMD for Geriatrics and Extended Care.

CONTENTS

CHAPTER 5. CIVIL RIGHTS

PARAGRAPH	PAGE
5.01 Discrimination Prohibited	5-1
5.02 Responsibility	5-1

CHAPTER 5. CIVIL RIGHTS

5.01 DISCRIMINATION PROHIBITED

VA (Department of Veterans Affairs) aid, as provided in M-1, part I, chapter 3, paragraphs 3.05 through 3.14, will not be paid unless there is compliance with the provisions of 38 CFR (Code of Federal Regulations) Part 18, Subparts A, D, and E, prohibiting discrimination on the bases of race, color, national origin, handicap, or age.

5.02 RESPONSIBILITY

a. The Secretary, Department of Health and Human Service, has agreed to assume the responsibilities of VA under 38 CFR Section 18.4, Section 18.6, and Section 18.7.

(1) Under this arrangement the Department of Health and Human Services will:

- (a) Make periodic compliance reviews of State homes,
- (b) Receive complaints, and
- (c) Conduct investigations.

(2) The VA specifically reserved for itself the responsibilities for the effectuation of compliance under 38 CFR Section 18.8, "Procedure for Effecting Compliance;" Section 18.9, "Hearing," and Section 18.10, "Decisions and Notices."

b. VA Facilities will promptly forward any information on possible violations of 38 CFR Part 18 to the ACMD (Assistant Chief Medical Director) for Geriatrics and Extended Care. Such information will be then forwarded to the Secretary, Department of Health and Human Services.

c. The ACMD for Geriatrics and Extended Care will obtain from each new State home, VA Form 27-8206, Statement of Assurance of Compliance with Title VI, Civil Rights Act of 1964, a Statement of Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, and a Statement of Assurance of Compliance with the Age Discrimination Act.

d. It will be the responsibility of the ACMD for Geriatrics and Extended Care to forward to the Director, Office for Civil Rights, Department of Health and Human Service, 5400 North Building, 330 Independence Avenue, SW, Washington, DC 20201, the following information:

November 4, 1992

M-5, Part VIII
Chapter 5

M-5, Part VIII
Chapter 5

November 4, 1992

- (1) Copies of VA Form 27-8206 when approving a new State home.
- (2) Notification when a new level of care is approved at an existing State home.

5-70

5-70