

John D. Rockefeller IV
Governor



L. Clark Hansbarger, M.D.
Director

State of West Virginia

DEPARTMENT OF HEALTH

CHARLESTON 25305

Certification

Legislative Rule: Nursing Home Licensure, Chapter 16-5C,
Series I, 1983

The above titled legislative rule constitutes the official
rule approved by the West Virginia Board of Health on June
18, 1982 and filed pursuant to law in the Office of the
Secretary of State, State of West Virginia.

A handwritten signature in cursive script, reading "L. Clark Hansbarger, M.D.", written over a horizontal line.

L. Clark Hansbarger, M. D.
Secretary
West Virginia Board of Health

Entered

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/16/82
Administrative Law Division

FISCAL NOTE FOR PROPOSED RULES

Rule No. 16-5C, Series I, 1983 Subject Nursing Home Licensure

Type of Rule: ☒ Legislative ☐ Interpretive ☐ Procedural

Agency Health Department Address 1800 Washington Street, East
Charleston, WV 25305

Authorized Representative _____ Phone 348-2411

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$	\$	\$ -0-	\$ -0-	\$ -0-
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Others					

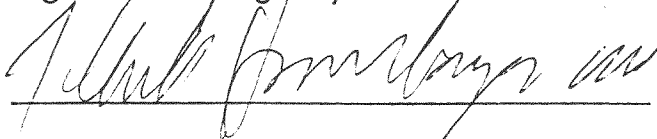
2. Explanation of above estimates.

We anticipate that the nursing home licensure program already in existence will be able to implement these rules. The estimated cost of the present program is included in the fiscal 1983-84 budget request at approximately \$100,000. Annual increases will be according to Finance and Administration guidelines.

The Health Department has requested a separate fiscal note from the Welfare Department.

3. Date 8/5/82 Agency Health Department

Signature of Agency Head



Signature of Authorized Representative

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/16/82
Administrative Law Division

STATEMENT OF ECONOMIC IMPACT OF PROPOSED RULES OR REGULATIONS

Agency Health Department

Rule No. Legislative 16-5C, Series I, 1983 Subject Nursing Home Licensure

1. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

We anticipate a minimal economic impact on the Health Department insofar as the proposed rule is concerned. The Health Department has requested a fiscal note from the Welfare Department.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

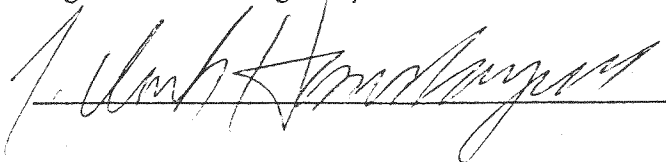
In the public hearing, some allegations were made that it would increase patient cost because of increased staffing requirements. If this does occur, we estimate approximately 80% of this increase will be reimbursed to the nursing home by Medicaid/Medicare Programs. The remaining will devolve to private pay patients for the increased services.

C. Economic Impact on Citizens/Public at Large.

We are unable to equate the increase in level of services required with an economic impact attendant to the increased health, safety and welfare potential for consumers of these services.

Date 8/5/82 Agency Health Department

Signature of Agency Head



Signature of Authorized Representative



WEST VIRGINIA LEGISLATIVE RULE
BOARD OF HEALTH

NURSING HOME LICENSURE

Legislative Rule 16-5C

Series I

(1983)

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/16/82
A.L.M. Division

WEST VIRGINIA LEGISLATIVE RULE
BOARD OF HEALTH

Nursing Home Licensure

Chapter 16-5C
Series I
(1983)

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WEST VIRGINIA LEGISLATIVE RULES
BOARD OF HEALTH

Chapter 16-5C
Series I
(1982)

Subject: Nursing Home Licensure

Section 1. General

1.01. Scope - These legislative rules establish general rules and procedures for the licensing of nursing homes.

1.02. Authority - These legislative rules are issued under the authority of Chapter 16, Article 5C, Section 5 and are related to Chapter 16, Article 5C, Section 1 et seq. of the West Virginia Code of 1931, as amended.

1.03. Filing Date - These rules were promulgated on the _____ day of _____, _____, and were filed on the _____ day of _____, _____, in the Secretary of State's office.

1.04. Effective Date - These legislative rules became effective on the _____, 19____.

Section 2. Supersession and Repeal of Former Regulations - These legislative rules supersede and repeal the West Virginia Nursing Home Licensing Board Rules and Regulations for Licensing of Nursing Homes, 1973.

Section 3. Application and Enforcement

3.01. Application - These legislative rules shall apply to every individual and every form of organization, whether incorporated or unincorporated, including any partnership, corporation, trust, association or political subdivision of the state which shall operate or apply to operate a nursing home as defined in Chapter 16, Article 5C, Section 2(c) of the West Virginia Code of 1931, as amended and these regulations.

3.02. Enforcement - The enforcement of these legislative rules is vested with the director of the West Virginia department of health or his lawful designee.

Section 4. Definitions

4.01. Applicant - The person who submits an application for a license or renewal of a license to operate a nursing home.

4.02. Bed Capacity - The maximum number of beds the facility is currently licensed to offer for patient occupancy.

4.03. Board - The West Virginia board of health.

4.04. Boarding Home - An establishment which is held forth to the public as providing, or which is operated to provide only room and board to persons not in need of medical or nursing treatment or personal supervision. In contrast to nursing homes or personal care homes, a boarding home does not provide personal assistance in eating, dressing, ambulation or any other daily living activities, any type of medical or nursing care, or any degree of personal supervision.

4.05. Change of Ownership - Any transaction which results in a change of control over the capital assets of a facility including but not limited to a conditional sale, a sale, a lease or a transfer of title or controlling stock (See Section 5.01.08 of these regulations).

4.06. Controlling Person - Any person who by reason of a direct or indirect ownership interest whether of record or beneficial has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of a facility. No employee of the department of health shall, by reason of his official position, be deemed to be a controlling person of any facility, nor

shall any person who serves as an officer, administrator or other employee or as a member of a board of directors or trustees of any facility be deemed to be a controlling person solely as a result of such position or his official actions in such position.

4.07. Day Care Services - Services and supervision provided to non-resident individuals who are capable and desirous of semi-independent living. Services may include supervised nutrition, planned, organized activities and protective supportive environment not to exceed twelve hours per day per person.

4.08. Department - West Virginia department of health.

4.09. Director - The director of the West Virginia department of health or other employee acting on behalf of the director with written designation and identification.

4.10. Facility - Any nursing home as defined in Section 4.19 of these regulations.

4.11. Gender - The pronoun "he" shall denote both the masculine and feminine gender. The use of any word denoting the masculine gender shall be taken to apply to both females and males.

4.12. Governing Body - The individual, agency, group or corporation, appointed, elected or otherwise designated in which the ultimate responsibility and authority for the conduct of the facility is vested.

4.13. Immediate Family - Each parent, child, spouse, brother, sister, first and second cousin, aunt and uncle of an individual, whether such relationship arises by reasons of birth, marriage or adoption.

4.14. License - The document issued by the director which constitutes the authority to receive patients and perform services included within the

scope of these regulations.

4.15. Licensed or Registered - When applied to a person means that the person to whom the term is applied is duly licensed or registered to follow a profession by the proper authority within the State of West Virginia and when applied to a facility means that the facility is duly licensed by the department of health.

4.16. Licensed Nursing Personnel - Registered professional nurses and licensed practical nurses.

4.17. Licensee - The person or body to whom the license is issued, who shall be held responsible for compliance with all rules, regulations and minimum standards.

4.18. Nursing Care - Those procedures commonly employed in providing for the physical, emotional and rehabilitational needs of the ill or otherwise incapacitated which require technical skills and knowledge beyond that which the untrained person possesses, including, but not limited to, such procedures as: irrigations; catheterization; application of dressings; supervision of special diets; objective observation of changes in patient condition as a means of analyzing and determining nursing care required and the need for further medical diagnosis and treatment; special procedure contributing to rehabilitation; administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally; and carrying out other treatments prescribed by a physician which involve a like level of complexity and skill in administration.

4.19. Nursing Home - Any institution, residence or place, or any part or unit thereof, however named, in West Virginia, which is advertised, offered, maintained or operated by the ownership or management, whether for

a consideration or not, for the express or implied purpose of providing accommodations and care, for a period of more than twenty-four hours, for three or more persons who are ill or otherwise incapacitated and in need of nursing care due to physical or mental impairment, or which provides services for the rehabilitation of persons who are convalescing from illness or incapacitation.

4.20. Nursing Personnel - The director of nursing, charge nurse and all employees under the direct supervision of the director of nursing or charge nurse who attend to patient-oriented nursing functions, including registered professional and licensed practical nurses, nursing aides and orderlies, but excluding employees engaged in administration, dietetics, housekeeping, laundry and maintenance.

4.21. Patient - An individual under care in a nursing home.

4.22. Person - An individual and every form of organization, whether incorporated or unincorporated, including any partnership, corporation, trust, association or political subdivision of the state.

4.23. Personal Assistance - Personal services, including, but not limited to, the following: help in walking, bathing, dressing, feeding, or getting in or out of bed, or supervision required because of the age or mental impairment of the patient.

4.24. Personal Care Home - Any institution, residence or place, or any part or unit thereof, however named, in this state which is advertised, offered, maintained or operated by the ownership or management, whether for a consideration or not, for the express or implied purpose of providing accommodations and personal assistance, for a period of more than twenty-four hours, to six or more persons who are dependent upon the services of

others by reason of physical or mental impairment but who do not require nursing care.

4.25. Premises - A tract of land, together with all buildings, equipment, fixtures and facilities erected, constructed or situated thereon, and all rights, powers, easements, and rights-of-way, and all interests in property, real, personal or mixed, now owned or hereafter acquired by a licensed person and appurtenant to or used in connection with the licensed facility.

4.26. Principal Stockholder - Any person who beneficially owns, holds or has the power to vote ten percent or more of any class of securities issued by a corporation.

4.27. Restraint - Any device which limits movement by the patient and which cannot be removed easily by the patient, or any chemical or drug used to limit movement by a patient or to limit the mental capacity of a patient beyond the requirements of therapeutic treatment.

4.28. Serious Physical Harm - That type of bodily injury in which: (a) a part of the body would be permanently removed, rendered functionally useless, or substantially reduced in capacity, either temporarily or permanently; or (b) a part of an internal function of the body would be inhibited in its normal performance to such a degree as to shorten life or cause reduction in physical or mental capacity.

4.29. Sponsor - The person or agency legally responsible for the welfare and support of a patient.

4.30. Substantial Probability - The more likely consequences.

4.31. Stop Order - A written policy that definitely prescribes the number of doses or the period of time after which administration of a drug

to a patient must be stopped automatically, unless the physician's order for the drug specified the number of doses or the period of time the order was to be in effect.

4.32. Transfer Agreement - An agreement with a hospital which provides the basis for arrangements under which inpatient hospital care or other services are available promptly to the facility's patients when needed.

4.33. Unit Dose - The ordered amount of a drug dispensed by a pharmacist in a dosage form ready for administration to a particular person by the prescribed route at the prescribed time.

Section 5. State Administrative Procedures

5.01. General Licensure Provisions

5.01.01. No person may establish, operate, maintain, offer or advertise within the State of West Virginia, a nursing home as defined in Chapter 16, Article 5C of the West Virginia Code of 1931, as amended and herein unless that person obtains a current valid license.

5.01.02. Neither an original nor a renewal license shall be issued under these regulations for a project reviewable under Chapter 16, Article 2D of the West Virginia Code of 1931, as amended unless the West Virginia Certificate of Need Program has issued a finding, after a final conformance review, that the completed project conforms to the terms of the Certificate of Need decision issued for the project.

5.01.03. A separate license shall be required for nursing homes maintained or operated on separate premises even though maintained or operated under the same ownership or management.

5.01.04. Separate buildings on the same premises operated under the

same ownership and management shall constitute one licensed facility, unless the director determines otherwise.

5.01.05. A license shall be valid only for the premises and persons named in the application.

5.01.06. A license is not transferable or assignable and shall be surrendered on demand to the director.

5.01.07. If the ownership of a facility with a valid unexpired license changes, the new owner shall apply for a new license.

5.01.08. The application of the new owner for a license shall have the effect of a valid license for three months from the date the application is received by the director.

5.01.09. The facility name shall be changed only with the director's approval.

5.01.10. An approved name change shall be shown in the next license issued.

5.01.11. The words "clinic," "hospital," "sanitarium," or any other word which suggests a type of institution other than the proposed facility shall not appear in the name.

5.01.12. A license shall state: (a) the name of the facility to which it applies; (b) the maximum bed capacity for which it is granted; (c) the rating assigned to the facility pursuant to Section 5.11 of these regulations; (d) the date of issuance; and (e) the expiration date.

5.01.13. The name on the license shall be that used in the application which specifically identifies the facility.

5.02. Exceptions

5.02.01. Unless such facilities request licensure as a nursing home,

nothing contained in these regulations shall apply to: (a) a hospital as defined in Chapter 16, Article 5B, Section 1 of the West Virginia Code of 1931, as amended; (b) a state or federally operated institution, as defined in Chapter 27, Article 1, Section 6 or in Chapter 25, Article 1, Section 3 of the West Virginia Code of 1931, as amended; (c) institutions operated for the care and treatment of alcoholic patients; (d) offices of physicians; (e) hotels; (f) boarding homes, as defined in Section 4 of these regulations, or similar places that furnish to their guests only room and board; (g) extended care facilities operated in conjunction with a hospital; (h) facilities, including intermediate care facilities for the mentally retarded, required to be licensed under Chapter 27, Article 9, Section 1 of the West Virginia Code of 1931, as amended; or (i) personal care homes as defined in Section 4 of these regulations.

5.02.02. The care or treatment in a household, whether for compensation or not, of any person related by blood or marriage, within the degree of consanguinity of second cousin to the head of the household, or his spouse, may not be deemed to constitute a nursing home within the meaning of these regulations.

5.03. Initial License

5.03.01. An applicant shall submit an application to the director, on a form prescribed by the director, containing information sufficient to demonstrate that the facility is in compliance with the standards for nursing homes established in Chapter 16, Article 5C of the West Virginia Code of 1931, as amended and these regulations.

5.03.02. The application shall be filed not less than thirty days and not more than ninety days prior to the date proposed for commencement of

operation (See also Section 6 of these regulations).

5.03.03. The application shall contain at least the information required by this section.

5.03.04. Where the information required pertains to activities proposed to be undertaken by the applicant, the applicant shall provide information on such proposed activities.

5.03.05. The following information pertaining to ownership shall be submitted: (a) the name and address of the individual submitting the application; (b) the name, address and principal occupation of the following:
- (1) each person, who as a stockholder or otherwise, has a proprietary interest of ten percent or more in the facility; (2) each officer and director of an incorporated facility; (3) each trustee and beneficiary of a facility which is a trust; and (4) each officer and director of any corporation which has a proprietary interest of fifty percent or more in the facility; (c) the name and address of the owner of the facility if the owner is not the applicant; and (d) the name and address of the owner of the facility premises if he is not the applicant or the owner under Section 5.03.05 of these regulations.

5.03.06. Where the applicant is the lessee or the assignee of the facility or the premises of the proposed facility, a signed copy of the lease and any assignment thereof shall be submitted with the initial application.

5.03.07. If the owner of the facility premises is a corporation, the name and address of the following shall be submitted as part of the application: (a) each person who, as a stockholder or otherwise has a proprietary interest of ten percent or more in the corporation; (b) each

officer and director of the corporation; (c) each trustee and beneficiary of the corporation if it is a trust; and (d) each officer and director of any corporation which has a proprietary interest of fifty percent or more in the owning corporation.

5.03.08. The following information pertaining to operation of the facility shall be submitted: (a) the specific name and address of the facility; (b) the level of participation, if any, in the Medicare and Medicaid programs (e.g., skilled nursing facility, intermediate care facility); (c) the proposed bed capacity of the facility, by unit where units will be specialized; (d) an organizational plan for the facility indicating the number of employees and their positions and duties; (e) the name and address of the administrator; (f) evidence of compliance with applicable laws and regulations governing zoning, buildings, safety, fire prevention, sanitation, and any other laws and regulations as specified in these regulations; (g) evidence of approval by the state health planning and development agency, if necessary (See Section 5.01.02 of these regulations); (h) the names and locations of any other facilities which are or have been operated by the owner or manager, or for which one of the individuals identified in Section 5.03.05 of these regulations is a controlling person as would be identified under Section 5.03.05 of these regulations for such facility; and (i) any additional information which the director may require.

5.03.09. A nonrefundable application fee of one hundred dollars shall be submitted with the application for an initial license.

5.03.10. An initial license shall be issued only after the director inspects the facility (See Section 6.02 of these regulations).

5.03.11. A facility found on inspection to have deficiencies shall be subject to Section 5.07 and Section 16 of these regulations relating to plans of correction and penalties relating thereto.

5.03.12. The director shall issue an initial license if he finds: (a) that the individual applicant, and every partner, trustee, officer, director and controlling person of an applicant which is not an individual is a person responsible and suitable to operate, direct or participate in the operation of a facility by virtue of the following: (1) financial capacity; (2) appropriate business or professional experience; (3) a record of compliance with any lawful orders of the department or other licensing agency for any jurisdiction in which the applicant or any individual identified in Section 5.03.05 of these regulations has operated, directed, or participated in the operation of a facility; and (4) lack of revocation of a license to operate a nursing or personal care home in West Virginia or any other jurisdiction during the previous five years; and (b) that the facility substantially complies with these regulations.

5.03.13. A license issued after the effective date of these regulations shall be valid for one year from the date of issuance.

5.04. Renewal License

5.04.01. An applicant for a renewal license shall submit an application to the director on a form prescribed by the director containing at least the following information: (a) a balance sheet of the facility prepared not more than one fiscal quarter preceeding the application date, setting forth assets and liabilities, including all capital, surplus, reserve, depreciation and similar accounts; (b) a statement of operations of the facility for the twelve-month period not more than one fiscal quarter

precedent to the application date, setting forth all revenues, expenses, taxes, extraordinary items and other credits or charges; (c) a statement showing any changes in the name, address, management or ownership information on file with the director; and (d) a report on the facility in the form prescribed by the director.

5.04.02. If a facility is in compliance with the requirements of the Health Care Facility Financial Disclosure Law, Chapter 16, Article 5F of the West Virginia Code of 1931, as amended, it will be considered to have met the requirements of Section 5.04.01(a-c) of these regulations.

5.04.03. For a facility having a valid license on the effective date of these regulations, the first application for renewal after the effective date of these regulations shall include the information required to be submitted by initial applicants pursuant to Section 5.03 of these regulations.

5.04.04. A completed application for renewal of a license shall be submitted not less than thirty days and not more than ninety days prior to the scheduled expiration date of the current license.

5.04.05. The fee for renewal of a license shall be four dollars per bed, determined according to the licensed bed capacity of the facility, and shall accompany the license renewal application.

5.04.06. The director shall renew an original license when the following conditions are met: (a) the director finds the facility in compliance with the provisions of Chapter 16, Article 5C of the West Virginia Code of 1931, as amended and with these regulations; (b) the licensee applied for a renewal within the time period specified in this section; and (c) the licensee submits the correct renewal fee with the application.

5.04.07. A renewal license shall be valid for one year from the date of issuance.

5.05. Provisional License

5.05.01. If the director finds that a facility applying for renewal of a license is not in substantial compliance with the requirements of these regulations and the provisions of Chapter 16, Article 5C of the West Virginia Code of 1931, as amended, the director may, at his discretion issue a provisional license.

5.05.02. A provisional license may be issued only when the director makes the following findings: (a) that the care given in the facility is adequate to meet patient needs; and (b) that the facility has demonstrated improvement and potential for substantial compliance within the term of the license for which renewal is requested.

5.05.03. A provisional license shall not be issued for a period greater than twelve months.

5.05.04. A provisional license shall not be renewed.

5.05.05. A provisional license shall not be issued to a facility with uncorrected violations of a Class I standard as identified in Section 5.10 of these regulations.

5.06. Inspections of Licensed and Unlicensed Facilities

5.06.01. The director shall conduct at least one unannounced inspection annually of a facility holding a license to determine compliance with the provisions of Chapter 16, Article 5C of the West Virginia Code of 1931, as amended and these regulations.

5.06.02. The director shall have the right to enter the premises of a facility which the director has reason to believe is being operated or

maintained as a nursing home without a license in accordance with Chapter 16, Article 5C, Section 9 of the West Virginia Code of 1931, as amended.

5.06.03. If the owner or person in charge of an unlicensed facility refuses entry pursuant to this section, the director shall apply to the circuit court of the county in which the facility is located for a warrant authorizing inspection.

5.06.04. If the director finds on the basis of the inspection that the facility is operating as a nursing home without a license, the facility shall apply within ten days for a license in accordance with the provisions of these regulations or shall reduce its patient census to less than three.

5.06.05. Failure to apply for a license shall be subject to the penalties established in Section 5.07.11 and Section 16 of these regulations.

5.06.06. A report of an inspection made pursuant to these regulations shall be made in writing and shall be maintained on file by the director.

5.06.07. An inspection report shall list each deficiency in the facility's compliance with statutes and regulations indicating for each deficiency specifically which provision has not been met.

5.06.08. The director shall send a copy of a report of an inspection to the facility.

5.07. Plans of Correction

5.07.01. A facility found on the basis of an inspection to have deficiencies shall develop a plan of correction and submit it to the director within thirty days of receipt of a report of inspection.

5.07.02. A plan of correction shall specify a reasonable time within which the facility shall correct each violation cited in the report.

5.07.03. The time shall be the shortest possible time within which the facility reasonably can be expected to correct the violation.

5.07.04. The time stated shall be subject to approval or modification by the director.

5.07.05. In determining whether to approve the time submitted by the facility, the director shall consider the following factors: (a) the seriousness of the violation; (b) the number of patients affected; (c) the availability of required equipment or personnel; (d) the estimated time required for delivery and installation of required equipment; and (e) any other relevant circumstances.

5.07.06. A plan of correction submitted by a facility shall be approved, modified or rejected by the director.

5.07.07. The director shall notify each facility within ten (10) days as to whether a plan of correction has been approved, modified or rejected.

5.07.08. If the director rejects or modifies the plan, the reasons for the action shall be stated.

5.07.09. When the director rejects a plan of correction, a reasonable time for submission of a revised plan may be allowed before civil penalties are assessed.

5.07.10. The director shall not allow time for submission of a revised plan where the deficiency to be corrected is a Class I deficiency.

5.07.11. Upon the failure by a facility with deficiencies to submit a plan of correction which is approved by the director or to correct any deficiency within the time specified in an approved plan of correction, the director may assess civil penalties as hereinafter provided or may initiate any other legal or disciplinary action available to him in accordance with

the West Virginia Code of 1931, as amended and these regulations.

5.08. Interference with Official Duties - No licensee or employee of any nursing home shall engage in the following activities:

5.08.01. Willfully prevent, interfere with or attempt to impede in any way the work of any duly authorized representative of the director or of the State fire marshal in the lawful enforcement of inspection duties;

5.08.02. Willfully prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of inspection duties; or

5.08.03. Willfully prevent or interfere with any such representative in the preserving of evidence of any violation of these regulations.

5.09. Classification of Standards

5.09.01. In accordance with Chapter 16, Article 5C, Section 5(c) of the West Virginia Code of 1931, as amended, the board has established a classification for each standard in these regulations.

5.09.02. Class I standards are those which when violated would present either an imminent danger to the health, safety or welfare of any patient or a substantial probability that death or serious physical harm would result.

5.09.03. Class II standards are those which when violated would have a direct or immediate relationship to the health, safety or welfare of any patient but which would not create imminent danger if violated.

5.09.04. Class III standards are those which if violated would have an indirect or a potential impact on the health, safety or welfare of any patient.

5.10. Point System

5.10.01. A Class I standard shall be assigned a value of 10 points if the facility fully complies with the standard. If the facility fails to comply fully with the standard but does demonstrate substantial compliance a score of 9 points may be assigned to the standard. If the facility fails to demonstrate full or substantial compliance with the standard but partial compliance is in evidence, a score of 4 points may be assigned to the standard. If the facility fails to demonstrate partial compliance or if the violation is a repeat of a deficiency cited during the previous annual survey a partial score shall not be assigned and the standard shall be scored as a zero.

5.10.02. A Class II standard shall be assigned a value of 9 points if the facility fully complies with the standard. If the facility fails to comply fully with the standard but does demonstrate substantial compliance a score of 8 points may be assigned to the standard. If the facility fails to demonstrate full or substantial compliance with the standard but partial compliance is in evidence, a score of 4 points may be assigned to the standard. If the facility fails to demonstrate partial compliance or if the violation is a repeat of a deficiency cited during the previous annual survey a partial score shall not be assigned and the standard shall be scored as a zero.

5.10.03. A Class III standard shall be assigned a value of 8 points if the facility fully complies with the standard. If the facility fails to comply fully with the standard but does demonstrate substantial compliance a score of 7 points may be assigned to the standard. If the facility fails to demonstrate full or substantial compliance with the standard but partial compliance is in evidence, a score of 4 points may be assigned to the

standard. If the facility fails to demonstrate partial compliance or if the violation is a repeat of a deficiency cited during the previous annual survey a partial score shall not be assigned and the standard shall be scored as a zero.

5.10.04. Certain standards are available for extra credit, if, in the opinion of the director, the facility performs significantly in excess of the minimum standards set by these regulations. No more than 1 extra credit point shall be assigned to any individual standard for which extra credit is available. Extra credit points are not permitted to offset zero scores. Items for which extra credit is available are identified in Sections 5.10.05, 5.10.06 and 5.10.07.

5.10.05. Class I standards are as follows; items for which extra credit is available are identified by an asterisk:

- 6.03. Construction, Life Safety and Related
- *6.04. Site Characteristics/Accessibility
- 6.05. Increase in Bed Capacity
- 6.07. Nursing Equipment, Sterile Supplies, and Linens
- 6.11. Laundry
- 8.01. General Health and Safety Requirements
- 8.04. Fire Drills
- 8.06. Provisions for Emergency Calls
- 8.07. Infection and Communicable Disease Control
- 8.08. Isolation
- 9.06. Rights with Regard to Treatment
- *10.02. Availability of Medical Services
- 10.03. Services of Attending Physician

- *11.01. Nursing and Patient Care Staffing
- 11.02. Management of Nursing Services
- *11.04. Nursing Staff Responsibilities
- *11.05. Restorative Nursing Care
- *11.06. Use of Restraints
- 11.07. Notice to Physician of Accident or Illness
- 12.01. Dietetic Service to be Maintained
- *12.04. Meals
- 13.01. Provision of Pharmaceutical Services
- *13.04. Pharmaceutical Policies and Procedures
- *13.05. Patient Medications
- *15.01. Plans for Care and Discharge.

5.10.06. Class II standards are as follows; items for which extra credit is available are identified by an asterisk:

- *6.06. Equipment and Furnishing of Patient Rooms
- *6.08. General Maintenance
- 6.09. Waste and Refuse Disposal
- 7.01. Governing Body
- 7.02. Administrator
- 7.03. Administrator Functions
- *7.04. Admission, Discharge and Transfer Policies
- 7.05. Admission Contract
- *7.11. Staff Development
- *8.02. Disaster Plan
- *8.03. Disaster Training
- 8.05. Disaster Rehearsal and Fire Drill Reports

- 8.09. Animals
- *9.01. Implementations of Patients' Rights
- 9.02. Limitation of Patients' Rights and Derivative Rights
- 9.03. Civil Rights
- *9.04. Rights to be Informed
- *9.05. Rights to Communication and Personal Property
- 9.07. Rights to Confidentiality
- 9.08. Financial Rights
- *9.10. Complaint Procedures
- *9.11. Access
- 10.01. Medical Director
- *10.04. Availability of Dental Services
- *10.05. Inservice Training in Dental Care
- 11.03. Charge Nurse
- 11.08. Accident and Incident Reports
- 12.02. Director and Staffing of Dietetic Service
- *12.03. Menus and Supplies
- *13.02. Supervision of Pharmaceutical Services
- 13.06. Medication Storage
- 14.01. Social Work Services to be Provided
- *14.02. Plan for Social Work Services
- *14.03. Social Work Services Staffing
- 14.04. Social Work Services Facilities
- *14.05. Recreation and Activities to be Provided
- *14.06. Recreation and Activities Staffing
- 14.07. Recreation and Activities Facilities

- 15.02. Medical Record Required
- 15.03. Confidentiality of Medical Records
- *15.04. Contents of Medical Records.

5.10.07. Class III standards are as follows; items for which extra credit is available are identified by an asterisk:

- 6.10. Cleaning Supplies
- 7.06. Life Care Contract
- 7.07. Prohibited Activities
- *7.08. General Recordkeeping Requirements
- 7.09. Administrative Records
- 7.10. Personnel Records
- 9.09. Fiduciary Responsibilities of the Facility
- 9.12. Notice and Posting Requirements
- 11.09. Report of Death
- 13.03. Pharmaceutical Services Committee.

5.10.08. Certain material within the body of the regulations is explanatory or otherwise necessary linguistically but will not enter into the scoring system.

5.10.09. If a standard is not applicable for a particular facility, a full compliance value shall be assigned for that item for scoring and rating purposes.

5.11. Facility Rating

5.11.01. The director shall assign a rating to each facility licensed under these regulations.

5.11.02. The rating shall be assigned and included on the license issued to the facility.

5.11.03. A rating shall be based on the results of the annual survey.

5.11.04. Scores and ratings for individual categories are shown in the table below.

SCORES REQUIRED FOR A, B AND C RATINGS
IN EACH CATEGORY OF THE REGULATIONS

Sec. No.	Category	Rating			
		F	C	B	A
		Less than or equal:			
6	Physical Facilities, Equipment and Related	70	71-74	75-79	80-88
7	Facility Governance and Management	66	67-78	79-87	88-97
8	General Health and Safety	72	73-75	76-80	81-89
9	General Patients' Rights Policies and Procedures	81	82-91	92-100	101-112
10	Medical and Dental Services	38	39-41	42-45	46-50
11	Nursing Services	72	73-78	79-82	83-90
12	Dietetic Services	31	32-34	35-36	37-40
13	Pharmaceutical Services	45	45-50	51-53	54-59
14	Social Work Services and Recreation and Activity Services	48	49-55	56-60	61-67
15	Plans for Care and Medical Records	29	30-32	33-34	35-39

5.11.05. A facility must obtain the number of points indicated in the table of Section 5.11.04 within each category to obtain a particular category rating. Points scored in any individual category shall not be permitted to offset deficiencies within another category. Therefore, no total of value points is to be computed. An overall rating for the facility cannot be determined solely on the basis of total points earned.

5.11.06. For purposes of assigning an overall rating, a category rating of "A" shall be assigned a score of four; a category rating of "B" shall be assigned a score of three; a category rating of "C" shall be assigned a score of two; and a category rating of "F" shall be assigned a score of zero. These category rating scores for the ten categories shall be totaled and an average category rating score shall be computed. An overall

facility rating shall be assigned based on the average category rating score and the number of categories rated "F" as follows: (a) if a facility is given a rating of "F" on as many as one category or has an average category rating score of less than 2.0, an overall rating of "F" shall be assigned; (b) for an average score of 2.0 through 2.59, an overall rating of "C" shall be assigned; (c) for an average score of 2.6 through 3.59, an overall rating of "B" shall be assigned; and (d) for an average score of 3.6 through 4.0, an overall rating of "A" shall be assigned.

5.11.07. A facility with an overall rating of "F" may be issued a provisional license as described in Section 5.05 of these regulations and in Chapter 16, Article 5C, Section 6 of the West Virginia Code of 1931, as amended, or may be subject to other actions by the director as described in Section 16 of these regulations and in Chapter 16, Article 5C of the West Virginia Code of 1931, as amended.

5.12. Complaint Investigation

5.12.01. Any person may register a complaint with the director alleging violation of applicable laws or regulations by the facility. A complainant shall state the substance of the complaint and shall identify the facility involved.

5.12.02. Upon receipt of a complaint, the director shall attempt to determine whether the complaint is willfully intended to harass a licensee or is without reasonable basis.

5.12.03. The director shall notify a complainant presenting a complaint determined either as intended to harass a licensee or as without reasonable basis that no further investigation will be conducted.

5.12.04. A complaint which is viable after initial determination pur-

suant to Section 5.12.02 of these regulations shall be investigated.

5.12.05. The director shall conduct an unannounced inspection of the facility to determine the validity of the complaint.

5.12.06. The department shall provide the facility with notice of the substance of the complaint only at the time of the inspection.

5.12.07. The director shall conduct such other investigation as is necessary to determine the validity of the complaint.

5.12.08. No later than five working days after completing an investigation of a complaint the director shall notify the complainant and the facility in writing of the results of the investigation.

5.12.09. A description of the corrective action the facility will be required to take and of any disciplinary action to be taken by the director will be sent to the complainant upon receipt of written request.

5.12.10. If a complaint has been found to have merit, the director shall advise any injured party of the possibility of a civil remedy under Chapter 16, Section 5C of the West Virginia Code of 1931, as amended.

5.12.11. The name of a complainant or of any person named in a complaint shall be safeguarded by the department and shall not be disclosed without the individual's written authorization.

5.12.12. Disclosure of the name of a patient identified in a complaint who is not the complainant shall be subject to the confidentiality provisions otherwise in effect in these regulations and shall not be disclosed without the patient's prior written authorization.

5.12.13. If a complaint becomes the subject of a judicial proceeding, nothing in this section shall be construed to restrict disclosure of information which would otherwise be disclosed in a judicial proceeding.

5.12.14. Before any complaint is disclosed to a facility, or to the public pursuant to Section 5.13 of these regulations, any information in the complaint which could reasonably identify the complainant or a patient shall be deleted.

5.12.15. A facility is prohibited from discharging or in any manner discriminating against a patient or employee because the individual has filed a complaint or participated in a proceeding authorized by Chapter 16, Article 5C of the West Virginia Code of 1931, as amended.

5.12.16. Violation of the prohibition of Section 5.12.15 of these regulations shall be grounds for suspending or revoking the facility's license.

5.12.17. A rebuttable presumption of retaliatory action against a patient shall arise against any facility which in any way adversely discriminates against a patient by whom or on whose behalf a complaint has been submitted to the director or who is involved in any proceeding instituted under Chapter 16, Article 5C of the West Virginia Code of 1931, as amended, within one hundred and twenty days of the filing of the complaint or the institution of any such proceeding.

5.13. Availability of Reports and Records

5.13.01. The director shall make available for public inspection and, upon request, provide at a nominal cost copies of the following documents: (a) applications and exhibits; (b) inspection reports; (c) reports of investigations conducted in response to complaints; and (d) any other reports filed with or issued by the director pertaining to the compliance of a facility with applicable laws and regulations.

5.13.02. If the director determines it is in the best interests of

the public, the director may provide copies of records and reports free of charge to nonprofit community organizations upon written request.

5.13.03. The director shall treat a report of inspection of a facility as public information from the time a written plan of correction is submitted.

5.13.04. If the facility does not submit a written plan of correction within the time specified by the director pursuant to Section 5.07 of these regulations, reports pertaining to the facility shall be made public at the expiration of the specified time.

5.13.05. Other records and reports shall be treated as public information from the time they are submitted to or issued by the director.

5.13.06. Nothing contained in this section shall be construed to require or permit the public disclosure of confidential medical, social, personal or financial records of any patient.

5.13.07. Before releasing a report or record deemed public information the director shall delete any confidential information regarding a patient which could reasonably permit identification of the patient.

5.13.08. The director shall delete from complaints made available to the public under this section any information required to be held confidential under Section 5.12 of these regulations.

5.14. Registry of Organizations with Right of Access

5.14.01. The director shall maintain a register of all organizations and groups approved for access to facilities under the provisions of Section 9.11 of these regulations and Chapter 16, Article 5C, Section 5, Paragraph (b), Subsection (1)(i) of the West Virginia Code of 1931, as amended.

5.14.02. Such groups shall render assistance to patients without

charge. The primary function of such groups shall be to improve or enhance the quality of life for patients in the facility. Eligible groups shall include, but not be limited to, such groups as ombudsman programs, long-term care advocates and legal service organizations.

5.14.03. Any organization or group desiring such approval shall apply in writing to the director, stating the name, address and general purpose of the organization or group and reasons why such access privilege should be granted. The director may in his sole discretion require additional information.

5.14.04. The director shall review any such application and shall notify the applicant in writing within ten working days of the receipt of all information requested whether access rights have been approved or denied.

5.14.05. The director shall have the right to revoke such approval of a group or organization or of a particular representative, upon presentation of evidence that any organization, group, or particular representative has failed to comply with the provisions of Section 9.11 of these regulations.

5.14.06. The director shall publish a list of approved groups and organizations annually. Copies of the list shall be distributed to facilities annually. Copies may be obtained upon request.

Section 6. Physical Facilities, Equipment, and Related

6.01. Applicability

6.01.01. The provisions of this part shall apply to the physical facilities and services of all nursing homes, except that the requirements may be modified for existing facilities if their application clearly would be impractical in the judgment of the director, and provided that such

alternate arrangements are not, in the opinion of the director, considered to be detrimental to the health or safety of the occupants and employees of such facility. Such modification shall conform as nearly as is practicable to the current regulations.

6.01.02. For purposes of these regulations, an existing facility shall be defined as a facility having either a valid nursing home license or licensed as an extended care facility according to West Virginia Rules and Regulations and Law for Licensing Hospitals, 1969 as of or within a period of one year prior to the effective date of these regulations.

6.02. Applications Required

6.02.01. Detailed plans for new construction, additions, renovations, and alterations, drawn to scale of not less than one-eighth inch equals one foot, shall be submitted to and approved by the director before construction is started.

6.02.02. Two copies of these plans and specifications signed by an architect registered in the State of West Virginia shall be submitted to the director, and shall show, properly identified, the general arrangement and construction of the building and location of all fixed equipment.

6.02.03. Preliminary drawings and outline specifications shall be submitted for approval prior to preparation of working drawings.

6.02.04. The requirement for a registered architect may be waived by the director.

6.02.05. A performance statement must be obtained by the owner from the builder of a proposed facility stating that in constructing the facility the builder has followed the architect's plans which are on file with and approved by the director.

6.02.06. All new facilities shall be inspected by the director and shall have the director's approval prior to admitting patients. A request for a pre-opening inspection shall be made in writing thirty days prior to the proposed opening date.

6.02.07. Unless substantial construction is started within one year of the date of approval of final drawings, it will be necessary for the owner or architect to secure written notification from the director that such plan approval for construction is still valid and in compliance with this section.

6.02.08. Plans for addition, removal or modification of equipment which is of the type which is permanently affixed to the building or which may otherwise involve or necessitate new construction, alteration of, or addition to the facility shall be submitted to and approved by the director, prior to beginning any construction, alterations, removal or modification.

6.02.09. Additionally, certain other changes involving equipment, which may or may not require physical changes in the facility, but which may relate to other standards and requirements of these regulations may require the director's approval. Facilities may request judgment and approval in advance from the director regarding a particular change or rearrangement. Areas in which changes are likely to require approval include, but are not limited to: kitchen; laundry; and heating equipment.

6.03. Construction, Life Safety and Related (Class I)

6.03.01. Except as provided in Section 6.01.01 of these regulations, the following documents are adopted as construction, equipment, physical facility and related procedural standards for all existing nursing homes, all new construction, and any additions, alterations, renovations, or con-

versions of existing buildings: (a) the relevant sections of Minimum Requirements of Construction and Equipment for Hospitals and Medical Facilities - U.S. Department of Health, Education, and Welfare (DHEW NO. (HRA) 81-14500); (b) minimum Property Standards for Care-Type Housing (4920.1) and Minimum Property Standards (4930.1), U.S. Department of Housing and Urban Development; (c) the 1981 edition of the National Building Code; (d) National Fire Protection Association - National Fire Codes; and Fire Prevention Code known as the Firesafety Code, as adopted by the West Virginia State fire commission and the additional promulgated fire safety regulations as filed by the State fire commission with the secretary of state; and (e) Article 10F, Chapter 18 of the West Virginia Code, and any rules and regulations promulgated thereunder regarding handicapped persons and public buildings and facilities.

6.03.02. When standards of these regulations exceed requirements of the documents listed above these regulations shall prevail.

6.04. Site Characteristics/Accessibility (Class I)

6.04.01. The facility shall be accessible to physicians, medical facilities and other necessary services.

6.04.02. There shall be good drainage, approved sewerage disposal, approved potable water supply, electricity, telephone, and other necessary facilities available on or near the site.

6.04.03. The facility shall be located in an environment which is free from flooding and excessive noise sources such as railroads, freight yards, traffic arteries and airports. The site shall not be exposed to excessive smoke, foul odors or dust.

6.04.04. Accessibility shall be facilitated by hard surfaced, all-

weather roads which are kept passable at all times. There shall be all-weather, hard surfaced walks and parking areas provided.

6.04.05. Local building codes and zoning restrictions shall be observed. Evidence of compliance signed by local fire, building and zoning officials shall be available.

6.04.06. Where local codes or regulations permit standards lower than those required by these regulations, the facility shall meet the standards set forth herein.

6.05. Increase in Bed Capacity (Class I) - Bed capacity may be increased only with the permission of the director.

6.06. Equipment and Furnishing of Patient Rooms (Class II)

6.06.01. Equipment and furnishings in patient rooms shall include at least the items in this section.

6.06.02. A bed shall be provided for each patient.

6.06.02.01. Each bed shall be substantially constructed, not less than 36" wide and in good repair.

6.06.02.02. Each non-ambulant patient shall be provided with a hospital-type bed.

6.06.02.03. Rollaway beds, folding beds and cots shall not be used.

6.06.02.04. Bed springs and mattress shall be in good repair and fit the bed.

6.06.03. At least one clean, comfortable pillow shall be provided for each bed; additional pillows shall be available to meet the needs of the patient.

6.06.04. Each patient shall be provided with a bedside stand with a drawer to accommodate toilet articles and utensils.

6.06.05. Each patient room shall have reasonable closet and drawer space for clothing and personal items currently being used by the patient.

6.06.06. Each room shall have individual towel and wash cloth racks or an equivalent substitute.

6.06.07. Window shades and curtains or draperies shall be provided and maintained in good condition.

6.06.08. One comfortable chair suitable for the patient's use shall be provided for each patient in each room.

6.07. Nursing Equipment, Sterile Supplies, and Linens (Class I)

6.07.01. Nursing equipment shall be sufficient to meet patients' needs. If warranted by a patient's condition, each individual shall have the following: (a) wash basin; (b) bedpan; (c) urinal; (d) emesis basin; and (e) water pitcher and cup or drinking glass.

6.07.02. Utensils shall be sterilized between use by different patients.

6.07.03. Styrofoam water pitchers and cups shall not be used.

6.07.04. Equipment constructed of enamelware or materials which cannot be sterilized shall not be used.

6.07.05. Damaged utensils shall not be used.

6.07.06. A facility shall have a sufficient number of thermometers to meet patient needs. These may be the standard mercury thermometers or electronic or thermo-chemical types of thermometers.

6.07.07. A facility shall disinfect each thermometer after each use.

6.07.08. A facility shall have sufficient hot water bottles with suitable covers to meet patient needs.

6.07.09. Nursing equipment and sterile supplies shall be stored in an

area which is completely separate from contact with patients.

6.07.10. Sterile supplies shall not be stored beyond their dated shelf life.

6.07.11. Storage space shall be provided on each nursing unit for clean linen.

6.07.12. Sufficient quantities of linens shall be available to nursing personnel to assure the cleanliness and comfort of each patient.

6.07.13. Individual towels, wash cloths and blankets shall be provided for each patient.

6.07.14. Waterproof mattresses or mattress covers shall be provided for each patient.

6.07.15. When electric blankets are used they shall be UL approved and they shall be checked periodically by facility staff for safety.

6.08. General Maintenance (Class II)

6.08.01. The facility shall establish a program of preventive maintenance to ensure that equipment is operative and that the interior and exterior of the building are safe, clean and orderly. Maintenance and housekeeping services may be provided by another organization under written contract.

6.08.02. Stairwells and corridors shall be kept free from obstruction at all times.

6.08.03. The grounds shall be kept in sanitary, safe, and presentable condition and shall be free from accumulated rubbish and other health hazards of a similar nature.

6.08.04. A facility shall be kept free from insects, rodents, and vermin through operation of a pest control program.

6.08.05. Pesticides shall be applied so as to prevent contamination to patients and food.

6.08.06. Insecticidal strips shall not be used.

6.08.07. All essential mechanical, electrical and patient care equipment shall be maintained in safe operating condition.

6.09. Waste and Refuse Disposal (Class II)

6.09.01. Accumulated waste or refuse shall be kept in sanitary, covered refuse containers and shall be removed from the building daily or more often as necessary.

6.09.02. A facility shall have procedures for disposing of soiled dressings and similar items in a safe and sanitary manner.

6.10. Cleaning Supplies (Class III) - A facility shall have sufficient supplies and equipment, properly stored and conveniently located, to permit frequent cleaning of floors, walls, woodwork, windows, screens, and to facilitate all necessary building and grounds maintenance.

6.11. Laundry (Class I) - The facility shall have written procedures for handling, storing, processing and transporting of linens and other laundered goods in such a manner to prevent the spread of infection.

Section 7. Facility Governance and Management

7.01. Governing Body (Class II)

7.01.01. A facility shall have an effective governing body, or designated persons so functioning, which is legally responsible for the operation of the facility.

7.01.02. The governing body shall adopt and enforce rules and regulations governing the health care and safety of patients, the protection of their personal and property rights, and the operation of the facility.

7.01.03. The governing body shall develop a written facility plan (See also Section 5.03.08 of these regulations) which shall be reviewed annually. In addition to the other requirements described in law and in these regulations, the facility plan shall include: (a) an annual operating budget including all anticipated income and expenses; and (b) a capital expenditure plan for at least a three-year period.

7.01.04. The governing body shall assure the development and maintenance of written policies and procedures which govern the services the facility provides. Such policies and procedures shall include as a minimum all policies and procedures required by these regulations.

7.01.05. A copy of each written policy shall be available for inspection on request by staff, residents, patients and members of the public.

7.02. Administrator (Class II)

7.02.01. The owner or governing body of a facility shall appoint a qualified administrator who holds a currently valid license or an emergency permit issued by the West Virginia Nursing Home Administrators Licensing Board, pursuant to Chapter 30, Article 25 of the West Virginia Code of 1931, as amended.

7.02.02. A facility shall notify the director in writing within ten days of any change in administrators.

7.02.03. An emergency administrator shall be employed only upon prior verbal approval from the director which the director shall confirm in writing.

7.02.04. The administrator shall be given the necessary authority and responsibility to manage the facility, to implement administrative policy,

and to plan, organize and direct the responsibilities delegated to him by the owner or governing body or assigned to him under these regulations.

7.02.05. A facility having an administrator performing in that capacity on other than a full-time basis shall have a written contract, or, if the owner functions as the administrator, a written statement, specifying the extent of the administrator's responsibility to the facility and stating specifically how the facility will assure that the functions assigned to the administrator under these regulations will be performed.

7.02.06. An individual shall not act as or be the administrator of more than two long-term care facilities, and shall otherwise conform to applicable rules and regulations promulgated by the West Virginia nursing home administrator's licensing board including limitations and documentation of service.

7.02.07. The governing body or owner shall designate in writing, by name or position, a qualified individual to act for the administrator in his absence.

7.03. Administrator Functions (Class II)

7.03.01. The administrator shall be responsible for managing the operations of the facility and delegating his authority as necessary.

7.03.02. The administrator shall have the authority to assure facility compliance with applicable provisions of laws and regulations.

7.03.03. The administrator shall assure that public information describing the facility's services is accurate and fully descriptive.

7.03.04. The administrator shall serve as liaison to the governing body, medical staff and other professional and supervisory staff.

7.03.05. The administrator shall evaluate and implement recommenda-

tions from the facility's committees established pursuant to these regulations.

7.03.06. The administrator shall participate regularly in continuing education programs and other professional activities in the field of long-term care and health services administration.

7.03.07. The administrator shall be responsible for the completion, maintenance and submission of reports and records required by the director.

7.03.08. Each member of the governing body and each owner shall be apprised by the administrator of all: (a) official inspection reports and complaint investigation reports issued by the director; (b) plans of correction submitted by the facility to the director; (c) facility licensure classification; and (d) requests, orders, complaints or policy statements filed with the administrator by the director.

7.03.09. Where these regulations require either statements of policy or procedures, or documentation the administrator shall be responsible for ensuring that all such statements are in writing, and unless these regulations state otherwise, such statements shall be reviewed annually, and signed and dated by the administrator at the most recent review.

7.03.10. The administrator shall be responsible for the reporting of deaths, reportable diseases, and any other reports required by state and federal law and regulations.

7.04. Admission, Discharge and Transfer Policies (Class II)

7.04.01. A facility shall develop and implement written policies regarding the admission, discharge and transfer of patients. Policies shall include but are not limited to those in this section.

7.04.02. A facility shall admit only those persons whose needs it can

meet with its services alone or in cooperation with other providers with whom it has appropriate written agreements to ensure its responsibility for the care provided to its patients.

7.04.03. A facility shall maintain written agreements assuring that medical and remedial services required by the patient but not regularly provided within the facility can be obtained promptly when needed.

7.04.04. A facility shall have written transfer agreements with one or more hospitals assuring prompt transfer of a patient to a hospital or other appropriate provider when that patient's physical or mental condition has changed so that the facility can no longer meet that patient's needs.

7.04.05. Except in an emergency, a facility shall consult the patient, his next of kin, his physician and the responsible agency, if any, at least seven days in advance of a patient's transfer or discharge.

7.05. Admission Contract (Class II)

7.05.01. The relationship of a patient to the facility shall be covered by a contract entered into at the time of or prior to the patient's admission, between the patient or his legal representative and the facility.

7.05.02. Each party to the contract shall have a copy of the contract.

7.05.03. The facility shall keep each contract on file for five years after the date it is terminated.

7.05.04. A contract shall include at least the following provisions:

(a) the daily, weekly or monthly rate charged by the facility, and refund provisions for unused portions;

(b) the services and accommodations to be provided by the facility in consideration for the daily, weekly or monthly rate;

(c) the services for which the facility will make arrangement;

(d) delineation of responsibilities for provision of payment for services not covered by the basic rate, including but not limited to medical treatment, medications, special equipment and appliances, dressings, clothing, personal supplies of the patient, services of related medical and paramedical personnel;

(e) facility procedures governing emergencies including immediate care of the patient, persons to be notified, and reports to be prepared;

(f) provision for review and renegotiation of the contract thirty days prior to any change in the terms of the contract; and

(g) the specification of any rights, duties, and obligations of the parties in addition to those required by law.

7.05.05. Subsection 7.05.04 shall not apply to patients receiving care and treatment pursuant to a provider agreement between the nursing home and the Department of Welfare under Title XIX and Chapter 9 of the Public Welfare Law of West Virginia; except that such patients shall receive a written contract delineating their responsibilities in accordance with Subsection 7.05.04.

7.06. Life Care Contract (Class III)

7.06.01. A facility or licensee is prohibited from entering into a life care contract as a provider of services without the director's prior written authorization.

7.06.02. An application for authorization must be submitted to the director, on forms provided by the director, stating fully the terms and conditions of the contract, the financial conditions of the applicant and other information as the director may require.

7.06.03. For the purposes of this subsection, a life care contract is an agreement between a facility and an individual in which the facility agrees to provide to the individual for the duration of his life or for a term of more than one year, nursing services, medical services or personal care services, in addition to board and lodging. The agreement is conditioned upon the individual's paying consideration to the facility in lieu of or in addition to the payment of the facility's customary charges for the care and services involved.

7.07. Prohibited Activities (Class III)

7.07.01. A facility is prohibited from advertising, asserting, representing or otherwise implying in any manner that it may render care or services other than those specifically within the scope of the license issued to it by the director.

7.07.02. A facility is prohibited from renting, leasing or using its premises for any purposes not related to that for which it is licensed, unless the use is specifically authorized in advance, in writing, by the director.

7.07.03. Residence in a facility is restricted to patients and staff, unless otherwise approved in writing by the director.

7.08. General Recordkeeping Requirements (Class III)

7.08.01. The facility shall maintain records in accordance with these regulations and accepted professional standards and practices.

7.08.02. Compliance with this section shall not preclude compliance with other specific provisions in these regulations.

7.08.03. Records and reports required by the provisions of these regulations shall be completed legibly in ink or typewritten.

7.08.04. Complete legible photocopies of records will be accepted in fulfillment of the requirements of these regulations.

7.09. Administrative Records (Class III) - The facility shall maintain on file in its administrative office the following records:

(a) documentation of the facility's professional and administrative staff meetings;

(b) documentation of visits by professional consultants employed by the facility in accordance with the requirements of these regulations;

(c) a current copy of these regulations;

(d) a copy of the facility's current policy and procedures manual containing copies of all policies and procedures required by the provisions of these regulations;

(e) reports of all inspections by government agencies together with summaries of corrective action taken in response to each report during the previous five years;

(f) reports of any other inspections required by these regulations;

(g) copies of contracts and agreements, including agreement for the provision of professional services by outside agencies or contractors, to which the facility is a party;

(h) documents demonstrating control and ownership of the facility;

(i) by-laws of the governing body, if applicable;

(j) reports of accidents or incidents involving patients as required by Section 9.06.01 and Section 11.08 of these regulations;

(k) records of all transactions conducted by the facility involving personal funds of patients in the facility during the previous five years (See Section 9.09 of these regulations);

(l) all menus prepared by the facility in accordance with the requirements of Section 12.03 of these regulations;

(m) records of food purchases made in compliance with Section 12.03 of these regulations;

(n) a copy of the facility's emergency evacuation plan as required by Section 8.02 of these regulations;

(o) a chronological record of all patients admitted to the facility with an identifying number, date of admission and where appropriate date of discharge; and

(p) all other records required by state or federal laws and regulations, except those for which maintenance elsewhere is required.

7.10. Personnel Records (Class III)

7.10.01. The facility shall maintain a confidential personnel record for each employee containing sufficient information to support the employee's assignment. The record shall contain at least the following information:

(a) a dated application for employment which includes a resume of the applicant's training and experience and verification by references;

(b) an employee health record containing the results of pre-employment and annual physical examination, including tuberculosis screening if indicated by exposure or prevalence;

(c) evaluations of work performance signed by employee and supervisor;

(d) subsequent change of status forms including change of address, salary adjustments, merit increases, promotions;

(e) current licensure, registration or certification status demonstrating appropriate licensure, registration or certification and periodic

verification; and

(f) a summary record of each employee's in-service training.

7.10.02. The facility shall make available to employees and assure explanation of written personnel policies, procedures, organizational charts and job descriptions.

7.10.03. The facility shall maintain a job description for each job category, including the following: (a) job title and qualifications, including educational and skill requirements; (b) general description of duties and responsibilities including limitations, if applicable; and (c) supervision to be given and received.

7.11. Staff Development (Class II)

7.11.01. Reference should be made to the following sections of these regulations to determine the minimum appropriate orientation and training requirements:

- (a) Section 7.10.01(f) (relating to in-service training records);
- (b) Sections 7.10.02 and 7.10.03 (relating to personnel policies, job descriptions, etc.);
- (c) Section 8.03.01 (relating to training for disasters);
- (d) Section 9.01.04 (relating to patients' rights training);
- (e) Section 9.10.07 (relating to training in complaint procedures);
- (f) Section 10.01.03(h) (relating to physician participation in training);
- (g) Section 11.02.04(e) (relating to director of nursing duty to orient and train nursing service personnel); and
- (h) Section 11.05.02 (relating to orientation and training in restorative nursing).

7.11.02. Personnel who provide direct patient care but are not required to be licensed, registered or certified shall receive special instruction under the direction of the director of nursing services.

7.11.03. A facility shall provide for a written plan covering a period of twelve months at a time for continuing education and training to develop the skills of all personnel. This program shall include at least:

- (a) training related to problems and needs of the aged, ill and disabled;

- (b) inservice training concerning prevention and control of infections, fire and safety rules, accident prevention, confidentiality of patient information, protection of patient privacy and personal property rights, and all other topics required by these regulations; and

- (c) provisions for periodic inservice training for all employees of the facility.

7.11.04. A facility shall document the contents of and attendance at inservice training.

7.11.05. A facility shall designate an inservice training coordinator who shall be responsible for: (a) implementing the planned program of inservice training; and (b) ensuring the documentation of attendance at all inservice training programs.

7.11.06. No employee with more than one year's tenure with the facility shall be counted in terms of meeting staffing requirements for licensure purposes unless that employee has completed appropriate inservice training requirements.

7.11.07. No employee shall be counted in terms of meeting staffing requirements for licensure purposes, unless that employee has completed

appropriate orientation requirements.

Section 8. General Health and Safety

8.01. General Health and Safety Requirements (Class I)

8.01.01. A facility shall develop and implement written policies and procedures to assure that a safe and sanitary environment exists for patients and personnel.

8.01.02. Employees with symptoms or signs of communicable diseases or infected skin lesions shall not be permitted to work.

8.01.03. Incidents and accidents to patients and personnel shall be reviewed to identify health and safety hazards.

8.02. Disaster Plan (Class II)

8.02.01. The facility shall have a written disaster plan approved by the director which states procedures to be followed in the event of fire, explosion or other internal disaster or occurrence which severely affects the functioning of the facility.

8.02.02. The disaster plan shall be developed and maintained with the assistance of qualified fire, safety, and other appropriate experts.

8.02.03. Brief instructions and guidelines regarding procedure shall be available at the nurses station.

8.02.04. Evacuation routes shall be posted as appropriate.

8.02.05. There shall be policies and procedures for implementing the plan.

8.02.06. The disaster plan shall include at least the following:

(a) assignment and training of personnel for specific tasks and responsibilities;

(b) procedures for identification and prompt transfer of casualties

and records, when necessary, to the facility most appropriate for the administration of definitive care;

(c) policies and procedures with regard to transporting casualties and uninjured individuals;

(d) instructions regarding the location and use of alarm systems and signals, and of firefighting equipment;

(e) information regarding methods of fire containment;

(f) procedures for notification of appropriate personnel;

(g) specification of evacuation routes and procedures; and

(h) frequency of fire drills.

8.03. Disaster Training (Class II)

8.03.01. The facility shall operate an internal disaster preparedness program which includes orientation and ongoing training and drills in procedures and specific assignments.

8.03.02. The disaster plan shall be rehearsed at least annually.

8.04. Fire Drills (Class I) - Fire drills shall be held at least quarterly for each shift.

8.05. Disaster Rehearsal and Fire Drill Reports (Class II) - A dated written report and evaluation of each disaster rehearsal and fire drill shall be maintained on file for at least two years.

8.06. Provisions for Emergency Calls (Class I)

8.06.01. A facility shall have at least one non-coin operated telephone or one extension on each patient occupied unit and additional telephones and extensions if needed to summon help in case of emergency.

8.06.02. A facility shall post emergency call information conspicuously near each telephone, exclusive of patient telephones, in the

facility. Such information shall include at least the following: (a) telephone number of fire, police and other appropriate emergency services; (b) names and telephone numbers of all personnel to be called in case of fire or emergency; (c) the name and telephone number of the physician on call; and (d) where applicable, name and telephone number for the consulting nurse when on call.

8.07. Infection and Communicable Disease Control (Class I)

8.07.01. A nursing home shall establish an infection control committee which shall consist of at least the following persons: (a) the administrator; (b) the medical director or another physician; (c) the director of the nursing services; (d) the director of the dietetic services; and (e) the housekeeper.

8.07.02. The infection control committee shall develop for the facility written policies and procedures on at least the following: (a) preventing and controlling infection in the facility; (b) maintaining a sanitary environment; (c) indentifying infections within the facility; (d) reviewing the health status of employees; (e) ensuring staff compliance with infection control policies and procedures; and (f) aseptic and isolation techniques.

8.07.03. The infection control committee shall meet no less than twice a year.

8.08. Isolation (Class I)

8.08.01. Any patient who contracts a communicable disease shall be segregated from other patients as described in the policies required by Section 8.07.02 of these regulations.

8.08.02. Isolation techniques to prevent the transfer of the disease

to other patients and staff of the facility shall be employed.

8.08.03. If ordered by a physician, the patient shall be removed from the facility as soon as suitable arrangements are made for continuing his care.

8.09. Animals (Class II)

8.09.01. No dogs, cats or other domestic animals shall be permitted within a nursing home or on its premises other than as specified herein.

8.09.02. If domestic animals other than strays are present on the nursing home grounds, there shall be provisions or areas set off and restricted so that patients may be free from risk of exposure to or physical harm from the animals, or the animals shall be leashed or otherwise limited in movement.

8.09.03. In the case of the presence of animals as part of a therapeutically designed and professionally supervised program which is of short duration, Subsection 8.09.02 need not apply.

8.09.04. If animals are present in the nursing home, they shall not be permitted in: (a) food preparation areas; (b) the pharmacy; (c) any storage areas; and (d) patient areas except as specified in Subsections 8.09.05, 8.09.06 and 8.09.07 herein.

8.09.05. Animals may be permitted in: (a) non-patient areas not otherwise prohibited by these regulations; (b) recreation areas or rooms; (c) areas especially set aside for such usage; and (d) halls, if leashed or caged, in transit to and from permissible areas. Animals shall not be displayed or transported during meal times.

8.09.06. Patients shall not be permitted to have pets living in their rooms.

8.09.07. Animals may be allowed in patient rooms only under strictly supervised conditions; only if none of the occupants of the room object; and only if the patients' medical conditions are not prohibitive.

8.09.08. Wild, dangerous or obviously ill animals are prohibited, except that such wild animals as squirrels, birds, chipmunks and the like which are natural to the neighborhood of the facility shall not be prohibited from the facility grounds.

8.09.09. Animals and their quarters shall be kept clean at all times.

8.09.10. State and local laws regarding rabies prevention and animal licensure shall be observed.

8.09.11. Appropriate sanitation procedures shall be applied.

8.09.12. Residents shall not be physically endangered.

8.09.13. The provisions of Section 8.09.01 do not apply to fish in aquariums.

Section 9. General Patients' Rights Policies and Procedures

9.01. Implementation of Patients' Rights (Class II)

9.01.01. The governing body of a facility shall develop written policies and procedures regarding the rights and responsibilities of patients.

9.01.02. Policies adopted shall be consistent with the provisions of these regulations.

9.01.03. The governing body shall be responsible for the facility's adherence to procedures implementing patients' rights policies.

9.01.04. The staff of a facility shall be oriented to and trained at least annually in proper implementation of patients' rights policies.

9.01.05. A copy of patients' rights policies and procedures shall be made available to patients, guardians, committee, next of kin, sponsoring

agencies, representative payees, as applicable, and upon request shall be made available to members of the public.

9.02. Limitation of Patients' Rights and Derivative Rights (Class II)

9.02.01. When the rights of an individual must be limited or restricted for medical reasons, those reasons shall be set forth in specificity in the individual's medical record and such restriction shall be only for a specific and limited period of time.

9.02.02. The rights and responsibilities set forth in these regulations shall devolve to parties other than the patient only under the following circumstances: (a) a patient is adjudicated incompetent; or (b) a patient has appointed, in writing, a power of attorney.

9.02.03. Nothing in these regulations shall in any way be construed to diminish or deprive any individual of rights recognized and established under other laws of the State of West Virginia or of the United States.

9.03. Civil Rights (Class II)

9.03.01. No facility which offers services to members of the general public shall deny admission to a prospective patient on the grounds of race, color, religion or national origin.

9.03.02. No patient shall be segregated, given separate treatment, restricted in the enjoyment of any advantage or privilege enjoyed by others in the facility, or provided with any aid, care services, or other benefits which are different or are provided in a different manner from those provided to others in the facility on the grounds of race, color, religion or national origin.

9.04. Rights to be Informed (Class II)

9.04.01. A patient shall be fully informed of these rights and of all

rules and regulations governing patient conduct and responsibilities during the duration of the patient's stay.

9.04.02. A patient shall be notified and informed of his rights, responsibilities and any applicable rules and regulations prior to or at the time of admission, and at least annually thereafter.

9.04.03. A patient shall acknowledge in writing that he has received notification of rights, responsibilities, rules and regulations.

9.04.04. An individual already in a facility at the time these regulations become effective shall be given notification of these patient rights within thirty days of the effective date of these regulations.

9.04.05. When a mentally retarded person is notified, notification shall be witnessed by a third person.

9.05. Rights to Communication and Personal Property (Class II)

9.05.01. A patient shall be encouraged and assisted throughout the duration of his stay to exercise his rights as a patient and as a citizen.

9.05.02. A patient shall be permitted to express grievances and to communicate to facility staff and outside representatives of the patient's choice the need for changes in facility policies.

9.05.03. A patient shall be free from restraint, interference, coercion, discrimination or reprisal as a result of exercising any of his rights.

9.05.04. A patient has the right to associate and communicate privately with persons of his choice.

9.05.05. A patient has the right to send and receive personal mail unopened.

9.05.06. A patient shall have access to telephones to make and

receive calls in privacy.

9.05.07. A patient has the right to meet with and participate in the activities of social, religious and community groups, at his discretion.

9.05.08. A married patient shall be assured privacy for visits by his spouse. If both spouses are inpatients in a facility, they shall be permitted to share a room.

9.05.09. A patient has the right to retain and use personal clothing and possessions subject to space limitations and the potential for infringing upon the rights of other patients.

9.05.10. A facility may specify in the admission contract conditions of facility liability for a patient's personal clothing and possessions.

9.06. Rights with Regard to Treatment (Class I)

9.06.01. No patient shall be verbally, mentally or physically abused, or neglected or mistreated, or restrained by physical or chemical means except in accordance with Section 11.06 of these regulations (relating to use of restraints). Alleged violations shall be reported immediately to appropriate individuals as designated by the facility and there shall be evidence that: (a) all such alleged violations are thoroughly investigated; (b) the results of such investigation are reported to the administrator or his designated representative within twenty-four (24) hours of the report of the incident; and (c) appropriate sanctions are invoked when the allegation is substantiated.

9.06.02. A mentally retarded individual who is a minor shall participate in a behavior modification program involving the use of restraints or aversive stimuli only upon the prior written informed consent of his parent or guardian.

9.06.03. A patient shall participate in experimental research only on the basis of prior written informed consent. Any such informed consent procedures shall be in conformance with applicable state and federal laws and regulations.

9.06.04. A patient shall be given the opportunity to participate in the planning of his total health and medical treatment.

9.06.05. A patient shall have the right to be fully informed of his medical condition.

9.06.06. A patient has the right to refuse any medical treatment.

9.06.07. A patient shall not be required to perform services for the facility, nor be required to participate in any social, recreational or religious activity.

9.07. Rights to Confidentiality (Class II)

9.07.01. A patient shall be assured confidential treatment of his personal and health care records and condition, which shall not be discussed without the patient's consent with persons not treating or caring for the patient.

9.07.02. A patient has the right to refuse the release of his personal or health care records to any individual outside the facility, except as required by law or third-party payment contracts applicable to that patient. A specific signed release shall be obtained for all other releases and no prior executed blanket release shall be used.

9.07.03. A patient shall have access to his records.

9.07.04. A patient who is being discharged shall have the right to obtain a copy of his records subject to paying the facility's reasonable fee to cover the expense of copying the records.

9.07.05. A patient shall be treated in a manner which assures privacy in treatment and in care for his personal needs.

9.08. Financial Rights (Class II)

9.08.01. A patient has the right to manage his personal financial affairs.

9.08.02. A facility shall manage a patient's personal funds only on the written prior authorization of the patient.

9.08.03. A patient shall be liable only for charges which have been included in the admission contract between the patient and the facility pursuant to Section 7.05 or Section 7.06 of these regulations or included in any written modification of the contract as provided in Section 7.05 or Section 7.06 of these regulations, except in the case of charges for emergency services which could not have been reasonably anticipated when the contract was signed or amended.

9.08.04. If emergency services provided are not included in the admission contract, the facility shall, when feasible, obtain the prior written consent of the patient or other financially responsible persons or agency stating the amount of the applicable charges.

9.08.05. No patient shall be transferred from or discharged by a facility except for medical reasons, for the patient's welfare or safety or the welfare or safety of other patients, for nonpayment for his stay or upon the patient's consent or request.

9.08.06. A patient whose cost of care is reimbursed under Titles XVIII or XIX of the Social Security Act shall be discharged for nonpayment only in accordance with the provisions of the Social Security Act and regulations.

9.09. Fiduciary Responsibilities of the Facility (Class III)

9.09.01. A facility which handles money for patients within the facility shall hold separately and in trust all patients' funds.

9.09.02. The facility shall administer the funds on behalf of the patient in the manner directed by the depositor.

9.09.03. The facility shall render a true and complete account upon request to the depositor and to the director and at least quarterly to the patient on forms provided by the director.

9.09.04. Upon termination of the deposit the facility shall account to the depositor for all funds received, expended and held on hand on forms specified by the director.

9.09.05. A facility which, in any one month, handles at least \$25 of patients' funds per patient, or at least \$500 for all patients shall give evidence of furnishing bond as assurance that the facility will comply with the requirements of this subsection.

9.09.06. The amount of the bond shall be at least \$2,500.

9.09.07. The director shall have the discretion to require more than a \$2,500 bond based on the amount of patients' funds handled by the facility.

9.09.08. The facility shall execute the bond with a corporate surety licensed to do business in the State of West Virginia.

9.09.09. The director may require a facility to file an additional bond in the following circumstances:

9.09.10. when the director determines that the amount of the bond or collateral on deposit is insufficient to protect the patients' money; or

9.09.11. when the amount of the bond or collateral is impaired by

recovery against it pursuant to the provisions of Chapter 16, Article 5C, Section 7 of the West Virginia Code of 1931, as amended by a person injured as a result of improper or unlawful handling of a patient's funds.

9.09.12. When a facility ceases to handle patients' funds in amounts which require a bond under this section, the director shall allow the release of the bond upon the facility's rendering a true and complete account to the depositors of patients' funds.

9.09.13. When a facility determines on the basis of medical judgment that a patient appears unable to manage his affairs, the administrator of the facility shall notify the patient's next of kin to initiate guardianship or incompetency proceedings.

9.09.14. A facility may initiate guardianship or incompetency proceedings on behalf of the patient if the patient has no family or if the family, once notified, fails to act.

9.09.15. An employee of a facility, or a person having a financial interest in the facility, with the exception of anyone related to such a person by consanguinity as defined in Section 5.02.02 of these regulations is prohibited from accepting appointment as guardian, committee or conservator of the estate of a patient, or from accepting a power of attorney for a patient.

9.09.16. An individual serving in a prohibited capacity under Subsection 9.09.15 of these regulations on the effective date of these regulations shall initiate proceedings within thirty days following the effective date of these regulations, to have himself removed from the prohibited capacity and to have another qualified person appointed.

9.10. Complaint Procedures (Class II)

9.10.01. A facility shall develop and implement written procedures for registering and responding to complaints by patients, their sponsors and the public.

9.10.02. A facility shall designate an employee to be responsible for receiving complaints.

9.10.03. A facility shall establish a method to inform the administrator of all complaints.

9.10.04. A facility shall establish a process for investigation and assessment of the validity of all complaints.

9.10.05. A facility shall provide a mechanism to record all complaints received and action taken on them.

9.10.06. A facility shall assure that careful consideration is given to each complaint even when it has been made by an individual who often makes complaints having no valid basis.

9.10.07. A facility shall establish a program to assure that its personnel are familiar with complaint policies and procedures.

9.10.08. A facility shall establish a program to educate patients, their next of kin and sponsors about the facility's complaint policies and procedures.

9.10.09. A facility's compliance with this section shall not obviate compliance with the provisions of Section 5.12 of these regulations.

9.11. Access (Class II)

9.11.01. A facility shall establish visiting hours, consisting of at least eight hours per day between 8:00 a.m. and 8:00 p.m., seven days per week. Visiting hours shall be posted conspicuously in a public place in the facility.

9.11.02. Relatives and members of the clergy shall be permitted to visit a critically ill patient at any time.

9.11.03. A facility shall permit full and free access to the facility to representatives of recognized community organizations and groups approved for such access by the director in the registry described in Section 5.14 of these regulations. Such access shall be limited to normal visiting hours unless by permission of the facility or as specified in Section 9.11.12 of these regulations regarding complaint investigation by the State commission on aging and its agents or as permitted by other state and federal law or rules and regulations.

9.11.04. Such representatives shall be permitted to visit, talk with, and to make personal, social and legal services available to any patient and to inform patients of their rights, entitlements and corresponding obligations under federal and state laws and rules and regulations through distribution of educational materials and in discussion with individual patients or groups of patients.

9.11.05. Such representatives shall be permitted to assist patients in asserting their legal rights including claims for public assistance, medical assistance, social security benefits and in other legal matters. Assistance may be provided individually or on a group basis, and may include organizational activity, counseling and litigation.

9.11.06. Such representatives shall be permitted to view all areas of the facility with the following exceptions: (a) living areas of a patient who objects to such inspection; (b) business records of the facility, unless the administrator consents; (c) personal and medical records of a patient, unless the patient consents in writing; (d) drug storage areas

which are not secure from access by unauthorized persons; (e) food service areas requiring sanitary conditions; and (f) any other areas where inspection might endanger any individual or might invade the privacy of any employee or patient.

9.11.07. An individual entering a facility pursuant to Section 9.11.03 of these regulations shall, upon entering the facility, notify the administrator or other available agent of the facility of said individual's presence. If requested by the facility, the individual shall provide identification as an authorized representative of an agency on the registry of such agencies maintained by the director.

9.11.07.01. No such person shall enter a patient's room without identifying himself to the patient and receiving the patient's permission to enter.

9.11.07.02. A patient shall have the right to refuse a visit pursuant to Section 9.11.03 of these regulations and such visit shall be terminated upon the patient's request.

9.11.07.03. Such individuals shall coordinate their activities with the facility's social worker or activity director.

9.11.08. A facility may restrict a particular visitor, or individual obtaining access under Section 9.11.03 of these regulations from the facility if his behavior is, in the judgment of the administrator, unreasonably disruptive of the functioning of the facility. The reasons for such judgment and restriction must be documented in writing and kept on file.

9.11.09. Communications between a patient and a person visiting pursuant to Section 9.11.03 of these regulations are deemed confidential.

9.11.10. No patient shall be punished or harassed by a facility, its

agents, its employees or its contractors because of his efforts to avail himself of his rights to communicate with others under this section. Violation of this provision shall be subject to the provisions of Section 5.12.17 of these regulations.

9.11.11. Nothing in this section shall be construed to restrict the rights of a patient to receive or refuse visitors other than those obtaining access under the provisions of Section 9.11.03 of these regulations.

9.11.12. The board of health recognizes the lawful interests of and the responsibilities of the State commission on aging with respect to the senior citizens of the state. In accordance with those interests and responsibilities, the commission on aging and its recognized affiliates, including the nursing home ombudsman program shall be granted full and free access privileges for the necessary conduct of complaint investigations.

9.12. Notice and Posting Requirements (Class III)

9.12.01. A facility shall post its license in a conspicuous and public place in plain view of all patients and visitors to the facility.

9.12.02. A facility shall post in a conspicuous place on each floor a legible notice stating the civil rights requirements of Section 9.03 of these regulations, the patients' rights requirements of Sections 9.04 through 9.08 of these regulations, the complaint procedures of Section 9.10 of these regulations, and the access requirements required in Section 9.11 of these regulations. In addition, a notice stating the visiting hours and access requirements of Section 9.12 shall be posted conspicuously at or near the entrance to the facility.

9.12.03. A facility shall provide each patient with a personal copy of a statement setting forth the requirements of Section 9 of these regula-

tions.

9.12.04. The document shall include in a prominent position the following statement:

"This Bill of Rights sets forth some fundamental human rights to which you, as a facility resident or patient, are entitled under West Virginia law and regulations. If you see a violation of any of the rights listed here, you are encouraged to report the violation to the administrator or [insert the name of the individual identified under Section 9.10.02 here], who is responsible for handling complaints. If the facility does not respond to your complaint promptly, favorably or sufficiently, or if you are dissatisfied for another reason, you may contact the Health Facilities Evaluation Division of the West Virginia Department of Health at 1800 Washington Street, East, Charleston, West Virginia, 25305, telephone (304) 348-0050, to report the violation and to request an inspection of the facility. Alternatively, you may contact the West Virginia Commission on Aging at the State Capitol, Charleston, West Virginia, 25305, telephone (304) 348-2411 or their local representative, if any [insert the appropriate name, address and telephone number here]. The names of those filing complaints will be kept confidential."

9.12.05. A copy of the above statement shall be given to each patient upon admission.

9.12.06. A copy of the above statement shall be given to each person already a patient or resident in a facility within fourteen days of the effective date of these regulations.

9.12.07. A facility staff member shall read the statement to any patient who for any reason cannot read the notice and shall also give the

patient a written copy.

9.12.08. A facility shall include in the patient's record a certification that the patient has received the required document, and where necessary that it has been read to him. The certification shall be signed both by the patient and the administrator of the facility and shall be dated to show when actual notice was received by the patient.

9.12.09. The facility shall inform each patient of the availability within the facility of a complete copy of these regulations and of Chapter 16, Article 5C of the West Virginia Code of 1931, as amended.

9.12.10. Upon request by a patient, the facility shall provide the patient the opportunity to inspect the law and these regulations.

Section 10. Medical and Dental Services

10.01. Medical Director (Class II)

10.01.01. Pursuant to a written agreement, a nursing home shall retain a physician licensed in West Virginia to serve as a medical director.

10.01.02. The medical director shall be responsible to the administrator as to medico-administrative matters.

10.01.03. The medical director's responsibilities shall include, but not be limited to the following:

- (a) delineating the responsibilities of attending physicians;
- (b) communicating with attending physicians to ensure that medical care plans are written as required by Section 10.03 of these regulations;
- (c) establishing written policies for the utilization of medical consultants and specialist services;
- (d) monitoring the health status of the facility's personnel, as required by Section 7.10.01 and Section 8.01 of these regulations;

(e) documenting investigation of incidents and accidents that occur on the premises;

(f) providing documented information to the administrator, in order to ensure a safe and sanitary environment for patients and personnel;

(g) assuming with the administrator responsibility for the execution of patient care policies;

(h) participating in the development of ongoing staff educational programs;

(i) participating or ensuring physician participation in facility committees such as: pharmaceutical and infection control; and

(j) reviewing and approving the credentials of any physician's assistant who will be working in the facility. A physician assistant shall be duly certified by the West Virginia board of medicine or the West Virginia board of osteopathy.

10.02. Availability of Medical Services (Class I)

10.02.01. A nursing home shall require upon admission the patient or the patient's sponsor to designate in writing a physician to attend the patient.

10.02.02. A facility shall confirm with the designated physician as soon as possible after the admission of the patient that the physician will provide at least those services required in Section 10.03 herein.

10.02.03. A facility shall require the attending physician or the patient to designate or authorize the administrator to designate an alternate physician to attend the patient in an emergency or whenever the attending physician is unavailable.

10.02.04. The administrator or his designee shall assure availability

of physician services in at least the following ways:

(a) verify that the patient's medical record contains documentation of the name, address and telephone number of the attending physician and the alternate physician;

(b) notify the attending physician whenever a physician is required or in an emergency;

(c) ensure that the patient is visited by a physician for required visits and in response to an emergency;

(d) assist in the development of, and implement, written procedures to provide emergency medical care;

(e) provide at each nurses' station a list of physicians available to provide emergency care; and

(f) ensure that efforts are made to notify the patient's next of kin or sponsor promptly after the patient has had an accident or suffers a serious deterioration in condition, in accordance with Section 11.08 of these regulations regarding accident and illness and Section 11.09 regarding death.

10.03. Services of Attending Physician (Class I)

10.03.01. An attending physician shall provide at least the following services:

(a) not more than five days before nor more than forty-eight hours after a patient's admission to a nursing home, a signed, dated admission and medical history including: a current physical examination; a current assessment of mental status; an admission diagnosis; and an estimate of rehabilitation potential;

(b) a medical visit to the patient as is medically necessary but at

least every thirty (30) days unless longer intervals are documented as sufficient by the physician in the patient's record. In no case shall the interval between visits be longer than sixty (60) days;

(c) a written, signed and dated progress note in the patient's record at the time of each visit;

(d) orders for medical care;

(e) a documented review and such revision as is necessary in the medical care plan at each visit;

(f) emergency medical service when available; and

(g) a signed review of any report made under Section 11.08 of these regulations (relating to incidents or accidents).

10.03.02. If the interval between physician visits to a patient is more than thirty (30) days, that patient's medical plan of care shall be reviewed by the designated physician with a licensed nurse of the facility by telephone and rewritten at least every thirty (30) days.

10.03.03. Whenever a physician fails to comply with the requirements of Section 10.03.01(b) or Section 10.03.02 of these regulations regarding visits to patients, the nursing home shall notify the physician of record of the requirements by registered mail and request the physician's compliance. If the physician then fails either to comply with the requirements or to make other arrangements for his patients within ten (10) days, the nursing home administrator shall declare the patient to be abandoned and notify the director in writing. The director shall notify the West Virginia board of medicine. The nursing home administrator shall then be allowed to seek other medical care for the patient.

10.03.04. If a physician uses a physician's assistant in a nursing

home, the physician first shall write to the facility identifying the physician assistant, delineating the physician assistant's functions and limitations, and documenting that the physician assistant is duly certified by the West Virginia board of medicine or the West Virginia board of osteopathy.

10.04. Availability of Dental Services (Class II)

10.04.01. A facility shall have a written plan to assist patients in obtaining routine and emergency dental care.

10.04.02. A facility shall help a patient to arrange transportation to and from a dentist, as appropriate.

10.05. Inservice Training in Dental Care (Class II) - A facility shall ensure that a dentist participates at least annually in its staff development program on dental and oral hygienic practices. If approved in writing by a dentist, this requirement may be satisfied by a licensed dental hygienist.

Section 11. Nursing Services

11.01. Nursing and Patient Care Staffing (Class I)

11.01.01. A nursing home shall provide licensed nursing services twenty-four hours a day, seven days a week.

11.01.02. The number of nursing personnel on duty shall be determined by the number of patients, their medical needs and the physical arrangement of the facility, but will at no time other than during short unforeseeable emergencies be less than sufficient to make available an average of two hours of nursing personnel time per patient per day. This two hours shall include four tenths of an hour (0.4 hours) of licensed nurse time and one and 6 tenths of an hour (1.6 hours) of aide time as shown in the table in

Section 11.01.03 of these regulations.

In facilities with less than sixty (60) beds, the director of nursing may be included in these staff to patient ratio calculations; in facilities with sixty (60) or more beds, the director of nurses shall not be included for purposes of evaluating compliance with this standard. In facilities with forty (40) or fewer beds, some exceptions to the general average have been made to provide for minimum coverage on all shifts. These exceptions are detailed in Section 11.01.03.

For purposes of evaluating compliance with these ratios, licensed nurses are included as nursing personnel. Adequate personnel to meet patient needs must be employed on each nursing shift. "Available" or "on call" does not meet the requirements for minimum staffing. For purposes of determining compliance with the minimum staffing allowable, no individual shall be counted as meeting these numerical requirements on any two consecutive shifts, unless the facility can demonstrate extenuating circumstances and only then as a non-routine occurrence. The director shall have the authority to require staff above the specified minimum ratios if required to meet patient needs.

11.01.03. MINIMUM RATIOS^(a) OF PATIENT CARE PERSONNEL TO PATIENTS

NUMBER OF PATIENTS	LICENSED NURSES		AIDS		TOTAL PATIENT CARE PERSONNEL	
	NUMBER PER DAY	HOURS PER DAY	NUMBER PER DAY	HOURS PER DAY	NUMBER PER DAY	HOURS PER DAY
3-10	3(b)	24	3	24	6	48
11-20	3(b)	24	4	32	7	56
21-30	3(b)	24	6	48	9	72
31-40	3(b)	24	8	64	11	88
41-50	3(b)	24	10	80	13	104
51-60	3(b)	24	12	96	15	120
61-70	3.5	28	14	112	17.5	140
71-80	4	32	16	128	20	160
81-90	4.5	36	18	144	22.5	180
91-100	5	40	20	160	25	200
101-110	5.5	44	22	176	27.5	220
111-120	6	48	24	192	30	240
121-130	6.5	52	26	208	32.5	260
131-140	7	56	28	224	35	280
141-150	7.5	60	30	240	37.5	300
151-160	8	64	32	256	40	320
161-170	8.5	68	34	272	42.5	340
171-180	9	72	36	288	45	360
181-190	9.5	76	38	304	47.5	380
191-200	10.0	80	40	320	50	400
Over 200	Shall be calculated for each facility					

(a) Numbers are full-time personnel equivalents based on forty (40) hours per week per shift.

(b) May include the director of nurses.

11.01.04. In addition to the requirements of Section 11.01.01, Section 11.01.02 and Section 11.01.03 of these regulations, if there is not a registered professional nurse on duty, there shall be a registered professional nurse on call.

11.01.05. There shall be a written agreement identifying the responsibilities of the individual on call.

11.02. Management of Nursing Services (Class I)

11.02.01. A nursing home shall organize, manage and operate its nursing services in accordance with a written organizational plan which describes the responsibility, authority and accountability relationships for the functions, activities and training of the nursing staff.

11.02.02. The facility shall have on duty at least five (5) days a week, eight (8) hours a day during the day shift a registered professional nurse designated in writing as the director of nursing services.

11.02.03. The director of nurses shall be a graduate of a school accredited by the West Virginia board of examiners for registered professional nurses. In addition, this individual shall meet, as a minimum, the following requirements for experience:

(a) for a graduate of a two-year program, three years of nursing experience, at least one of which shall have been in a supervisory capacity; or

(b) for a graduate of a three-year program, two years of nursing experience, at least one of which shall have been in a supervisory capacity; or

(c) for a graduate of a four-year program, at least one year of nursing experience; or

(d) for an individual with education beyond a four-year program (post-graduate), at least one year of nursing experience.

11.02.04. The director of nursing services shall be responsible for the direction, provision and quality of nursing care including, but not limited to, the following:

(a) assuring that a nursing care plan is established for each patient and the plan is reviewed and modified as necessary, but not less often than

quarterly;

(b) establishing written nursing procedures which are: essential to ensure safe practices; up to date and consistent with the type of service provided by the nursing home;

(c) evaluating nursing care practice;

(d) coordinating nursing services with other patient care services such as medical, physical therapy, occupational therapy, recreational activities, social services and dietary services;

(e) planning and conducting orientation and training programs for new nursing service personnel and a continuing inservice education program for all nursing service personnel;

(f) participating in the selection of prospective patients in terms of nursing services they need and nursing competencies available; and

(g) designating in writing a charge nurse on each nursing unit for each shift, seven days a week.

11.02.05. The director of nursing services shall establish procedures to assure that the patient's medical record is completed in a timely manner in accordance with the requirements of Section 15 of these regulations and includes at least the following:

(a) patient care plan, in accordance with the orders of the attending physician establishing and maintaining the plan;

(b) treatment notes;

(c) nursing notes in accordance with Section 15.04.01(f) of these regulations;

(d) nursing summaries;

(e) summaries of conferences with the designated physician or other

personnel involved in patient care;

(f) a record of medications administered; and

(g) the signed nursing discharge note.

11.03. Charge Nurse (Class II) - The charge nurse designated according to the provisions of Subsection 11.02.04.(g) of these regulations shall be responsible for at least the following: (a) supervising all nursing and ancillary personnel and activities related to nursing care in the nursing unit; and (b) assessing the needs of each patient, initiating the nursing care plan for meeting those needs, and coordinating the patient care plan.

11.04. Nursing Staff Responsibilities (Class I)

11.04.01. Each patient shall receive care in accordance with the physician's written orders and the nursing care plan.

11.04.02. Patients shall be kept clean, dry and comfortable.

11.04.03. Each patient shall receive care toward prevention of decubitus ulcers, infection, accidents and injury.

11.04.04. If necessary, a patient shall receive assistance in feeding.

11.04.05. All patients shall be treated in accordance with the provisions of Section 9 of these regulations specifying patient rights, policies and procedures.

11.04.06. Each patient shall have an individual medication record.

11.04.07. After each administration of medication, the following information shall be recorded on the medication record by the person who administers the medications: (a) name and strength of the drug administered; (b) date and time of administration; (c) dosage administered; (d) route of administration; and (e) signature of the individual administering

the drug.

11.04.08. Drugs and biologicals shall be administered to the patient as soon as possible after the doses have been prepared.

11.04.09. The medication shall be administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems.

11.04.10. Self-administration of medications by patients is not permitted except on written order of a physician and only permitted in special circumstances, which shall be set forth specifically in the individual's medical record.

11.05. Restorative Nursing Care (Class I)

11.05.01. An active restorative nursing care program shall be an integral part of the nursing service. The purpose of the program is to assist the patient to achieve and maintain an optimum level of functioning and self-care through education and retraining in the activities of daily living. Restorative nursing care services shall be performed daily for those patients who need such services. The program shall include, but not be limited to, such techniques as:

(a) maintaining proper body alignment and positioning of bedfast patients and those confined to chairs;

(b) encouraging the activity of patients by getting them out of bed for reasonable periods of time, except when this is contraindicated by physician's orders;

(c) maintaining a program of skin care to prevent pressure sores;

(d) maintaining a bowel and bladder training program;

(e) assisting patients to ambulate and to carry out prescribed

exercises between visits of the physical therapist;

(f) assisting patients to adjust to any disabilities and to direct their interest into useful activities; and

(g) assisting and teaching patients the activities of daily living such as: eating, dressing, grooming, and toilet activities.

11.05.02. Restorative nursing shall be a distinct part of the in-service education program. There shall be orientation and training of new employees and continuing education of all the nursing service employees in restorative nursing.

11.05.03. Observation of patients documented in the nursing notes shall give evidence that care is adequate and that the restorative nursing care program is followed. Observations which assist in determining if care is adequate may include such items as personal appearance and grooming, freedom from offensive odors, absence of pressure sores, and clean mouth and dentures. There shall be evidence that the staff encourage the patient to be out of bed, maintain good body positioning, eat in the dining room if able and to take part in diversional or recreational activities.

11.06. Use of Restraints (Class I)

11.06.01. Restraints shall be used only when necessary to protect the patient from self-injury or from injuring others. No patient shall be restrained for the convenience of the staff.

11.06.02. The use of physical or chemical restraints shall be authorized in writing by a physician for a specified and limited period of time.

11.06.03. The use of restraints on a mentally retarded individual shall be permitted when authorized by a physician or qualified mental

retardation professional for use during behavior modification sessions.

11.06.04. For purposes of evaluating compliance with Section 11.06.03 of the regulations a qualified mental retardation professional shall be: (a) a currently licensed physician, psychologist or registered nurse who has had at least one year of specialized training or experience in working with the mentally retarded; or (b) an M.S.W. with at least one year of specialized training or experience in working with the mentally retarded.

11.06.05. In case of emergency, licensed nursing personnel authorized by the facility in writing may order the use of restraints. Non-physician personnel shall notify the attending physician promptly.

11.06.06. Patients shall not be subjected to the following types of restraints under any conditions: canvas jackets, canvas sheets, or canvas cuffs; leather belts, leather cuffs or leather hand mitts. Locked restraints are prohibited. A patient shall not be confined to any room by locking or fastening a door from the outside.

11.06.07. A patient who is restrained shall have his position changed and the restraints removed long enough to give skin care every two hours.

11.06.08. Methods of restraint shall permit quick removal in case of fire or other emergency.

11.06.09. Side rails on beds are not subject to the provisions of Section 11.06.07 of these regulations.

11.07. Notice to Physician of Accident or Illness (Class I)

11.07.01. Any accident or change in a patient's condition shall be reported immediately to a registered professional nurse who shall notify the attending physician and the patient's family, guardian, committee or sponsor, as relevant.

11.07.02. The physician shall be notified within a reasonable period of time, depending upon the seriousness of the patient's condition.

11.08. Accident and Incident Reports (Class II)

11.08.01. A written report shall be made of any incident or accident in which a patient is involved, either inside or outside the nursing home.

11.08.02. The report shall include the following: (a) date; (b) time of occurrence; (c) place of occurrence; (d) details of the occurrence; (e) date and time physician was notified; and (f) date and signature of reviewing physician (as required in Section 10.03.01(g) of these regulations).

11.08.03. The report shall be written and signed by the person who is responsible for the patient at the time that the accident or change in condition occurred.

11.09. Report of Death (Class III) - The death of a patient shall be reported immediately to the attending physician and to the patient's family, guardian, committee or sponsor as relevant.

Section 12. Dietetic Service

12.01. Dietetic Service to be Maintained (Class I)

12.01.01. A nursing home shall maintain a dietetic service which shall be organized either directly by the nursing home or through written agreement with a contractor who complies with the standards of these regulations concerning the dietetic service.

12.01.02. The dietetic service shall be in full compliance with current West Virginia Food Service Sanitation Regulations promulgated by the West Virginia board of health.

12.02. Director and Staffing of Dietetic Service (Class II)

12.02.01. The dietetic service shall be under the direction of a qualified dietitian employed by the nursing home on a full or part-time basis.

12.02.02. A qualified dietitian must be registered, or eligible for registration, as determined by the Commission on Dietetic Registration of the American Dietetic Association.

12.02.03. If a part-time consultant dietitian is employed, the consultant visits must be at appropriate times and of sufficient duration to allow the carrying out of the duties set forth in Section 12.02.04 of these regulations, but shall not be less than four (4) hours per month per thirty (30) patients.

12.02.04. The duties of a dietitian director or consultant dietitian shall include at least the following:

- (a) advice to the administrator;
- (b) liaison with the medical and nursing staff;
- (c) patient counseling;
- (d) planning or approval of all menus;
- (e) guidance to the food service supervisor and staff; and

(f) all duties of the food service supervisor as set forth in Section 12.02.07 of these regulations if a food service supervisor is not employed on a full-time basis.

12.02.05. A dietetic service shall employ a full-time qualified food service supervisor as defined in Section 12.02.06 of these regulations whenever a full-time dietitian director is not employed.

12.02.06. A qualified food service supervisor must be:

- (a) a qualified dietitian; or

(b) a graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or

(c) qualified for membership in the Hospital, Institution, and Educational Food Service Society or its equivalent; or

(d) trained and experienced in food service supervision and management in a military service equivalent in content to the requirements specified in paragraphs (b) or (c) of this section.

12.02.07. The food service supervisor, under the direction of the dietitian director or consultant dietitian, shall be responsible for at least the following:

(a) daily operation of the dietetic service;

(b) ensuring that therapeutic diets are served as ordered by a physician, and that no patient receives a therapeutic diet except as ordered by a physician;

(c) recommending the quantity, kinds and variety of food and supplies to be purchased; and

(d) maintaining a file of standardized recipes for menu items which shall be used in preparing foods listed on the posted menus.

12.02.08. The dietetic service shall have sufficient supportive personnel trained in the preparation and service of food to carry out the functions of the dietetic service.

12.03. Menus and Supplies (Class II)

12.03.01. A facility shall have written dated menus which state portion sizes, as applicable, planned at least fourteen days in advance for all diets. Menus shall be posted in the food preparation area.

12.03.02. A menu shall not be used more than once in a week.

12.03.03. If cycle menus are used, the cycle must cover a minimum of three weeks.

12.03.04. A current therapeutic diet manual approved by the dietitian must be readily available to dietetic service personnel, nursing staff and attending physicians.

12.03.05. All menu changes shall be recorded.

12.03.06. The dietetic service shall keep on file all menus and menu changes for at least ninety days.

12.03.07. The dietetic service staff shall identify patients' likes and dislikes and substitute foods and drinks with equivalent nutritional values.

12.03.08. A supply of non-perishable foods sufficient to meet all patient needs for three days or such period as the department shall designate shall be kept on the premises for use in the event of an unforeseen interruption in normal food service. This supply may be incorporated with the regular stock of food supplies.

12.04. Meals (Class I)

12.04.01. The dietetic service shall ensure that each patient receives at least three meals daily or their equivalent which are prepared and served that day.

12.04.02. Dietetic service staff shall offer substitute foods and drinks with equivalent nutritional value to all patients who refuse the food served at meal times.

12.04.03. Meals served to a patient shall provide nutrients and calories for each patient, as ordered by a physician, based upon current

recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council as adjusted for age, sex, weight, physical activity and therapeutic needs; or as follows:

(a) Meat Group: Two or more servings of lean meat, fish, poultry, eggs or cheese with dried beans, other legumes or peanut butter as occasional alternatives. At least four ounces of edible meat or its equivalent shall be served daily. Eggs shall be served at least four times per week;

(b) Milk: Two or more cups of milk or its equivalent. Cheese, cottage cheese, yogurt or ice cream may be used to meet part of the milk requirement;

(c) Vegetables: Two or more 1/2 cup servings each day including yellow, orange or leafy green vegetables or other good source of Vitamin A at least four times per week;

(d) Fruit: Two or more 1/2 cup servings each day, at least one of which shall be a citrus fruit or other good source of Vitamin C;

(e) Whole Grain or Enriched Bread and Cereal Products: One or more servings each meal with at least four servings each day;

(f) Other foods to round out meals and snacks to provide additional calories.

12.04.04. Therapeutic and regular diets shall be served to patients in accordance with a physician's written orders retained in the patient's record of care.

12.04.05. Food service personnel shall be advised in writing of such diet orders.

12.04.06. Physician orders for regular and therapeutic diets shall be reviewed at the same time all other orders are reviewed and at least every

three months.

12.04.07. Not more than fourteen hours shall elapse between an evening meal and breakfast the next morning, which shall not be served before 7:00 a.m.

12.04.08. Every patient shall be encouraged to eat in designated dining areas, unless medically contraindicated.

12.04.09. Bedtime snacks of nourishing quality shall be offered routinely to all patients, unless medically contraindicated.

12.04.10. Trays served to patients in their rooms shall be provided with firm supports.

12.04.11. Self-help feeding devices shall be provided as appropriate and their use shall be encouraged.

12.04.12. Foods shall be prepared by methods that conserve nutritional value, flavor and appearance and shall be attractively served at optimum temperatures in a form to meet the needs of individual patients.

12.04.13. All salt used shall be iodized.

12.04.14. Salt shall not be omitted in food preparation unless by physician's orders.

Section 13. Pharmaceutical Services

13.01. Provision of Pharmaceutical Services (Class I)

13.01.01. A facility shall ensure the provision of pharmaceutical services. All pharmaceutical services shall be provided in accordance with these regulations and all other applicable federal, state and local laws and rules and regulations of the West Virginia board of pharmacy.

13.01.02. The nursing home shall have a written agreement with any consultant pharmacist in accordance with these regulations and rules and

regulations of the West Virginia board of pharmacy.

13.02. Supervision of Pharmaceutical Services (Class II)

13.02.01. The pharmaceutical services shall be under the supervision of a pharmacist currently registered with the West Virginia board of pharmacy.

13.02.02. The consultant pharmacist shall be responsible for:

(a) the receipt, control and distribution of drugs and for maintaining at least those records required by applicable federal, state and local laws and regulations;

(b) developing in consultation with the pharmaceutical services committee a manual of policies and procedures in accordance with these regulations and including at least those matters required by the rules and regulations of the West Virginia board of pharmacy;

(c) providing at least one educational program each year and additional inservice training as necessary for all nursing personnel on any subject pertaining to the pharmaceutical service of the facility or drug therapy in geriatric patients;

(d) participating in the activities of the pharmaceutical services committee;

(e) providing the pharmaceutical services committee with a written report at least quarterly concerning the status of the facility's pharmaceutical services and an analysis of any incidents relating to drug therapy;

(f) providing a documented drug regimen review in the medical record of each patient at least monthly and reporting any irregularities in writing to the attending physician, the director of nursing services and to the

facility administrator; and

(g) inspecting each nursing station and all other areas of the nursing home where drugs are stored at least once each month. The inspection shall be documented in writing with a signed and dated report by the pharmacist; the reports shall be submitted to the pharmaceutical services committee at its next scheduled quarterly meeting.

13.03. Pharmaceutical Services Committee (Class III)

13.03.01. A nursing home shall have a pharmaceutical services committee which develops written policies and procedures for safe and effective drug therapy, administration, distribution, control and use.

13.03.02. The committee shall be composed of at least the pharmacist, the director of nursing services, the nursing home administrator and one physician.

13.03.03. The committee shall oversee pharmaceutical services in the nursing home, make recommendations for improvement and monitor the pharmaceutical service to ensure its accuracy and adequacy.

13.03.04. The committee shall meet at least quarterly and document its activities, findings and recommendations in writing.

13.03.05. The pharmaceutical services committee shall review incidents relating to drug therapy and the monthly inspection reports of the pharmacist.

13.04. Pharmaceutical Policies and Procedures (Class I)

13.04.01. All orders for medications and treatments for patients shall be in writing and signed by the attending physician.

13.04.02. A physician's verbal or telephone order for medications or treatments may be received only by a licensed nurse, a pharmacist or a

certified physician assistant, if identified as a responsibility in the physician assistant's job description.

13.04.03. A physician's verbal or telephone orders shall be written immediately on the patient's order sheet, noted in the permanent medical record and signed by the accepting licensed nurse, pharmacist or certified physician's assistant and shall be countersigned by the physician on his next visit or by mail if returned within ten (10) days.

13.04.04. Drugs shall be administered only by physicians, licensed nurses or certified physician assistants as detailed in their job descriptions.

13.04.05. Written policies and procedures shall be established by the pharmaceutical services committee to ensure that drugs are checked against physicians' orders before the drugs are administered to the patient.

13.04.06. Medication errors and adverse drug reactions shall be reported immediately to the patient's physician verbally, and entered in the patient's medical record. A written incident report shall be submitted to the pharmaceutical services committee.

13.04.07. An adverse drug reaction or allergy shall also be documented on the outside cover of the medical record.

13.04.08. An up-to-date medication information reference book, determined by the pharmaceutical service committee, concerning prescription and non prescription drugs, their indications, actions, adverse reactions, interactions, contraindications, administration, precautions and dosages shall be kept at each nursing station.

13.04.09. Medications not specifically limited as to time or number of doses when ordered by the physician shall be controlled by automatic stop

orders in accordance with written policies and procedures established by the pharmaceutical services committee.

13.05. Patient Medications (Class I)

13.05.01. A patient's medications shall be labeled in accordance with these regulations and rules and regulations of the West Virginia board of pharmacy.

13.05.02. Except for single unit dose package drug distribution systems, the label of each patient's individual prescription medication container shall clearly state the following information:

- (a) the patient's name;
- (b) the name and strength of the drug;
- (c) drug's date of issue from the pharmacy;
- (d) name of prescribing physician;
- (e) the pharmacy name, address and telephone number;
- (f) the prescription number; and
- (g) the directions on how and when to administer the medication.

13.05.03. All drugs shall be stored in a locked cabinet or medicine cart near the nurses station, and only personnel authorized in writing shall have access to the keys.

13.05.04. A patient's prescription medication shall be stored in the container in which it is received from the pharmacy and all nonprescription drugs shall be stored in their original container as labeled and distributed by the manufacturer. Nursing personnel shall not package, repackage, bottle or label in whole or in part any medication or alter in any way by tampering or defacing any labeled medication.

13.05.05. A medication container with an incomplete or illegible

label shall be returned to the pharmacy for relabeling.

13.05.06. Medication shall be released to a patient upon discharge only on the written authorization of a physician.

13.05.07. Medication released to a patient shall be properly labeled and packaged by the pharmacist with directions for use in accordance with the rules and regulations of the West Virginia board of pharmacy.

13.05.08. Documentation of medication released to a patient shall be entered in the patient's medical record.

13.05.09. All discontinued, outdated, adulterated, deteriorated and deceased patients' medications shall be disposed of or destroyed in the nursing home by the consulting pharmacist and a licensed nurse employed by the nursing home once each month or more often if needed. This procedure shall be documented in writing in accordance with guidelines established by the director. All medication destruction records shall be signed and dated by the consultant pharmacist and by the licensed nurse. All medication destruction records shall be kept on file at the nursing home for a period of two (2) years. The medication destruction record shall clearly state the following information:

- (a) the name of the patient for whom the drug was prescribed;
- (b) the prescription number;
- (c) the name of the pharmacy;
- (d) the name and strength of the drug; and
- (e) the amount of drug that was destroyed.

13.06. Medication Storage (Class II)

13.06.01. Schedule II controlled drugs shall be stored in such a manner so that they are securely protected by two locks.

13.06.02. Medications which require refrigeration shall be kept in a locked medication refrigerator, in a refrigerator located in a locked area, or in a locked box in a refrigerator separate from food. The refrigerator shall have a thermometer to indicate temperature.

13.06.03. Medication for external use only shall be kept separate from medications which are taken internally.

13.06.04. The control of drugs subject to the Uniform Controlled Substances Act (Chapter 60A of the West Virginia Code of 1931, as amended) shall comply with federal and state laws and rules and regulations of the West Virginia board of pharmacy concerning procurement, storage, dispensing, administration and disposition of controlled substances.

13.06.05. The pharmaceutical services committee shall establish and approve in writing each year the list of contents of the emergency medication kits. In accordance with guidelines established by the director and rules and regulations of the West Virginia board of pharmacy, an emergency medication kit shall be stored in a locked room or locked compartment near each nursing station.

13.06.06. There shall be a typewritten list of contents of the emergency medication kit, stating the name, strength and quantity of the drugs present in the emergency medication kit and posted near the telephone at each nursing station.

13.06.07. Each time the emergency medication kit is used the following information shall be written on an Emergency Medication Kit Inventory Record as described below:

- (a) the patient's name;
- (b) the name and strength of the drug administered;

- (c) the route of administration;
- (d) the date and time the drug is administered;
- (e) the amount of drug administered;
- (f) the amount of drug remaining in the kit;
- (g) the type of emergency;
- (h) the name of the physician who ordered the drug; and
- (i) the signature of the licensed nurse administering the drug.

13.06.08. Emergency oxygen and tracheal suction devices shall be readily available in the facility.

Section 14. Social Work Services and Recreation and Activity Services

14.01. Social Work Services to be Provided (Class II)

14.01.01. A facility shall maintain the capacity directly or through contracted services to identify and meet social, psychosocial, emotional and cultural needs which are related to illness, stress, family and community relationships, death, treatment and stay in the facility.

14.01.02. If social services are provided by contract, a nursing home shall keep a current list of available social service agencies and resources including but not limited to those agencies affiliated with the West Virginia commission on aging.

14.01.03. The social work service shall serve as a liaison between patient needs and community resources and where multiple-agency contacts are necessary the social work service shall serve as the coordinating agent for the patient.

14.02. Plan for Social Work Services (Class II)

14.02.01. There shall be written policies and procedures regarding the scope and conduct of the social work service.

14.02.02. In addition to general social work activities, the social work service responsibilities shall include at least:

(a) pre admission contact and assessment, including the exploration of alternative types of placement or services with both the patient and the family;

(b) orientation at admission;

(c) integration of social services with other services and care provided for the patient;

(d) communication to other services of psychosocial factors which could affect services rendered or care delivered to the patient;

(e) provision of counseling to patient's families;

(f) participation in the development of patient care plans as described in Section 15.01 of these regulations;

(g) special attention to needs related to death and dying; and

(h) coordination of discharge planning as described in Section 15.01.07 and Section 15.01.08 of these regulations.

14.03. Social Work Services Staffing (Class II)

14.03.01. A designated staff member shall be responsible for directing social work services.

14.03.02. An individual may serve as the director of social services provided one of the following requirements regarding education, experience and post-degree training are met: (a) an M.S.W. graduate of a school of social work accredited by the Council on Social Work Education or an M.S. graduate in gerontology; (b) an M.S. or M.A. graduate in a related field or an M.S.W. graduate of a non-accredited school of social work, provided that supervision by a qualified social work consultant be provided with quarterly

consultation for a period of one year; (c) a B.S.W. graduate from an accredited school of social work with one year of experience in a health care facility, medical social work or gerontology, provided that supervision by a qualified social work consultant be provided for a period of one year with consultation every two months for a period of six months and quarterly for six additional months; (d) a B.A. or a B.S. graduate in a related field or a B.S.W. graduate of a non-accredited school of social work with two years of experience in a health care facility, medical social work or gerontology, provided that supervision by a qualified social work consultant be provided for a period of one year with consultation every two months for six months and quarterly for six additional months; (e) an individual meeting the educational requirements of (c) or (d) above but not the experience requirements, provided supervision be provided by a qualified social work consultant with consultation every two months for a period of two years and as specified in (c) or (d) thereafter; or (f) a non-degreed individual or an individual with a degree in a non related field, provided that supervision by a qualified social worker be provided for a period of two years with consultation every two months and thereafter no less than quarterly.

14.03.03. An individual who has completed all educational, experience and received any supervision and consultation required by Sections 14.03.02.(a), 14.03.02.(b), 14.03.02.(c), 14.03.02.(d) or 14.03.02.(e) may qualify as a social work consultant for the purposes of these regulations.

14.03.04. For purposes of evaluating compliance with the requirements of Section 14.03.02 of these regulations, a degree related to social work shall include: gerontology, clinical psychology, sociology, vocational

rehabilitation, community mental health, counseling and guidance or any other degree for which prior written approval is obtained from the director.

14.03.05. There shall be sufficient social work staff to provide the equivalent of one staff person per one hundred and twenty (120) patients. This requirement may be satisfied by part time staff or staff with assignments and responsibilities in both social services and recreation and activities, provided the overall requirements of Section 14 of these regulations are met.

14.03.06. The director of social services may also serve as the director of recreation and activities, provided the overall requirements of Section 14 of these regulations are met.

14.04. Social Work Services Facilities (Class II) - Facilities shall be adequate for social services personnel and easily accessible to patients, families and staff and shall provide privacy for interviews and space for confidential storage of records.

14.05. Recreation and Activities to be Provided (Class II)

14.05.01. A nursing home shall provide a planned and diversified program of patient activities.

14.05.02. The patient activities program shall be planned to maximize self care, resumption of normal activities and an active level of patient participation.

14.05.03. Only upon a physician's orders shall a patient's participation in an activities program be restricted and such order shall be given in accordance with Section 9.05.07 Section 9.06.07 and Section 9.02 of these regulations.

14.05.04. A diversity of physical, social, spiritual and recreational

activities shall be planned and available seven days a week.

14.05.05. A facility shall make provisions to enable relatives and friends of a patient to participate in activities with a patient.

14.06. Recreation and Activities Staffing (Class II)

14.06.01. A nursing home shall appoint a patient activities director and such additional staff as needed to carry out the patient activities program, but not to be less than the equivalent of one staff member per 120 patients in the nursing home.

14.06.02. For the purposes of evaluating compliance with these regulations, a patient activities director must meet one of the following combinations of experience, training and consultation:

(a) completion of a 36 hour patient activity coordinator course approved by the Federal Department of Health and Human Services or the director, and two fulltime years of experience in patient activities in a health care facility under the supervision of a qualified consultant in patient activities as described below in Section 14.06.02(c); or

(b) a bachelor-level degree in a relevant field of training, such as recreation or recreation therapy with no experience, or in a related area such as physical therapy, occupational therapy, arts and crafts, music, human behavior, sociology or social work, psychology, etc., and a year of fulltime experience in patient activities in a health care facility under the supervision of a qualified patient activities director or consultation from a qualified consultant as described below in Section 14.06.02(c) of these regulations; or

(c) a masters degree in recreation or recreation therapy or a masters degree in a related area with one fulltime year of experience in a patient

activity program in a health care facility or in a geriatric program. An individual with such qualifications shall also qualify as a consultant in patient activities.

14.06.03. A patient activities director's duties shall include at least the following:

(a) maintenance of a current record of community services, resources, programs and facility materials accessible to the staff, patients, and patients' relatives and friends;

(b) development of a written monthly activities schedule at least one month in advance;

(c) ascertaining from each patient's care plan any physician's orders limiting any patient's participation in the activities program; and

(d) providing inservice training to other staff members and volunteers on patient activities.

14.07. Recreation and Activities Facilities (Class II)

14.07.01. A patient activities area shall be provided with comfortable furniture in good repair.

14.07.02. A facility shall provide transportation for patients to and from patient activities.

14.07.03. Appropriate activities shall be provided to patients unable to leave their rooms.

Section 15. Plans for Care and Medical Records

15.01. Plans for Care and Discharge (Class I)

15.01.01. A patient care plan shall be developed for each patient upon admission and maintained by the nursing service in cooperation with all other services. The plan of care shall provide a profile of the needs of

the individual patient, identify the role of each service in meeting those needs, and the supportive measures each service will use to complement each in the accomplishment of the overall goal of care. The patient care plan shall be in writing and contain at least the following:

- (a) goals to be accomplished;
- (b) individually designed activities to meet goals;
- (c) therapies;
- (d) treatments, including diet requirements; and
- (e) a statement of which professional service or individual is responsible for each element prescribed in the plan.

15.01.02. A nursing home shall have written policies and procedures to ensure that through patient care conferences or other methods of coordination, the patient care plan shall be reviewed and revised as needed but at least quarterly. Such review shall be noted in the medical record.

15.01.03. Policies and procedures shall delineate the rules and responsibilities of each service in relation to the patient care plan.

15.01.04. The patient care plan shall be available for use by all personnel caring for the patient.

15.01.05. Relevant information from the patient care plan shall be made available with other information that is transmitted when the patient is transferred to another facility or referred for continuing care by other agencies upon discharge to the community.

15.01.06. A nursing care plan shall be maintained in accordance with the orders of the designated physician establishing and maintaining the plan. It shall include directions for the following:

- (a) how the nursing staff will provide care needed to achieve the

goals in the patient care plan;

- (b) medications and treatments;
- (c) diets and special dietary needs;
- (d) activity limitations, if any;
- (e) a bathing and grooming schedule; and
- (f) recreational activities and limitations for the patient.

15.01.07. A discharge plan shall be maintained and shall include at least the following: (a) an initial assessment at admission or within no less than seven (7) days after the date of admission, including discharge potential and goals; (b) relevant information concerning such areas as nursing assessment, social history, rehabilitation potential, patient needs at discharge and community resources available; (c) periodic review and reevaluation at regular intervals, preferably on a monthly basis for the first three months after admission and in no instance less than quarterly. Detail and content of the discharge plan after the initial assessment will vary with the condition of the patient.

15.01.08. When a patient is discharged to another facility or agency or to his home, a discharge summary shall be prepared prior to the discharge. The complete discharge summary shall be transmitted to the receiving facility or agency at the time of discharge. If the patient is discharged to his home, the patient shall be given appropriate information concerning his needs for care and medication. The discharge summary shall include: (a) patient name and identifying number; (b) name of attending physician; (c) date of admission; (d) date of discharge; (e) provisional and final diagnosis; (f) course of treatment and care in the facility; (g) pertinent diagnostic findings; (h) essential information regarding the

patients' illness or problems; (i) restorative procedures; (j) medication instructions; (k) facility, agency or location to which discharged; and (l) dated physician signature.

15.02. Medical Record Required (Class II)

15.02.01. A facility shall maintain a medical record for each patient, which complies with the standards set forth in this section.

15.02.02. Medical records shall be completed promptly within a time specified in the facility's policies and procedures, not to exceed thirty days past discharge.

15.02.03. All clinical information pertaining to a patient's stay and medical care shall be centralized in a single medical record following discharge.

15.02.04. Medical records of discharged patients shall be maintained for at least three years from date of discharge, or in the case of a minor, three years after the patient becomes of age under state law.

15.02.05. Overall supervisory responsibility for the maintenance of medical records services shall be assigned to a fulltime employee of facility.

15.02.06. The facility shall employ sufficient personnel competent to perform the functions required of a medical record service.

15.02.07. Records shall be maintained at a location that is accessible to appropriate staff.

15.02.08. Medical records shall be kept in a manner which is orderly and which maintains ready accessibility and retrieval of information.

15.03. Confidentiality of Medical Records (Class II)

15.03.01. The facility shall safeguard medical record information

against loss, destruction or unauthorized use.

15.03.02. The facility shall establish written policies and procedures specifying who may use medical records, under what conditions they may be removed from the facility and under what conditions information from them may be released.

15.03.03. Access to medical records shall be limited to designated staff members, physicians, representatives of the West Virginia board of health, authorized representatives of federal or state departments of health, agencies designated by a third party payment contract, the patient or a person or agency given written permission by the patient or by the patient's guardian or committee.

15.04. Contents of Medical Records (Class II)

15.04.01. A patient's medical record shall contain at least:

- (a) basic identifying information as listed in Section 15.04.04;
- (b) date and time of admission;
- (c) a signed, dated admission and medical history, completed in accordance with Section 10.03.01(a);
- (d) signed physician's orders, including those pertaining to medication, special procedures, treatments, diet and medical procedures;
- (e) progress notes signed and dated at the time of each entry by appropriate staff authorized to write notes according to the written policies of the facility;
- (f) nursing notes as kept current and signed by nursing personnel;
- (g) signed and dated laboratory and x-ray reports, when such procedures have been ordered;
- (h) a patient care plan as required in Section 15.01.01;

- (i) a nursing care plan as required in Section 15.01.06;
- (j) a discharge plan as required in Section 15.01.07; and
- (k) a discharge summary as required in Section 15.01.08.

15.04.02. A physician shall countersign all verbal orders at the time of his next visit or by mail if returned within ten (10) days.

15.04.03. Policies shall specify the authority of at least the following types of practitioners in addition to physicians to write progress notes in medical records: nurses; social workers; therapists; psychologists; dentists and podiatrists.

15.04.04. Basic identifying information shall include:

- (a) patient's name and any identification number;
- (b) room number;
- (c) social security number;
- (d) marital status;
- (e) date of birth;
- (f) sex;
- (g) home address;
- (h) telephone number of referral agency including hospital from which admitted;
- (i) name, address, telephone number of attending physician;
- (j) name, address and telephone number of next of kin or other responsible person;
- (k) religious preference; and
- (l) any pre-burial arrangements.

15.04.05. Nursing notes shall include at least:

- (a) description of the care provided;

- (b) nursing history;
- (c) assessment of observed signs and symptoms;
- (d) reactions to treatments and medications;
- (e) changes in patient's physical or emotional condition;
- (f) documentation of any unusual incident involving a patient; and
- (g) nursing summary as indicated by patient needs.

Section 16. Penalties

16.01. Director's Authority

16.01.01. The director shall have the authority to invoke penalties against a facility violating the provisions of these regulations in accordance with the provisions of these regulations and pursuant to Chapter 16, Article 5C of the West Virginia Code of 1931, as amended.

16.01.02. The director shall by order reclassify a facility or reduce the bed capacity of a facility or both, when on the basis of inspection he makes the following findings: (a) that the licensee is not providing adequate care under the facility's existing classification or bed capacity; and (b) that reclassification, reduction in bed capacity or both would place the facility in a position to render adequate care.

16.01.03. The director shall notify a licensee of reclassification, reduction in bed capacity or both, stating the terms of the order, the reasons therefor and the date set for compliance.

16.01.04. The director may suspend or revoke a license if he finds upon inspection that there has been a substantial failure to comply with the provisions of these regulations or Chapter 16, Article 5C of the West Virginia Code of 1931, as amended.

16.01.05. The director may refuse to grant a license and may revoke a

license if he determines there has been subterfuge or other dishonest action in applying for an original or renewal license.

16.01.06. The suspension, expiration, forfeiture or cancellation by operation of law or order of the director of a license issued by the director shall not deprive the director of the authority as provided by law and these regulations to take any of following actions: (a) institute or continue a disciplinary proceeding; (b) institute or continue a proceeding for the denial of a license application; (c) enter an order denying a license application; and (d) take any other disciplinary action as provided by state law or rules and regulations.

16.01.07. Withdrawal of a license application shall not deprive the director of the right to penalize the applicant on any other ground using any authority otherwise provided by law or these regulations.

16.02. Procedure for Director's Action

16.02.01. When the director takes action pursuant to Section 16.01 of these regulations, the director shall file a complaint stating the facts constituting a ground or grounds for the action.

16.02.02. When the director files a complaint, the director shall notify the licensee, in writing, of the filing of the complaint.

16.02.03. Notice shall include the following items: (a) a copy of the complaint; and (b) notification of the availability of a hearing pursuant to Section 17 of these regulations.

16.02.04. Notice shall be served by certified mail, return receipt requested.

16.02.05. The director has the right to enforce a regulation, administratively or in court, without first affording an opportunity to

correct a deficiency pursuant to Section 5.07 of these regulations when the director finds either of the following: (a) that violation of the regulation jeopardizes the health or safety of a patient; or (b) the violation is the second or subsequent violation of the same regulation within twelve months.

16.03. Procedure for Civil Penalties

16.03.01. Upon a determination that civil penalties are to be imposed pursuant to the West Virginia Code of 1931, as amended and Section 5.07.11 of these regulations, the director shall issue a citation to the licensee or non-licensed operator.

16.03.02. The citation shall be served personally upon the licensee or non-licensed operator by a duly authorized representative of the director. If a citation is not served personally, it shall be sent by registered or certified mail, return receipt requested.

16.03.03. Each citation shall be in writing and shall include at least the following: (a) an assessment of civil penalties according to the nature of the violation or violations; and (b) a description of the nature of the violation fully stating the manner in which the licensee or non-licensed operator violated a specific statutory provision or regulation and the particular place or area of the facility in which it occurred.

16.03.04. The name of any patient jeopardized by the violation shall not be specified in the citation in order to protect the privacy of the patient. However, at the time the licensee or non-licensed operator is served with the citation, the licensee or non-licensed operator shall also be served with a written list of each of the names of the patients alleged to have been jeopardized by the violation. If the violation jeopardized all

of the patients of the entire facility, such fact shall be specified in the citation and a written list of the names of the patients involved is not required to be furnished to the licensee or non-licensed operator.

16.03.05. For each violation of a Class I standard, as listed in Section 5.10.05 a civil penalty of not less than one hundred or more than one thousand dollars shall be imposed. For each violation of a Class II standard, as listed in Section 5.10.06, a civil penalty of not less than fifty dollars and not more than one hundred dollars shall be imposed. For each violation of a Class III standard, as listed in Section 5.10.07, a civil penalty of not less than twenty-five dollars and not more than fifty dollars shall be imposed.

16.03.06. Each day a violation continues, after the date by which correction was required by an approved plan of correction, or if an approved plan of correction was not submitted, the date on which such plan was due, shall constitute a separate violation.

16.03.07. In fixing the amount of the civil penalty to be imposed for violations, the director shall consider: (a) the gravity of the violation, which shall include: (1) the degree of substantial probability that death or serious physical harm will result and, if applicable, did result from the violation; (2) the severity of serious physical harm most likely to result, and if applicable, that did result, from the violation; and (3) the extent to which the provisions of the applicable statutes or regulations were violated; and (b) any previous violations committed by the licensee.

16.03.08. If a licensee or non-licensed operator does not wish to contest a citation, he shall submit to the director, within four business days after the issuance of the citation, the total sum of the penalty

assessed.

16.03.09. If a licensee or a non-licensed operator desires to contest a citation, or the date specified for correction of a violation, he shall, within four business days after service of the citation or specification of time in which a violation is to be corrected, serve upon the director, either personally or by registered or certified mail, the licensee's or non-licensed operator's written notice pursuant to the Rules of Procedure for Contested Case Hearings and Declaratory Rulings, Chapter 16-1, Series I, 1981 of the board of health.

Section 17. Administrative Due Process

17.01. An applicant for a license or a licensee or any other person aggrieved by an order or other action by the director pursuant to these regulations or to Chapter 16, Article 5C of the West Virginia Code of 1931, as amended shall have the opportunity for a hearing by the director, upon written request to the director in a manner prescribed in and by the aforementioned Rules of Procedure for Contested Case Hearings and Declaratory Rulings. The aforementioned Rules of Procedure are incorporated herein by reference.

17.02. A hearing pursuant to this section shall be conducted in accordance with the pertinent provisions of Chapter 29A, Article 5 of the West Virginia Code of 1931, as amended and the aforementioned Rules of Procedure for Contested Case Hearings and Declaratory Rulings.

17.03. Notice of an order suspending a facility's license shall specify the conditions giving rise to the suspension which the licensee must correct during the period of suspension in order to have the license reinstated.

17.04. If the director revokes a license, the director may stay the effective date of revocation by no more than ninety days upon a showing that the stay is necessary to assure appropriate placement of patients.

17.05. The director's order shall be final unless vacated or modified either personally or by registered or certified mail or the licensee's or non-licensed operator's written notice pursuant to the Rules of Procedures for Contested Case Hearings and Declaratory Rulings, Chapter 16-1, Series I, 1981 of the board of health.

17.06. In addition to all other powers granted to the director under Chapter 16, Article 5C of the West Virginia Code of 1931, as amended and these regulations, the director may hold a case under advisement and make a recommendation as to requirements to be met by the licensee in order to avoid suspension or revocation of a license, in accordance with Chapter 16, Article 5, Section 11 of the West Virginia Code of 1931, as amended.

17.07. Where the director takes a case under advisement, the director shall:

(a) enter an order stating the decision to hold the case under advisement;

(b) notify the licensee and his attorney of record, if any, of the action, by certified mail, return receipt requested;

(c) enter an order showing satisfactory compliance, dismissing the complaint, if the licensee meets the requirements of the order; and

(d) upon entering the second order, under this section, the director shall notify the licensee and his attorney of record, if any, by certified mail, return receipt requested.

Section 18. Severability - If any provisions of these rules or the appli-

cation thereof to any person or circumstance shall be held invalid, such invalidity thereof shall not affect the provisions or application of these rules which can be given effect without the invalid provisions or application, and to this end the provisions of these rules are declared to be severable.

John D. Rockefeller IV
Governor



L. Clark Hansbarger, M.D.
Director

State of West Virginia

DEPARTMENT OF HEALTH
CHARLESTON 25305

Notice

Legislative Rule: Nursing Home Licensure, Chapter 16-5C,
Series I, 1983

The above titled legislative rule is hereby submitted to
the Legislative Rule-Making Review Committee.

A handwritten signature in cursive script, reading "L. Clark Hansbarger, M.D.", written over a horizontal line.

L. Clark Hansbarger, M.D.
Secretary
West Virginia Board of Health

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE

THIS DATE

8/16/82

Administrative Law Division

Entered

DATE: August 13, 1982

TO:

FROM: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

SUBJECT: INFORMATION TO BE SUPPLIED TO THE COMMITTEE

RULES: Nursing Home Licensure

INFORMATION REQUIRED

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE

THIS DATE 8/16/82
Administrative Law Division

1. Please give the citation of the statute which authorizes your promulgation of these rules.

Chapter 16, Article 5C, Section 5 specifically authorizes the rule. All of Article 5C of Chapter 16 is related and is highly detailed.

2. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation: (29A-3-5)

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

NA

- b. Was the hearing held on the date scheduled and were all interested parties permitted to be heard?

NA

- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

NA

- d. Is the transcript of all evidence received preserved and available for public inspection and copying?

NA

3. For all rules promulgated:

- a. When did you file the rules in the State Register together with notice of a hearing time, date and location? (29A-3-5)

January 14, 1982

- b. Did you give at least 30 days notice and no more than 60 days notice? (29A-3-7)

Yes

- c. What other notice, including advertising, did you give of the hearing? (29A-3-5)

Press releases to the Capitol Pressroom. Copies of the notice and the proposed were sent to all licensed and certificate of need approved nursing homes, miscellaneous concerned professional and consumer groups, state agencies and others.

- d. Was the hearing held on the scheduled date? If not, why not?

Yes

- e. Was the opportunity given for all interested parties to submit data, objections, suggested amendments, views, evidence or arguments?

Yes

- f. List all persons who appeared at the hearing and what type of comment they made about the proposed rules (for, against, suggested and amendments). Please attach a copy of the minutes of the hearing.

See attached list of persons who either appeared at the hearing or mailed comments, and a copy of attendance at the hearing.

See also comments.

- g. On what date did you file in the State Register notice of your action on the proposed rules together with the text of such rules?

August 13, 1982

Signature of department head
board chairman or executive
secretary.

List of Persons and Groups
Who Presented Comments Regarding
Proposed Nursing Home Licensure Rule

<u>Person</u>	<u>Organization</u>	<u>Type Comment*</u>
<u>At the hearing:</u>		
F. Michael Martin	Professional Nursing Home Association	Against
Dan Farley	WV Chapter, NASW & Glenwood Park Methodist Home	For-Selected Sections
Alice Couch	WV Health Care Association	Amendments
James F. Hornbeck	WV Health Care Association	Amendments
Chet Bradeen	WV Health Care Association	Amendments
Ann Warnick	WV Commission on Aging	Amendments
Evelyn Heinzman	WV Nurses Association	Amendment
Tara Stevens	Region VI Area Agency on Aging	Pro-Selected Sections
Buzz McCormick	Area 17 Welfare Advisory Council	Pro
Connie Bell	Community Council of Kanawha Valley	Pro
Nile D. Cutlip	Green Valley Convalescent Center	Against
Betty Kisner	Self	Pro-Selected Sections
Jamie Riggs	Region V Ombudsprogram	Amendments
<u>By mail:</u>		
Rev. Everett Briggs	St. Barbara's Memorial Nursing Home	Amendments
C. L. Mancinelli	Preston Co. Sr. Citizens, Inc.	Pro-Selected Sections
M. M. Elliott	Preston Co. Sr. Citizens, Inc.	Pro-Selected Sections
Helen S. Huddy	Kanawha Valley Senior Services	Pro
Jean D. Hurst	Mid-Ohio Valley Regional Planning and Development Council	Pro
Fay Fike	Taylor Co. Senior Citizens, Inc.	Pro-Selected Sections
Sara Moreland	Grafton City Hospital	Pro-Selected Sections
S. G. Nazarro	Wheeling Hospital	Amendments
Barry L. Locke	WV Chapter National Association of Social Workers	Pro-Selected Sections

* Many persons with suggestions for amendments of some sections also made statements simply for or against other sections.

Summary of Comments Received at
Public Hearing(s) in re

Title, Type and Number: Nursing Home Licensure, 16-5C, Series I,
1983

Date(s) and Location(s): February 24, 1982. Conference Room
A and B, Building 7, 1900 Washington Street, East, Charleston,
West Virginia. Sessions were convened at 2:00 p.m. and at 7:00
p.m. Only two persons attended the evening session; both desired
only to observe.

This is a major rule which has attracted considerable attention and comment. A total of twenty-two commenters submitted nearly one hundred different detailed comments, many of which were suggested amendments. Two organizations were represented by multiple commenters. Most commenters presented written copies of their testimony, and a "summary" would be nearly as lengthy as the comments themselves. Because of the importance of this rule and the bulk of the comments, a complete copy of the testimony is attached.

It may be of interest that earlier drafts of this regulation were twice circulated widely on an informal basis for review and comment and that a public hearing was held for a later draft on March 10, 1981. Substantial revisions were made in earlier versions of this rule in response to comments made.

The following materials describe substantive changes made to the proposed rule following the public hearing.

1. Comment: Renewal and initial license application times should be consistant.

Response: There seems to be no reason to set a more narrow time frame for initial license application filing than for renewal. The word "ninety" was substituted for the word "sixty" in Section 5.03.02.

2. Comment: A time should be set within which the director will make a decision regarding a plan of correction.

Response: The department has a policy of response within ten days. This policy is now incorporated in the rule in Section 5.07.07.

3. Comment: The time limit of fourteen days for notification of patients already in the facility of patient rights is inadequate for all the work involved in making copies and distributing the new rights.

Response: Although we feel that procedures envisioned may be more elaborate than necessary to comply with this provision we have lengthened the time from fourteen days to thirty days in Section 9.06.01.

4. Comment: You should specify to whom reports of patient abuse should be made.

Response: The intent of the standard as proposed was that the facility should identify individuals and procedures for dealing with instances of patient abuse. The item has been changed as follows to clarify this confusion: 9.06.01. "No patient shall be verbally, mentally or physically abused, or neglected or mistreated, or restrained by physical or chemical means except in accordance with Section 11.06 of these regulations (relating to use of restraints). Alleged violations shall be reported immediately to appropriate individuals as designated by the facility and there shall be evidence that: ..."

5. Comment: In Section 9.09 on fiduciary responsibilities you should specify the "patient or responsible party," since the money would be for the benefit of the patient. Also, it is not possible to account to an anonymous depositer. Please be more specific about "account" and to whom.

Response: Even though funds may be deposited for the benefit of a patient, the responsibility of the facility is to account to the individual or agency which has placed the money under the management of the facility. The individual may, of course, be the patient, who is presumed by law to be competent in the absence of lawful proceedings declaring the individual otherwise. In the event of any anonymous depositer an accounting may be prepared and kept on file to evidence the facility's good faith. The present Sections 9.09.01, 9.09.02 and 9.09.03 reflect several changes in language which are intended to clarify the requirements regarding accounting for funds deposited on behalf of the patient; the rule retains the use of accounting to the depositer.

6. Comment: Individuals coming into the facility under the right of access provisions should be required to coordinate with facility personnel. "To the extent feasible" allows too much freedom not to coordinate at all.

Response: The board agrees that coordination with facility staff in order not to disrupt smooth functioning of the facility

is important. There is of course, a corresponding responsibility for coordination on the part of the facility. The words "To the extent feasible or possible" were deleted from the beginning of Section 9.11.07.03 and the word "may" was changed to shall.

7. Comments: Add "in writing" to Section 9.11.09 regarding the release of communications between a patient and a person visiting pursuant to the right of access provisions for purposes of documentation.

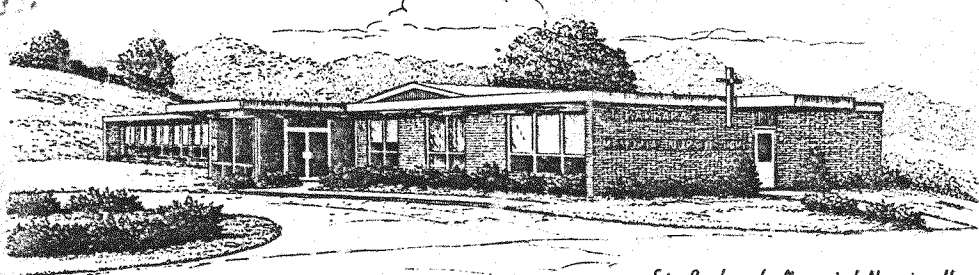
Response: This comment raised an awkward issue. As proposed for the hearing, Section 9.11.09 read "Communications between a patient and a person visiting pursuant to Section 9.11.03 are confidential unless the patient authorizes the release of information." The appropriate location for filing any written release and the responsibility for maintaining confidentiality would be with the organization or group represented by the visitor, not the patient's nursing home record. Such files would not be accessible to the health department. Additionally, the purpose of this requirement is to assure the patient any privacy desired with respect to the nursing home staff. That is, the nursing home may not demand to know what transpires between the patient and his visitor. Section 9.11.09 was therefor changed to state that such communications are "deemed" confidential and the statement regarding patient authorization of release was omitted as "meaningless" for the purposes of these rules.

8. Comment: Requiring the facility to maintain a list of dentists could be considered as discriminatory. What's wrong with a telephone book?

Response: The requirement was deleted from the rule.

9. Comment: The requirement for a dietician to have a year of supervisory experience in addition to registration is unduly stringent and discriminatory.

Response: The supervisory experience requirement was deleted from Section 12.02.02.



St. Barbara's Memorial Nursing Home
Box 86 (Off Route 19)
Monongah, W. Va., 26554

January 29, 1982

Nursing Home Regulations Revision Com.,
State Department of Health,
Charleston, W.V.

To Whom It May Concern:

Since we shall be unable to send a representative to the forthcoming Public Hearing of the revised nursing home regulations, we respectfully submit our reactions to the draft which you sent us.

- P. 25, 5.12.03: Some effort should be made to ascertain the mental competence of complaining patients prior to investigations. Anyone cognizant of the nursing home population can see the wisdom in this.
- P. 26, 5.12.10: 1. This is none of the Director's business. Why should he or she assume such an adversarial posture?
2. The facility, also, can seek legal redress if the Director or Department has damaged the facility's goodname, in any way.
- P. 28, 5.13.02: As above
- P. 28, 5.13.03: But said report must note also any findings contested by the facility. Eventually, this will become law. Inspectors should be held in justice to annotate their report-forms to this effect.

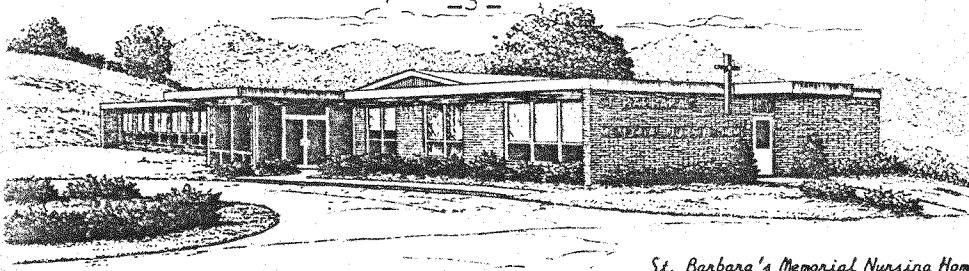
FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 8/16/82
Administrative Law Division

- P. 39, 7.02.06: This is a revision of past regulations and practice. This stipulation should state the distance between the two facilities. Why was it omitted?
- P. 48, 7.11.04(c): This stipulation is altogether too broad. Maintenance and yardmen, for example, know their own expertise. They do what must be done, every day. Also, for bookkeepers, receptionists, office personnel? They follow their job descriptions, and do the work assigned to them. Delete (c).
- P. 48, 7.11.07: This is altogether too broad a requirement, as above (7.11.04(c))
- P. 62, 9.11.01: Why does the Department continue in revision after revision of the nursing home regulations to insist on this absurd, unenforceable provision? It makes one wonder if those who revise the regulations really know what goes on in an S.N.F.

During the morning hours, patients are changed, gotten up, fed, bathed. Housekeepers are sweeping, mopping, cleaning the entire facility. "Open house" inevitably interferes with patient care, good order, and leads to accidents due to spillage, slippage, and what-not. In spite of unregulated access, is the facility to be held liable for neglect of patient-care, for accidents on wet floors, etc.?

Normal hours should be from 2:00 to 5:00 P.M., and from 6:30 to 8:30 P.M., without prejudice to patient-care and the provisions of 9.11.02. Present practice places no limitations on genuine exceptions to such a rule.

- P. 62, 9.11.03: In addition to normal visiting hours (stipulated 8:00 A.M. to 8:00 P.M.), individuals can pop in, at any time. This whole section, 9.11.01 and 9.11.03, should be rewritten in conformity with the demands of patient-care and the responsibilities of the facility.



St. Barbara's Memorial Nursing Home
Box 86 (Off Route 19)
Monongah, W. Va., 26554

P. 63, 9.11.06: This provision is altogether too broad. What about access to boiler rooms, mechanical equipment rooms (where one could be injured), stock rooms (where one might absquatulate with items, or "case" the area), sterilizing rooms (where public access would be unsanitary), the laundry (where workers need not tolerate such intrusions), etc.?

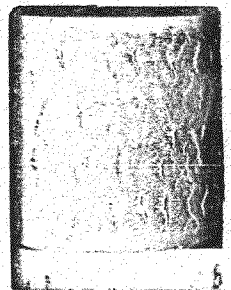
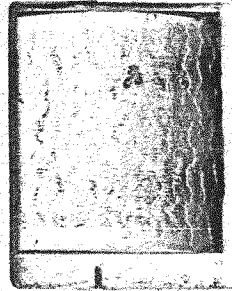
Under (d), there are other areas which must be "secured." Were facilities not recently required to sprinkle an assortment of doors with chain-locks? Are these "observers" to be granted right of entry denied to the patient population? This entire regulation needs redrafting.

P. 65, 9.12.03: The word "competent" should be inserted before "patient." It would be sheer playacting to go through this charade with the confused, not to mention the senile patient. If the responsible party is advised of the patient's rights (and responsibilities!), it should suffice.

P. 66, 9.12.05: The word "competent" should be inserted here before "patient." Likewise, in 9.12.06.

All this playacting helps to increase costs of health!

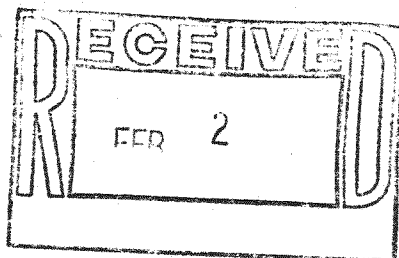
P. 67, 9.12.09: Insert "competent" before "patient." Again, I wonder how conversant the drafters of these regulations are with real-life conditions in the S.N.F.



- P. 71, 10.03.03: No nursing home administrator will categorize a patient as "abandoned" by a given physician. This could lead to a libel suit.
- P. 78, 11.05.01: "Patients who need such services"? Do we mean patients whose potential justifies these services?
- P. 80, 11.06.05 to 11.06.06: Some added provision should state that authorized personnel may sufficiently restrain a patient who becomes a violent, destructive, or dangerous to self or others, at least until conditions can be normalized
- P. 86, 12.04.08: Add: "...or patient refuses in exercise of his or her rights."
- P. 91, 13.05.03: Why in writing? Personnel are individually authorized.
- P. 101, 15.01.06: This should be integrated with "patient care plan." It is superfluous. Superfluities increase costs of health-care.

It is hoped that the foregoing reactions may be of some help.

Sincerely yours,
E. F. Briggs
(Rev.) Everett F. Briggs,
President





WHEELING HOSPITAL

Medical Park, Wheeling, West Virginia 26003
(304) 243-3000

February 5, 1982

cc:

Joe Kay
741
2-17-82
dse

L. Clark Hansbarger, M.D.
Director
State of West Virginia / Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305

Dear Doctor Hansbarger:

The attached comments are submitted for your information and consideration.

Feel free to call if there are any questions.

Sincerely,

Tom Nazzaro
S. G. Nazzaro
Administrator

SGN/va

Enclosure

cc: Dominic A. Brancazio, M.D.
Bruce J. Carter,
West Virginia Hospital Association

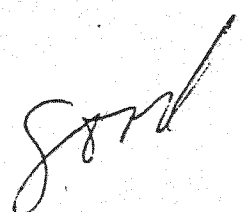
COMMENTS ON THE
PROPOSED NURSING HOME REGULATIONS

Wheeling Hospital has three major concerns with the Proposed Nursing Home Regulations: the point system and minimum staffing requirements, and classification and utilization of the patient care plans.

I Proposed Point System:

The rationale for assigning points to various classes of standards is appreciated. However, the method of assigning these points is not. For example, a Class I standard may receive a score of 10, or 9, or zero. If a standard is to be assigned a possible 10 point value, there should be the potential for assigning any number of points from 0 to 10. Without, this capability, it doesn't seem appropriate to assign a potentially high point value to a standard. It would appear more logical to assign a 2 point system where two (2) is full compliance, (one) 1 is substantial compliance, and zero (0) is out of compliance. The same comments are applicable to all standards.

An additional comment on the grading system is that credit should be given by the allocation of points for showing significant improvement. Many problems, including physical problems require significant expenditures which may have to be budgeted over an extended period of time. Although the deficiency may not be completely corrected within a six or eight month period, significant improvement should be noted and appropriate credit given.



II Proposed Minimum Staffing Requirements:

Wheeling Hospital's second comment has a bearing on a facility's ability to correct deficiencies as well as the quality of patient care. It is our opinion that staffing standards for nursing are set unrealistically low. It is interesting to note that Ohio and Pennsylvania have set 2.5 nursing hours/pt. day for ICF facilities and 3.0 nursing hours/pt. day for SNF facilities according to information I have received. The proposed regulation is establishing a minimum staffing at an unrealistic 2.0 nursing hours/pt. day.

Although it is argued that the 2.0 nursing hr/pt. day staffing level is a minimum, the reality of the situation is that a standard is being established that will place

quality of care well behind reimbursement and payment issues. This is especially disappointing in a time when nursing homes are finally taking steps to go beyond the image of warehouses for the forgotten and abused elderly.

We all recognize that Medicaid is the primary method of payment for the great majority of patients in our State's nursing homes. As such, all nursing homes are vulnerable to pressures to keep staffing as low as can be gotten away with which is 2.0 nursing hours per patient day under Medicaid. As Medicaid experiences tighter and tighter financial restrictions, the pressure will be correspondingly felt on nursing homes to reduce their #1 expense -- staff.

Pressure to keep staff down is certainly not to be considered negatively when patient care is not compromised. What the proposed regulations do, however, is to legitimize Medicaid's unrealistically low staffing minimums while making licensure regulation more unforgiving of deficiencies than ever before. Nursing homes are finding and will continue to find themselves penalized for staffing above Medicaid's staffing assessment levels. Yet compliance with licensure regulations is becoming more strict as the penalties for non-compliance becomes stiffer. With the pressure for reduced expense and paper compliance on the one hand and quality of care pressures on the other, nursing homes will have to place more emphasis on costs and compliance if they are to stay open. This is especially true when unrealistically low staffing patterns are legitimized. Patient care can do nothing but suffer in this environment, and we will once again be reading about the horror stories of patient neglect and abuse in our State's nursing homes.

III

Wheeling Hospital's third concern centers on Patient care plans. Nursing care plans are not life threatening and should not be considered under Class I. Also, the regulations should be simplified in regards to Patient Care Plans in order to clearly show the Patient Care Plan as the Multi-discipline plan in which common goals are developed. All other plans, i.e. nursing, activities, social work, etc. should be clearly shown as sub-plans utilizing the common goals of the patient care plan.

Not
True

In a closing note, the argument will be made that a nursing home with insufficient staffing will be sighted as deficient, and, therefore, this will not be a significant problem under the proposed regulations. Although this will be the case in theory it is unrealistic to expect inspectors who are charged with enforcement of this standard to make findings that will be enforceable without objective criteria for staffing. What is being proposed is only a minimum staffing criteria the only objective staff standards developed to date have been the standards developed by the W.V. Dept. of Welfare. If a nursing home's staffing is in line with the staffing levels developed by this Department of Welfare -- regardless of how low these levels are -- the licensure inspector has no objective criteria to dispute the facilities staffing pattern.

Wheeling Hospital would strongly urge the West Virginia Dept. of Health to re-evaluate its proposed point system, downgrading of Patient Care Plans from Class I to Class II, and minimum staffing requirements in light of these comments. Wheeling Hospital would especially encourage the W.V. Dept. of Health to study staffing levels of adjacent States and revise the proposed minimum staffing level to a level which will assure higher quality patient care.



MID-OHIO VALLEY REGIONAL PLANNING AND DEVELOPMENT COUNCIL

Area Agency on Aging

Region V

925 Market St. P.O. Box 247
Parkersburg, West Virginia 26101

Phone (304) 422-0522

February 16, 1982

West Virginia Department of Health
Regulatory Services Program
Room 416
1800 Washington Street, East
Charleston, West Virginia 25305

Dear Sir:

I have reviewed the proposed Rules and Regulations for Nursing Home Licensure. Due to other commitments, it will not be possible for me to attend the public hearing on February 24th. However, I would like to have the following comments receive consideration:

Section 5.14 --

Groups desiring to improve or enhance the quality of life for nursing home patients should have the right of access to nursing home facilities. Considerable numbers of institutionalized individuals have no family to assure that their circumstances are proper. Recognized groups, such as the ombudsprogram, should be free to perform this function for all residents without arbitrary restrictions being placed on them by the nursing home administrators. However, residents should be protected from having to deal with any group against their will.

Section 9.11.03 --

The Older Americans Act mandates that states establish and fund an ombudsprogram. For this project to be truly effective, and to allow it to achieve the goals outlined in the legislation, it should be formally recognized as a group which has access to nursing homes. To deny it this recognition would serve only to thwart its ability to assure a good quality of life for nursing home residents.

Section 9.11.12 --

It is important that the Commission on Aging, and the ombudsprogram which it sponsors, be fully recognized as active participants, with full authority, in the efforts to protect those who are institutionalized.

Section 9.10 --

It should be clearly stated in any written complaint procedure posted in a nursing home that, the Department of Health, Commission on Aging, and/or an Area Agency on Aging will receive complaints. The names and local phone numbers of these agencies should also be listed. Residents, or their families, will be more likely to discuss complaints if a third party is available, preferably locally.

Section 14.05, 14.06, 14.07 --

Provision of recreation, and other activities, by a trained and qualified staff member is crucial. Patients need the stimulation, both mentally and physically, as they cope with the routine incumbent with institutionalization.

Section 14.02 -- Plan for Social Work Services

Social services should be required for all nursing homes, as outlined in Sections 14.02, 14.03, and 14.04. Medical treatment of patients is not all that is needed. Attention must be given to the total needs of patients, as well as their families. These types of services, in order to be truly effective, must be provided by a qualified social worker.

With the proposed reduction in Federal regulations governing the operation of nursing homes, it is particularly important that West Virginia adopt meaningful regulations to protect rights of patients. The draft regulations seem to provide this needed protection.

Sincerely,



Jean D. Hurst, Director
AREA AGENCY ON AGING

JDH/jah

Taylor County Senior Citizen's, Inc.
20 E. Main Street
Grafton, West Virginia 26354
February 18, 1982

KJH

West Virginia Dept. of Health
Regulatory Services Program
Room 416
1800 Washington Street East
Charleston, W.V. 25305

Re: New Proposed Regulations:
Long-Term Care

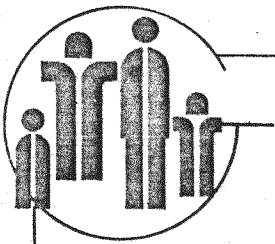
As an Outreach Worker for the Senior Center, I have been involved with situations that had there been a well established complaint procedure available, the complaint would have been resolved without undue burden on the client and/or the facility. So naturally, I'm in hopes you will add the "Complaint Procedure to the West Virginia Regulations.

Also, I feel strongly about the local Ombudsman Program, and believe that if the Ombudsman is to be effective, they should have easy access to both client and facility. So I would encourage your acceptance of Section 9.11.12 of the proposed regulations.

And with the establishment of these two proposals the rights of the patient will be protected. Thank you.

Respectfully,

Jaye Fike
Jaye Fike



GRAFTON CITY HOSPITAL

Kay

February 18, 1982

L. Clark Hansbarger, M.D.
West Virginia Dept. of Health
Regulatory Services Program
Room 416
1800 Washington St., East
Charleston, WV 25305

Dear Dr. Hansbarger:

I recently had the opportunity to review the proposed ammendments submitted for approval as the Rules and Regulations for Nursing Home Licensure. The sections I am most interested in include 5.12 to 14.07.03.

As the Director of Nursing of a small community hospital with an adjacent forty-six bed ICF unit, I daily have contact with the elderly. There are people whose whole life-styles have been altered, and many freedoms have been removed for what is labeled "for their benefit". One most important freedom that unpurposely has been excised is their right to have some method in sustaining their rights and their families right to have some input into the care given.

I am all for the approval and acceptance of the ammended regulations I listed above to ensure the maintenance of the patients' Bill of Rights in the long-term care facility.

Sincerely,

Sara Moreland

Sara Moreland, R.N.
Director of Nursing

SM:sg

KANAWHA VALLEY SENIOR SERVICES

CHARLESTON HOUSING AUTHORITY

FUNDED IN PART BY THE WEST VIRGINIA COMMISSION ON AGING

2001 BOWMAN COURT, P. O. BOX 86
CHARLESTON, WEST VIRGINIA 25321

TELEPHONE: 343-6565

February 18, 1982

West Virginia Department of Health
Regulatory Services Program
1800 Washington Street, E Room 416
Charleston, West Virginia 25302

Dear Dr. Hansbarger:

I have been directed by the Kanawha Valley Senior Services Advisory Committee to inform you of their stand on the proposed Nursing Home Regulations.

At a meeting on February 17, 1982, the committee took action to go on record at the February 24, 1982 Public Hearing for the support of immediate approval, implementation and enforcement of the proposed Nursing Home Regulations as follows:

Issue: Nursing Home Regulations have not been revised, approved and implemented to date even though nursing home legislation was enacted in 1977.

Comment: We need and support immediate approval, implementation and enforcement of the proposed Nursing Home Regulations to meet the legal obligation and to ensure quality care and protection of nursing home resident's health, safety and welfare.

Thank you very much for your consideration on this issue.

Sincerely,

Helen S. Huddy

Helen S. Huddy, Chairperson
Kanawha Valley Senior Services
Advisory Committee

HSB:ib

Preston County Senior Citizens Inc.

K. E. Wilson House
Senior World

Feb. 22, 1982

Dr. E. Clark Hansbarger
West Virginia Department of Health
Regulatory Services Program
Room 416
1800 Washington St., East
Charleston, WV 25305

Dear Dr. Hansbarger:

Due to the ever increasing cuts in funding, many service eligibility requirements or regulations are also being phased out. It seems to be the policy of our federal, state and local governments to decrease regulations to free up usages of ever decreasing funds. I hope this attitude does not effect the judgements of the Health Departments Regulatory Services Program.

The nursing home residents, are in a majority of cases, individuals whose rights must be protected for they themselves are physically or mentally unable to care for themselves. It is only by concise nursing home regulations being established that these individuals rights will be protected.

Access into a nursing home must remain open to the discretion of monitoring or investigating individuals such as a regional Ombudsman. The access to the nursing home cannot be set by that institution for this would have to negatively affect the objectivity of the monitoring individuals.

I fully support all recommendations to get regulations that would give open access of all nursing home facilities to individuals whose purpose it is to protect the rights of the residents within those facilities.

Sincerely,

Charles L. Mancinelli

Charles L. Mancinelli
Project Director

Preston County Senior Citizens Inc.

Kay The Citizen House
Senior World

Feb. 22, 1982

Dr. L. Clark Hansbarger
West Virginia Department of Health
Regulatory Services Program
Room 416
1800 Washington Street, East
Charleston, WV 25305

Dear Dr. Hansbarger:

As a social worker with the Preston County Senior Citizens I have a special interest in the well being of the institutionalized elderly of our state. I am writing in support of passage of the proposed rules and regulations for nursing home licensure.

I am specifically supportive of sections 5.12, 9.10 and 9.11 regarding complaint investigation, complaint procedure, and access. The implementation of internal grievance procedures (9.10), I feel will be effective as well as efficient in handling minor problems in the nursing homes. Section 9.11 .12 regarding access by the State Commission on Aging and its affiliates insures the patients rights to outside intervention in complaint investigations.

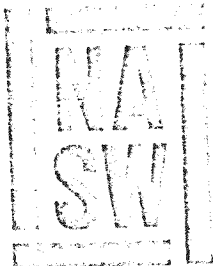
Another section that I feel is important to the regulations is "Social Work Services and Recreation, and Activity Services (Section 14)" since social services are not mandated at this time. I personally feel that these services must be provided to help meet the psychological and sociological needs of the nursing home residents.

In conclusion I again support all of the new proposed regulations and especially the afore mentioned sections and I feel that passage is crucial to protect the rights and privileges and provide maximum health care to our institutionalized senior citizens.

Sincerely,

M. Melissa Elliott

M. Melissa Elliott
Volunteer Coordinator



NATIONAL
ASSOCIATION
OF
SOCIAL
WORKERS
INC.

Barry L. Locke, ACSW
President, WV-NASW
Route 13, Box 167
Morgantown, WV 26505
(304) 293-3503

WEST VIRGINIA CHAPTER #360

February 16, 1982

Dr. L. Clark Hansbarger
Director
Department of Health
1800 Washington Street, East
Charleston, WV 25305

Dear Dr. Hansbarger:

This letter relates to the proposed Rules and Regulations for Nursing Home Licensure, Chapter 16-1, Series I, (1982). I am commenting on behalf of the WV-Chapter of NASW.

On reviewing the Rules and Regulations it was evident that the Health Department has made every effort to assure that patients in nursing homes in West Virginia will receive quality social services.

Section 14.02, A Plan for Social Work Services clearly specifies the need for a social service plan as well as outlines specific responsibilities. I have enclosed a recent publication of NASW standards for long term care that encompasses the W.V. proposed regulations.

We also strongly support Section 14.03 on the staffing of social work services. We were pleased with your definition of qualified social worker.

The educational credentials and other experience required for director to consultant should assure that patients will receive quality care from a trained and competent staff.

We commend you on your effort to develop effective regulations for nursing homes in West Virginia. Though I will not personally be able to attend the public hearings, Dan Farley, a member of NASW will be present. If there is anyway the chapter can be of help in the implementation of the regulations please contact me.

Sincerely,

Barry L. Locke, ACSW
President, WV-NASW

cc: Dan Farley

NASW standards for social work services in long-term care facilities

Prepared by the Long-Term Care Facilities
Standards Task Force of the NASW Com-
mittee on Aging

*Approved by the Board of Directors
June 20, 1981*

National Association of Social Workers, Inc.
1425 H Street, N.W.
Washington, D.C. 20005

Principle

Social work services must be available to long-term health care programs and their constituencies—persons with chronic physical, developmental, or emotional disabilities and the elderly who need supportive social and health care services. Such services include social work services to impaired, disabled, or frail individuals, their families and significant others, and community groups.

Social work services in long-term care settings focus on the social and emotional impact of physical or mental illness or disability, the preservation and enhancement of physical and social functioning, the promotion of those conditions essential to assure maximum benefits from long-term health care services, the prevention of physical and mental illness and increased disability or dysfunction, and the promotion and maintenance of physical and mental health and an optimal quality of life.¹ Social work objectives include the following:

1. Providing direct social services to residents, their families, and significant others.²
2. Assisting residents, families, and significant others to utilize appropriately and receive maximum benefit from the facility and community-based social and health resources on a continuum throughout the stay of each individual from preadmission to discharge or death.
3. Strengthening communications between residents, their families and significant others, and the program or facility staff.
4. Assisting the facility to achieve and maintain a therapeutic environment essential to the optimal quality of life and independent functioning of each resident and to provide for maximum participation of residents in planning activities and policies.
5. Promoting facility-community interaction

¹As used in these standards the term long-term care facility includes Skilled Nursing Facilities, Intermediate or Health-Related Care Facilities, and residential care facilities such as congregate, domiciliary, or proprietary adult homes. When these facilities have programs such as day care, home care, and so forth, these social work standards for long-term care shall apply.

²For the purpose of these standards, the term *resident* is used instead of *patient*, *client*, or *consumer*. A resident is defined as an individual who resides full time in a facility.

The reference throughout these standards to "families and significant others" should be read to imply "families and/or significant others" since it is recognized that for some residents there is no "family."

through encouraging community involvement in the facility and resident and staff involvement in the community, developing linkages with a wide range of community resources, and participating in the assessment of the need for and planning for other long-term social and health care resources.

STANDARD 1. The long-term care facility shall maintain a written plan for providing social work services designed to assure their availability to all residents, their families, and significant others. It shall be developed by a qualified social worker³ experienced in long-term care.

Interpretation

An organized department under the direction of a social work director⁴ responsible to the administrator of the facility is the preferable approach to providing social work services. When the plan includes some other organizational arrangement or purchase of services from an outside agency, a description of all services provided; the objectives, scope, and methods used; and a mechanism for evaluation shall be specified.

The plan must assure that a professionally directed program will be provided. It should articulate the philosophy and objectives of the social work services and the standards on which they are based. The plan should include services and programs directed toward preventing health and social problems and maintaining the resident at or restoring the resident to an optimal level of health and social functioning. It should allow for maximum participation by the resident, the family, and significant others, along with appropriate personnel in the setting, in the development and evaluation of service and treatment plans and in all other programs developed by the social work department.

The plan should provide access to services for all residents and for prospective residents from the pre-

³A qualified social worker is defined as a social worker who (1) is a graduate of a master's degree program from a school of social work accredited by the Council on Social Work Education, (2) has had two years of postgraduate experience in long-term or related programs, and (3) meets equivalent state certification or licensing requirements for social workers, when applicable, or, in jurisdictions not having such legal regulation, is a member of the Academy of Certified Social Workers.

⁴The term social work director as used in these standards is a qualified social worker who is the staff member responsible for the social work program in the facility.

I have not seen these
regulations until now—
but do not find any
stipulation for serving
food hot

Betty Kisner

Received 2/24/82
re NH Reg at
hearing



WEST VIRGINIA NURSES' ASSOCIATION, INC. • SUITE 511, UNION BLDG. • 723 KANAWHA BLVD. • CHARLESTON, WV 25301 • (304) 342-7978

February 24, 1982

*John J. Jarrell, Director
Health Facilities and Evaluation Program
West Virginia Department of Health
1800 Washington Street, East
Charleston, WV 25305*

Dear Mr. Jarrell:

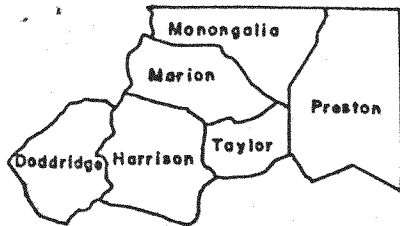
The West Virginia Nurses Association respectfully offers the following comments on the proposed "West Virginia Rules and Regulations for Licensing Nursing Homes", dated December, 1981.

Section 11.02.02: This section indicated that the Director of Nursing is to be a registered professional nurse on duty at least five (5) days a week, eight (8) hours a day... It makes no provisions for coverage by a registered professional nurse during the two (2) day absence of the director of nursing. It is to be assumed that this coverage will be by other licensed personnel, or the Licensed Practical Nurse. We question the legality of an LPN working in this capacity. Licensed Practical Nurses (LPN) are to be supervised by a registered professional nurse, a licensed physician, or a licensed dentist. The rules and regulations do not provide for the RN, physician or dentist to be present. It would appear that the LPN is being asked to function beyond her scope of practice; that the patient is not receiving consistent and continuous quality of care, which is their right.

Since the LPN is not educationally prepared to serve as a Director of Nursing Services for five (5) days a week we hardly see how she would be expected to function in this capacity in the interim period, which is likely to be the weekend.

The West Virginia Nurses Association urges you to provide for a licensed professional nurse to assume the responsibility of the director of nursing in her absence.

Section 11.02.03: We wish to commend you on the minimum requirements for experience designated for the director of nursing.



REGION VI AREA AGENCY ON AGING

A PROGRAM OF REGION VI PLANNING and DEVELOPMENT COUNCIL

201 DEVENY BUILDING • FAIRMONT, WEST VIRGINIA 26554 • 304-366-5693

February 23, 1982

WV Department of Health
Regulatory Services Program
Room 416
1800 Washington Street, East
Charleston, WV 25305

Ladies & Gentlemen,

The Long-Term Care Ombudsman Program strives to ensure that residents of nursing homes and other long-term care facilities receive quality care and are treated with respect and dignity. The Ombudsman program which operates in North-central West Virginia is sponsored by the Region VI Area Agency on Aging and encompasses six counties: Doddridge, Harrison, Marion, Monongalia, Preston and Taylor. In four of those counties, (Harrison, Marion, Preston and Taylor) Ombudsman Support Groups have been established to coordinate advocacy efforts and serve as focal points for the dissemination of information on long-term care. These four groups met recently to review and discuss the Department of Health's proposed Rules and Regulations for Nursing Home Licensure.

Agencies and organizations represented in those meetings included Senior Citizens Centers, the Departments of Welfare and Health, Mental Health, Community Action Programs, Family Services, a county Medical Center and both private and State hospitals. The proposed regulations we reviewed included six sub-sections: 5.12 Complaint Investigation, 5.14 Registry of Organizations with Right of Access, 9.10 Complaint Procedures, 9.11 Access, 9.12 Notice and Posting Requirements, and 14.01 through 14.03 Social Work Service.

No formal recommendations or votes were taken on the information contained in these sub-sections; however, there was general agreement among members on many, if not most, of the proposals. What follows is a summary of the opinions and recommendations expressed by the Ombudsman Support Group Members.

Regarding sub-section 5.12 Complaint Investigation, members were supportive of it throughout, and especially noted that the procedure is well-defined and thus should facilitate thorough investigations, as well as protect the confidentiality of those involved. Two members expressed their belief that a time frame should be developed which specifies how quickly a complaint investigation must begin following receipt of same. They were particularly concerned about complaints of a serious nature such as patient abuse. It was suggested that the Department of Health consider developing a timetable for investigation of complaints, to ensure that prompt action is begun.

Sub-section 5.14 Registry of Organizations with Right of Access was generally viewed as positive. There was some concern expressed that the registry would need to be updated in a timely manner, perhaps more often than annually, so that groups would not be needlessly denied access. Members recognized that organizations and groups must have access to the facilities and their residents if they are to have the opportunity to affect positive change, and, therefore, this sub-section was felt to be necessary and worthy of support.

Sub-section 9.10 Complaint Procedures received many strong positive comments from members. It was expressed that the creation of a clear, intrinsic procedure for receiving, documenting, resolving and reporting complaints would, if conscientiously implemented by facilities' administrations, permit problems to be handled expeditiously and without the intervention of other agencies and individuals. Indeed, the point was made that this procedure could not only benefit the residents but also the employees of the facility, in that they, too, could be assured that problems are not overlooked or assumed to be without basis.

Regarding Sub-section 9.11 Access, there was a great deal of discussion concerning the need for such a section. As with sub-sections 5.12 and 9.10, members were pleased with the clarity and specificity of this section. Members acknowledged and supported the specific reference to the Commission on Aging and its affiliates to "be granted full and free access privileges for the necessary conduct of complaint investigations." (9.11.12) One member suggested that it should be reiterated that access by the Commission on Aging and its affiliates includes those areas named in 9.11.06. Also, one member suggested that in cases where the resident is too ill or is adjudged incompetent that a provision be included which specifies that a guardian or other responsible party be contacted and informed of the resident's rights, etc.

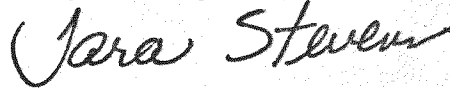
The Notice and Posting Requirements of Sub-section 9.12 were met with positive comments and support. Several members pointed out that it is imperative that visitors as well as the residents and staff have easy access to all of this information, and having it posted will facilitate this. One member questioned the procedure to present or read to a patient the information specified regarding rights, etc. when a patient has severe mental impairment. Perhaps some thought should be given as to who should then receive this information.

Section 14.01 - 14.03 Social Work Service received many comments. In general the responses were very positive. The educational and experiential requirements for the Director of Social Services that the members supported were those proposed by the Department of Welfare Medical Fund Advisory Board, which are less stringent than those presented in these proposed regulations. Members were pleased to see that this entire section has been upgraded as compared to the current regulations. Several mentioned that the social and emotional well-being of the patients has, in the past, been sporadically attended to or totally neglected, and they believe that social work services are as crucial to the well-being of the patients as good medical and nursing care. Some members stated that a ratio of one social work staff

person per 120 patients is too high a ratio, but members felt that this is at least a step in the right direction. They expressed support for the defining of responsibilities for social work services, pointing out that this would help to more clearly define the function of this service. One member recommended that the social work service person serve as a liaison between the Medical Director or attending physician and the patient.

In summary, the Ombudsman Support Group members were supportive of these six sub-sections of the proposed Licensure Requirements for Nursing Homes and urge the WV Department of Health to maintain these in the final regulations.

Respectfully submitted,



TARA STEVENS
Long-Term Care Ombudsman

/dlt

cc: Region VI Advisory Council
Ann Warnick, State Ombudsman
Region VI Ombudsman Support Group Members



Community Council of Kanawha Valley, Inc.

702½ Lee Street, P. O. Box 2711, Charleston, W. Va. 25330

304-342-5107

Area Agency on Aging
342-5107

Information & Referral Bureau
342-5109

Volunteer Service Bureau
342-5108

February 24, 1982

West Virginia Department of Health
Regulatory Services Program
1800 Washington Street, East, Room 416
Charleston, West Virginia 25305

Attention: L. Clark Hansbarger, M.D.

Dear Dr. Hansbarger:

The Area Agency on Aging in Region III strongly supports the concept that the West Virginia Department of Health has regulations governing nursing homes and personal care homes that ensure safe, healthful and pleasant surroundings.

Therefore, we support the portion in the proposed Regulations describing plans for Social Work Services because of the constructive contribution these services provide for residents and their families.

- The portion covering complaint procedures.
- The portion describing pharmaceutical services.
- The portion describing full and free access to the facility to representatives of community organizations and groups, and access by the Commission on Aging and its agents.
- The well defined portion describing Dietetic Service.

The proposed Regulations cover all requirements that the federal government is considering eliminating and these Regulations should be adopted.

Thank you for your consideration.

Sincerely,

Connie Bell

Connie Bell
Director
Region III Area Agency on Aging

CB/am

A United Way Agency

Remarks to the Regulatory Services
Division of the WV Dept. of Health
regarding the Dec., 1981 Draft of Proposed
"Rules and Regulations for Nursing Home Licensure"

Presented at
Public Hearing, Feb. 24, 1982
Charleston, WV

by

F. Michael Martin, N.H.A.
Davis, West Virginia

My name is Michael Martin and I make these remarks today on behalf of the Professional Nursing Home Association of West Virginia, Cortland Acres Nursing Home of Thomas, West Virginia and myself as a duly licensed nursing home administrator in the State of West Virginia.

First let me say that I do not look upon regulations as a necessary evil. I do not consider myself, in providing long term care, as being in an adversary role when it comes to the well being of the chronically ill and disabled elderly. I do not, my facility does not, and my fellow Association members do not shun their responsibilities in providing for our resident's needs. I dare say that when Society, Relatives, Friends, Neighbors, the Courts and other service organizations fail in their obligations, it is the caring, concern and commitment of the quality long term care facility that picks up where these others turned away.

I feel it is necessary for me to express these thoughts to you since they were seemingly not part of the foundation of your thoughts in drafting these regulations. I might go so far as to say that the reason we don't have some viable, quality control nursing home standards today is because of the drafter's underlying distrust of the nursing home industry, and an obsessive attempt to control every possible action, every policy and every detail in the provision of care. The problem is that these proposed regulations go beyond attempts to set reasonable standards, and could possibly harm those

that were targeted for help. (unless the ones we are trying to help are the Masters of Social Work, or the Dietician, or the Nurses, or the Recreational Therapist, etc....)

There are five areas that I feel are worthy of your consideration. Patients Rights, Professional Qualifications, Repetition, Cost, and Punishment. I will be as brief as possible.

Patients Rights are nothing new. I might remind all here today that it was the caregiver, in the form of associations and gerontological research that first recognized the need for patients rights. It was not the government. Their purpose was to highlight the vulnerable areas of rights that already existed; to point out where the provider needed to take extra caution in protecting the dignity and welfare of nursing home residents. They were not created to provide documented support for the existence of ombudspersons, or to tie the hands of the provider in giving care, or to make the nursing home resident a prisoner of non-therapeutic activity.

I support the 14 rights outlined by the federal Medicare regulations. Beyond that you do damage to their worth.

If the Commission on Aging is so concerned with patients rights, (I know they are) they don't need special access requirements; they need to get busy with the legislature and the legal services agencies and provide responsible guardianship for the one out of every two nursing home residents that is a nonadjudicated incompetent. You have no rights if you are confused or disoriented and have no legal guardian. You have no rights if the guardian who is appointed is indifferent or irresponsible.

I propose a total redrafting of the patients rights section with an emphasis on inservice education, staff, family and resident awareness, and the current practice of survey team review. One final remark on nonajudicated incompetents. Please do not draft regulations that put the nursing home in any more jeopardy than already exists in the treatment of nonadjudicated incompetent patients. You may wake up one day and find that even the nursing home may turn away from its obligations to these people.

Professional Qualifications

Again, I agree that certain standards must be set, but there is no cause to force untold members of very qualified individuals out of their profession because they don't have post degree or even degreed training. I have a Master in Gerontology and Long Term Care Administration, but I feel safe in saying that there are many lesser trained administrators who do fantasitc work. I can also safely say that ^{some} colleagues of mine with graduate training are lousy administrators. The same goes for Social Workers. My social worker who has a B.S. degree has more caring, concern knowledge and dedication for his work than most M.S.W.'s I've encountered, and he is not the exception. Four years of college training and a philosophical dedication to service are all the ingrediants necessary for Social Services in the nursing home. This draft also exceeds in the activity director's position. They exceed by one year the experience necessary in a health care setting in the Medicare regulations and by two years ^{of} what I think is necessary. More important are qualities such as maturity, leadership skills

and creativeness. These can be found without serving the special interest of the Recreation Therapist.

Also on this subject, isn't it about time that the state health department begin to allow the private industry the same privilege it has been enjoying for years and that is the use of nonlicensed nursing personnel to pass medications? This is a common practice around the country and certainly should be for a state with many rural health care providers that face a daily shortage of professional nurses. Training programs can be devised that will produce better care than exist now with the overburdened professional nurse.

Repetition

I call a 400% increase in the length of regulations either "Overkill" or Redundancy. Unfortunately it's a little of both. Essentially, the section on Patients Rights is the same thing the federal government says in 1/2 page. It only takes these regs. 13 pages to say it. In sec. 15.01.01 (the number itself is a pretty good example of what I mean) there is a discussion about patient care planning. Then another whole section ^{follows} on the nursing care plan. I've always assumed that a patient care plan included the nursing care plan as well as the other available disciplines. So why spell out nursing care plans in 15.01.06. Section 15.01.03 already said that each service (including nursing) must participate. These are just a few examples. Much verbage could and should be eliminated. Don't be redundant, don't be redundant, don't be redundant. Get the message?

Cost

Since many of my colleagues are addressing this point, I won't belabor the issue except to say, do you know what you're doing to the Welfare Department's pocketbook?

One suggestion is to allow for some reduction in the surveys that are done if a facility is consistently above average in their grade or accreditation or whatever standards are established. Consider a provision to waive inspections and costly paperwork if quality is evident. I'll defer the rest of this issue to others.

Finally - Punishment

For the sake of that lone surveyor out there who has just driven 150 miles in a whiteout blizzard, wrecked her car in the drainage ditch in front of the nursing home, has just found out her annual increase was frozen and doesn't like me anyhow, I suggest you choose your words very carefully in devising punishment for the nursing facility. Section 16.02.05 scares me in particular. This wording means that civil penalties can be used even without a chance for a plan of correction in the event "the violation jeopardizes the health or safety of a patient". What is jeopardy. Does it mean life threatening? or the fact that water was found on the floor. For once, a further definition is called for. Generally speaking, the punitive nature or attitude of these proposed regulations is adverse to the assurance of quality care. Rather than set punishment, these regulations should set standards that give everyone a clear incentive to achieve.

In closing I'd like to reiterate the point that Dr. Alex Portz, member, State Board of Health made as his rationale to revising the last draft of proposed nursing home regulations.

"There must be some trust in the nursing home administration to serve the patient's best interest. There has to be a balance between regulations to protect patients from the misdeeds of a few on the one hand and the choking of good care by excessive regulations and documentation. There are ample standards in the regulations to evaluate the trustworthiness of nursing home administration and quality of care without regulating every detail."

Thank you for allowing me to speak on behalf of myself and those I represent.

Testimony - Public Hearing

February 24, 1982

Daniel W. Farley, ACSW-FACNHA

I rise to speak to two sections in the proposed Rules and Regulations for Nursing Home Licensure as revised December, 1981. They are Section 14 pertinent to Social Work Service and Section 7, subsection 7.06 Life Care Contract.

Related to Section 14, and more particularly subsection 14.02, Plan For Social Work Services, in behalf of the West Virginia Chapter of the National Association of Social Workers, we heartily endorse proposed language. It clearly specifies the need for a social service plan as well as outlines specific responsibilities.

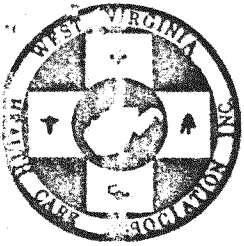
Related further to Section 14, subsection 14.03, Social Work Services Staffing, our organization of more than 350 members in West Virginia strongly seeks its adoption. It is the belief of our Associations' leadership, staffing as prescribed will provide a climate for more effective service to long term care patients in West Virginia; thus, improving overall quality of care. This position is taken because of our knowledge of the number of social work graduates from the School of Social Work at West Virginia University with a gerontology concentration and because of knowledge related to current enrollment. What is needed in order to further improve availability of trained social workers in nursing home practice in our state is more demand which will create more interest.

As a long term care administrator practicing in West Virginia, I realize economics are tough. However, as a professional certified by the Academy of Certified Social Workers coupled with recognition as a Fellow by the American College of Nursing Home Administrators, I sense the need to improve standards when timing is right for the benefit of those served. To me, that time is now. Seeking for perfection is never without struggle, and I am certain new rules will create new problems, but to me, there is no better time to begin than now.

My final remarks will be addressed to Section 7, subsection 7.06, Life Care Contract. As an individual with experience related to the "extreme hazards" associated with these contracts, I applaud the position of the Department of Health. If there is one section in all of the regulations with severe hidden dangers, it is here. Dangers are for both providers and persons for whom contracts are written; thus, in my opinion, the Department

of Health cannot be too careful with life care as an approach for serving the elderly.

Thank you for giving me the opportunity to provide this testimony.



West Virginia Health Care Assoc.

502-21ST STREET
VIENNA, WV 26105
304/295-9392

WEST VIRGINIA RULES AND REGULATIONS FOR LICENSING NURSING HOMES

PUBLIC HEARING

February 24, 1982
Charleston, West Virginia

Comments by Alice Couch NHA, Administrator of Valley Haven Rest Home, Inc. of Wellsburg, W. Va. President of the West Virginia Health Care Association, and Board of Directors member of American Health Care Association.

In reviewing the services aspects of the regulations, I find the West Virginia Department of Health has not simplified or clarified requirements. They should focus on patient care and on outcome rather than the means to achieve those ends. These regulations fail to promote cost containment while maintaining quality care, which is essential in the present economical climate of our state and nation.

The latest draft of proposed regulations from the Department of Health and Human Services has recognized the significant differences between intermediate and skilled care and will have separate regulations for each. If HHS recognizes the need for two different sets of regulations I feel this should also be a serious consideration of our state for uniformity between the two.

I address first SECTION 10, page 67 and 68 in regard to the Medical Director requirement. Federal and state regulations both have very exacting duties and responsibilities of the physician in relation to their patients. Thus the necessity of medical presence is already established. We firmly believe a medical director is an unnecessary requirement of the administration of a facility, given the wide variety in size, organization and administrative structure. The cost of this requirement would add an additional cost of a minimal \$250,000 per year. We recommend deletion of this section.

10.03.03, SERVICES OF ATTENDING PHYSICIAN, Page 70 and 71. This regulation addresses the physician of record who does not meet requirements. I feel this particular section ignores patient rights and can also jeopardize patient safety and well being during a period of "administrative compliance" with regulations. We have previously suggested rewording of this section.

10.04.02, DENTAL SERVICES, Page 71. Reference to the nursing home having a list of dentist in the community. Could such a list be construed as discriminatory? What's wrong with a telephone book?

11.02.03, MANAGEMENT OF NURSING SERVICES, Page 74 and 75. The state regulations are ignoring registered nurses who do not have experience. How are they to be encouraged to enter the Geriatric setting with state regulations that tend to prohibit them from proving their capabilities. Many are very capable, and although experience is valuable, they are still well trained professionals.

11.04.10, NURSING STAFF RESPONSIBILITIES, Page 77. The regulation refers to self-administration of medications. We do not believe in self-administration in the ICF or SNF setting because the patients can forget to take their medications, overdose, and give medications to other patients. Also we lose control of record keeping and accountability

12.02.02, DIETETIC SERVICES, Page 82. The state regulation is again discriminating a person trained and registered as a dietitian in regulating them to have at least one year of supervisory experience in food and nutritional services in a health care facility.

12.02.06, DIETETIC SERVICES, Page 82 and 83. This refers to the qualifications of the food service supervisor. With all of the duties of the consultant dietitian it is unnecessary for the food service supervisor to have all the requirements as set forth in this section. Many competent individuals have for many years been doing excellent jobs. I'm sure the department's inspectors can testify to this fact. These people can follow menus and directions, and are well able to carry out their responsibilities as outlined in detail in 12.02.07 of these regulations. Is the state to say these individuals are no longer qualified and take away their jobs, their livelihood?

13.03.04, PHARMACEUTICAL SERVICES, Page 89. This section requires quarterly meetings of the pharmacy committee. This does nothing to improve quality of patient care. The regulation of these services of pharmacy are extensive under 13.02 on pages 87 and 88 and if carried through should make the necessity of the Pharmaceutical Committees an annual requirement or in cases of extreme problems.

14.03.02, SOCIAL WORK SERVICES, Page 95 and 96. While recognizing the importance of social services, the nursing home industry feels the health department has gone to extremes in requirements of degreed individuals. The minimal cost of the changes proposed by the department is \$1,276,524 yearly. We are attaching proposals which have been agreed upon with the Long Term Care Committee of the West Virginia Department of Welfare's Medical Fund Advisory Council. These proposals would represent a minimal increase cost of \$500,000 per year.

And we do not feel this would adversely affect the social service programs.

14.06, RECREATION AND ACTIVITIES STAFFING, Page 98 and 99. The long term care representatives feel through the Long Term Care Committee of the West Virginia Department of Welfare's Medical Fund Advisory Council, that the proposed regulations are too restrictive and inflationary in regards to staffing. We do agree with the hours and perhaps they are too low, however the qualifications and degree requirements of individuals are unrealistic. The projected cost increase is a minimal \$571,315 per year. We are attaching recommendations that would eliminate the cost impact almost entirely.

I am a member of the Board of Directors of the American Health Care Association which represents some 8,000 nursing home facilities in the nation, serving more than 750,000 convalescent and chronically ill of all ages, I am prepared to make a statement in regards to the proposed federal regulations.

The general assessment of the proposed rules is that it deletes many paperwork and administrative requirements but retains most patient care and patient rights requirements. The patient care management system is similar to that found in the original 1980 proposal and reflects a high standard of quality care.

Since quality care should be the objective of all regulations - both state and federal - we strongly urge the West Virginia Department of Health to rewrite these regulations and follow the guide of HHS.

This concludes my remarks. I thank you, on behalf of the West Virginia Health Care Association, for your time and attention. We appreciate the many hours of work contributed to the writing of these regulations, and the changes that will come about as a result of them. We, like all of you in this room today, are interested in quality care in safe surroundings for our disabled and senior citizens.

Alice Couch

14.05.05. A facility shall make provisions to enable relatives and friends of a patient to participate in activities with a patient.

14.06. Recreation and Activities Staffing (Class II)

14.06.01. A nursing home shall appoint a patient activities director and such additional staff as needed to carry out the patient activities program, but not to be less than the equivalent of one staff member per 120 patients in the nursing home.

14.06.02. For the purposes of evaluating compliance with these regulations, a patient activities director must meet one of the following combinations of experience and/or training and consultation:

- (a) completion of a 36 hour patient activity coordinator course approved by the Federal Department of Health and Human Services or the director, and two full-time years of experience in patient activities in a health care facility under the supervision of a qualified consultant in patient activities as described below in Section 14.06.02(e).
- (b) completion of a 36 hour patient activity coordinator course approved by the Federal Department of Health and Human Services or the director, and five full-time years of experience in patient activities in a health care facility.
- (c) a bachelor-level degree in a relevant field of training, such as recreation or recreation therapy with no experience, or in a related area such as physical therapy, occupational therapy, arts and crafts, music, human behavior, sociology

or social work, psychology; etc., and a full-time year of experience in patient activities in a health care facility under the supervision or a qualified patient activities director or consultation from a qualified consultant as described below in Section 14.06.02(e) of these regulations.

- (d) a bachelor-level degree in a relevant field of training, such as recreation or recreation therapy, or in a related area such as physical therapy, occupational therapy, arts and crafts, music, human behavior, sociology or social work, psychology; etc., and three full-time years of experience in patient activities in a health care facility.
- (e) a masters degree in recreation or recreation therapy, or a masters degree in a related area with one full-time year of experience in a patient activity program in a health care facility or in a geriatric program or a bachelor degree in a relevant field of training with five full-time years of experience in a patient activity program in a health care facility or in a geriatric program.
- An individual with such qualifications shall also qualify as a consultant in patient activities.

14.03.02

An individual may serve as the director of social services provided one of the following requirements regarding education, experience and post-degree training are met:

- (a) A B.S.W. graduate from an accredited school of social work,
- (b) a B.A. or B.S. graduate in a related field or a B.S.W. graduate of a non-accredited school of social work with two years of experience in a health care facility, medical social work or gerontology,
- (c) an individual meeting the educational requirements of (b) above but not the experience requirements, consultation provided by a qualified consultant [meeting the qualifications of (a) or (b)], every two months for a period of two years; or
- (d) a non-degreed individual or an individual with a degree in a non-related field, provided that consultation by a qualified consultant (meeting the qualifications of (a) or (b),) be provided for a period of two years with consultation every two months and quarterly thereafter, for a period of three years.

QUALIFICATIONS FOR DIRECTOR OF SOCIAL SERVICES

Degree	Experience	Qualified Consultant
B.S.W. from accredited school of social work	none	none
B.A. or B.S. in related field or B.S.W. from non-accredited school of social work	2 years	none
B.A. or B.S. in related field or B.S.W. from non-accredited school of social work	none	Every two months for period of two years
Non-degreed or degree in non-related field	none	Every two months for period of two years and quarterly thereafter, for a period of three years.

Chet Braden
WVHCA

WEST VIRGINIA HEALTH CARE ASSOCIATION

Testimony on

Rules and Regulations for Nursing Home Licensure

February 24, 1982

Section 5

- 5.02.01 State operated facilities should be included under the proposed licensure regulations and should meet those minimum standards proposed.
- 5.04.04 Renewal license time frame should be consistent with
5.04.02 initial license application time frames in or not less than 60 days, rather than the proposed 90 days.
- 5.07.07 A facility plan of correction shall be approved, modified, or rejected by the director in writing within ten days of receipt.
- 5.07.09 A rejected plan of correction should be revised within 30 days from notification of the initial rejection.
- 5.10.01 If a facility does demonstrate substantial compliance - need quantitative definition or criteria list determining what "substantial" is defined as.
- 5.10.04 Examples and guidelines for "performs significantly in excess of minimum standards" need to be provided.
- 5.10.09 Minimum standards should be applicable to all facilities. Examples of exceptions are needed.
- 5.12.01 Complaints registered should be in writing, identifying the person registering the complaint to the director.
- 5.12.08 Good - notify those affected parties in writing five working days after completing the investigation.
- 5.12.10 The director should not practice law by advising the injured party as to what civil remedy they should pursue.
- 5.13.01 The director should make available upon written request the results of complaint reports.
- 5.14.02 Groups shall render assistance to patients with their consent or at their request.



WEST VIRGINIA COMMISSION ON AGING

Holley Grove — Capitol Complex

State Capitol

Charleston, West Virginia 25305

Telephone (304) 348-3317

February 25, 1982

John D. Rockefeller IV
GOVERNOR

Phillip D. Turner
EXECUTIVE DIRECTOR

West Virginia Department of Health
Regulatory Services Program
Room 416
1800 Washington Street, East
Charleston, West Virginia 25305

Dear Sirs:

The West Virginia Commission on Aging has made a commitment to the continuum of care concept. This concept includes the belief that individuals requiring long term care should receive those services in the least restrictive setting.

Services which are offered by nursing homes are located at the end of the continuum. In the event that more skilled care is required, it will be necessary for individuals to be placed in nursing homes. These individuals should be guaranteed quality care.

On behalf of the institutionalized elderly in West Virginia, I would like to comment on the Proposed Rules and Regulations for Nursing Home Licensure.

As you are well aware, a number of the most vulnerable elderly reside in nursing homes. These residents are, for the most part, hesitant about commenting on the care they receive.

One may perceive that the residents' family members participate in assuring that the residents receive the quality care they deserve. This may be true for approximately fifty percent of the residents. The other fifty percent of the residents have no immediate family to assist them.

In order to insure quality care for residents of nursing homes, the federal and state government have regulations to assist in this effort.

Currently, the Reagan administration is attempting to deregulate at the federal level.

This effort may be described from two points of view: (1) Nursing homes are over-regulated and should be deregulated at any level. (2) Federal regulations are being decreased under the assumption that states currently possess the necessary regulations.

It is my contention that the latter point of view is the reasoning for the federal government considering deregulation.

Presently, West Virginia does not possess the necessary regulations. Yet, the Proposed Regulations under discussion will enable our state to insure quality care to the residents of nursing homes.

One question most people have when confronted with the Proposed Regulations is -- how can the state afford to implement them?

Understandably, the question is not easily answered. Yet, another question is -- how can we afford not to implement them?

The following specific sections in the regulations are supported to remain as written:

Section 5.14 - Registry of Organizations with Right of Access

Section 9.11.02 - Access of Commission on Aging Agents

Section 9.11.12 - Describes Mandate of Commission on Aging and Ombudsprogram (It should be noted that the Ombudsprogram is a federally mandated program. See attachment A.)

Section 9.12.04 - Document in Each Facility Stating "if complaint" - Contact Department of Health, Commission on Aging, or Area Agency on Aging

Sections 14.05 - Recreation and Activities to be provided
14.06 & 14.07

Several sections may be seen as possessing problems:

Section 4.24 - One should insert "on-going" "...but who do not require on-going nursing care."

Section 6.06 - Privacy curtains should be included in rooms other than private rooms.

Section 9.06.07 - Should read only - "A patient shall not be required to perform services for the facility."

- Sections 9.06.08 - This section should be added so as to address the second point which is currently in Section 9.06.07. It should read: "A patient may be encouraged, but not required to participate in any social, recreational or religious activity."
- Section 9.02.02 - "(b) a patient has appointed, in writing, power of attorney." This segment should be omitted. The reasoning being that a person may appoint someone "power of attorney" for reasons other than mental status.
- Section 9.04.04 - This section should be changed from fourteen to sixty days after these regulations are effective for residents of the facility to be notified. This change is recommended in view of the fact that "motification" actually refers to a detailed explanation.
- Section 14.03 - Social Work Services Staffing (Class II) - A staff member of the Commission on Aging served on the Long Term Care Committee to the Medical Fund Advisory Council which developed a revision of this section. This revision was done due to possible financial constraints. Support for this revision is given. (See attachment B.)
- Section 14.06 - Recreation and Activities Staffing Class II) - Changes that may be made in this section which would recognize experience of staff and minimize costs should be considered.

In 1977, West Virginia's law pertaining to nursing and personal care homes was amended. Today, five years later, we are continuing to develop the regulations necessary for implementation. The staff

West Virginia Department of Health
Regulatory Services Program
February 25, 1982
Page Four

of the Commission on Aging is most willing to assist in assuring that these regulations are implemented as quickly as possible.

Sincerely,

Phillip D. Turner /mc

Phillip D. Turner
Executive Director

PDT/bj

Attachments

QUALIFICATIONS FOR DIRECTOR OF SOCIAL SERVICES

Degree	Experience	Qualified Consultant
B.S.W. from accredited school of social work	none	none
B.A. or B.S. in related field or B.S.W. from non-accredited school of social work	2 years	none
B.A. or B.S. in related field or B.S.W. from non-accredited school of social work	none	Quarterly for a period of two years
Non-degreed or degree in non-related field	none	Quarterly for a period of five years

An individual may serve as the director of social services provided one of the following requirements regarding education, experience and post-degree training are met:

- (a) A B.S.W. graduate from an accredited school of social work,
- (b) a B.A. or B.S. graduate in a related field or a B.S.W. graduate of a non-accredited school of social work with two years of experience in a health care facility, medical social work or gerontology,
- (c) an individual meeting the educational requirements of (b) above but not the experience requirements, provided that consultation by a qualified consultant [meeting the qualifications of (a) or (b)] be provided quarterly for a period of two years; or
- (d) a non-degreed individual or an individual with a degree in a non-related field, provided that consultation by a qualified consultant [meeting the qualifications of (a) or (b)] be provided quarterly for a a period of five years.

Region 5 Ombudsprogram

Ritchie County Committee on Aging, Inc.

112 S. COURT STREET - P. O. BOX 57
HARRISVILLE, WEST VIRGINIA 26362
Jami C. Riggs, Ombudsperson
February 22, 1982

TELEPHONE: 643-2781

West Virginia Department of Health
Regulatory Services Program
Room 416
1800 Washington Street, East
Charleston, WV 25305

Dear Sir:

In reviewing the Proposed Rules and Regulations for Nursing Home Licensure, I became concerned about a few of the sections. I have made comments expressing my concerns on the afore mentioned sections. I would like to have these comments receive consideration:

Section 5.05.03 page 15

In this section it is stated that a provisional license shall not be issued for a period greater than 12 months. I think the time period should be less, because it is the same for the regular or renewal of a license and this license would be issued to a facility having deficiencies.

Also I think the deficiencies should be listed and posted with the license, so the people would be able to tell the license is a provisional one and why.

Section 5.12.17 page 27

I think the period of time the residents or any one who has filed a complaint on the behalf of the resident are protected should be extended from 120 days to 150 days unless it is against the WV Code chapter 16, Article 5C of 1931 as amended.

Section 6.04.04 page 33

This section states that "There shall be all weather, hard surfaced walks and parking areas provided." Would this not be a hardship for some homes to put the hard surface parking areas in? I am afraid this would constitute a price increase to residents in order to pay for the extra expense.

Section 8.04 page 50

This section should have an addition. The addition should state that for at least one drill a fireman or a representative from the Fire Marshall's office should be present to make comments on the drill. (eg. ways to shorten evacuation time).

Section 10 pages 67 and 68

Would the requirements of having a physician as a full time medical director require the facilities to pass on the cost to the residents in a cost increase?

Section 14.06.03 page 99

In the list of duties for the Activities Director or Social Services Director there should be included a duty of letting the residents know that the Ombudsprogram exists for them.

Region 5 Ombudsprogram

Ritchie County Committee on Aging, Inc.

112 S. COURT STREET · P. O. BOX 57
HARRISVILLE, WEST VIRGINIA 26362

TELEPHONE: 643-2781

Section 5.14 page 29

Recognized groups, such as the Ombudsprogram, should have the right of access to nursing home facilities in order to improve or enhance the quality of life for the residents of such nursing home facilities.

Residents should however, be closely guarded from groups they do not wish to have contact with in anyway. Thus section 5.14 is, will be a great asset to both residents and desirable groups, such as the Ombudsprogram.

Section 9.11.03 page 62

This section is clearly stated and should remain in tact.

Section 9.11.12 page 65

It is important that the Ombudsprogram, the Commission on Aging and its recognized affiliates be granted access with full authority to protect insitituionalized persons.

Section 9.10 pages 61,62

This section should state that in any written complaint procedure the Department of Health, Commission on Aging, Ombudsprogram, Area Agency and/or County Committee on Aging will receive complaints. The correct names and local phone numbers of these agencies should be posted. By having contact with a third party there may be more oppurtunity to discuss complaints objectively.

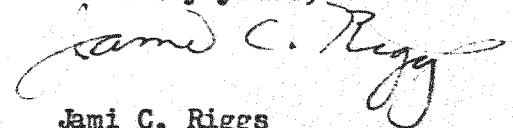
Sections 14.02, 14.03 and 14.04 pages 94,95,96 and 97

A qualified social worker should be available in the facilities to ensure the residents receive the needed attention to the total needs, after all medical care is not all that is needed.

I have received letters through the mail concerning the residents rights. The letters all have the same theme, that is the residents' rights should remain intact and should be enforced, through programs such as the Ombudsprogram.

In adopting regulations it must remain important in this time of budget cuts that the protection of the residents remain the priority.

Sincerely yours,



Jami C. Riggs

Ombudsperson



West Virginia Department of Welfare

Citizens' Welfare Advisory Council

Key: 1/1/1982

Kanawha County Office (304) 345-1200
601 Morris Street Charleston, WV 25301

Dennis Sutton, Chairperson

March 11, 1982

Joe Richards
Regulatory Services
WV Department of Health
Building 3, Room 415
1800 Washington St., E.
Charleston, WV 25305

Dear Sir:

As you are aware, members of the Citizens' Welfare Advisory Council have worked for several years to obtain improved Nursing Home Regulations. Through our representative at the February 24 hearings on the proposed regulations, we were advised of several changes under consideration in the three categories: Social Services, Medical Director, and Recreation Activities. Comments heard at the hearings were good and many should be incorporated in the final draft. We feel these changes, however, were not of the magnitude that they would justify an extensive delay.

We therefore recommend that the proposed two to three months projected for completion of the regulations be reduced. We urge acceptance and implementation of these regulations as soon as possible and encourage you to take whatever steps are necessary to avoid further delays.

Thank you for your consideration of our concern for the well being of those who require Nursing Home care.

Sincerely yours,

Dennis Sutton
Chairperson

Attached: Presentation at hearing for Nursing Home Regulations

cc: L. Clark Hansbarger, Ph.D.; M.D.
Director of Health

Presentation at Hearing
For Nursing Home Regulations
2-24-82

Specific sections have been addressed. Quality and Concern on the part of Nursing Home Administration is evident. The comments were many and appear negotiable.

- I The remarks that I make are substantively the position of Area 17 Citizens Welfare Advisory Council. We are asking and recommending that:
- a) these regulations be implemented immediately
 - b) that they be accepted as is, especially those parts that relate to Social Services

- II Citizens Welfare Advisory Committee has an interest and involvement in these regulations:
- a) 1975 members met with managers of local nursing homes.
 - b) began work on the related issue of Adult Protective legislation in 1974
 - c) 1976 there were on site visits by members to evaluate conditions and complaints from residents, family and workers on the deficiencies of Human Services
 - d) 11/77 urged Director to draft regulation, numerous letters since then
 - e) 1978 documented persons using nursing home care that didn't need it and personal care would be adequate
 - f) 1981 encouraged Health & Welfare staff to jointly draft Social Services section
 - g) 1982 now urge implementation

III Sense of Urgency

- Federal Government is no longer interested in being a regulatory agent for this area of human service. On the federal level there is almost total deregulation - see attachment - note editorials - read into the record
- these deletions would ostensibly be met by these proposed state regulations
- the state law and subsequent regs are not outrageous but present a standard of care that I have heard voiced today. A standard of care that:
 - a) is decent
 - b) shows concern for patients as people
 - c) protects the rights of residents
 - d) confirms the value of what many nursing homes are already doing
 - e) encourages continuing education for staff in every control area
- nursing homes like other systems are not perfect nor are they unable to improve.

* These regs will insure that improvement

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Freida E. Gorrecht
President

*asked to
be part of
record*
Elma L. Griesel
Executive Director

Summary of Proposed Revisions in Current Regulations
Governing Skilled Nursing Homes Participating in the
Medicare and Medicaid Programs

*N.H. reg
hearing
2/*

The National Citizens' Coalition for Nursing Home Reform opposes regulatory changes sought by the Reagan administration that would:

* Delete social services, which assist residents in their emotional, social and physical adjustment to life in a nursing home, as a condition of participation.

* Delete the requirement for a medical director who oversees patient care and the health status of employees.

* Delete the requirement for quarterly accounting of financial transactions made on patients' behalf. (The 1977 Medicare-Medicaid Anti-Fraud and Abuse Act required the Department of Health and Human Services to develop standards to prevent abuse of patients' funds.)

* Delete the specific requirement for staff development designed to educate employees about safety measures, standard practices and the special problems and needs of the aged and disabled. (A rule proposed in 1980 included greatly strengthened staff training requirements, but was never acted upon. See p. 2 of news release.)

* Delete qualifications for an activities director or an activities consultant.

* Delete the requirement for weekly time records of the number and type of personnel on duty. Such reports would only be required from facilities with a history of staffing deficiencies.

* Delete many specific rules guarding against mishandling of the administration of drugs, use of psychotropic (mind altering) drugs, and 48-hour physician countersignature of verbal orders.

* Delete the requirement for written policies for control of communicable disease that insure employees with symptoms or signs of communicable diseases are not allowed to work.

* Delete a pharmacist's responsibility to supervise drug dispensation and record-keeping. Also eliminated is the requirement for a pharmaceutical services committee that develops written policies and procedures for safe and effective drug therapy, control and use.

** These proposals were drafted by the Task Force for Regulatory Reform of the Health Care Financing Administration at the U.S. Department of Health and Human Services.

* Direct that federal standards regarding staff hygiene and sanitary conditions apply only in the absence of state laws or regulations.

* Delete the requirement for medical care evaluation studies, which analyze patient care in facilities and recommend improvements to maintain high quality services.

* Delete the requirement for separate housekeeping staff, which prevents nursing staff from being assigned housekeeping duties.

* Delete the requirement for an advisory dentist to participate in staff development programs. Facilities also no longer would be required to have a cooperative agreement with a dental service or to maintain a list of dentists for residents who don't have private dentists.

* Delete the standard requiring nursing homes to accommodate the handicapped and disabled. The administration contends the Office of Civil Rights already enforces this standard under Sec. 504 of the 1973 Rehabilitation Act.

* Delete the requirement for a full-time medical records supervisor or medical records consultant.

* Delete the requirement that "foods are prepared by methods that conserve nutritive value, flavor and appearance and are attractively served at the proper temperature and in a form to meet individual needs."

RECEIVED

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Freida E. Gorrecht
President

Elma L. Griesel
Executive Director

For more information,
contact Linda Daily,
202-797-8227

For immediate release
Jan. 20, 1982

NEWS RELEASE

WASHINGTON - The Reagan administration's deregulation approach to nursing homes jeopardizes the health, safety and quality of life for nursing home residents, according to a national consumer advocacy group.

Elma Griesel, executive director of the National Citizens' Coalition for Nursing Home Reform (NCCNHR), said draft proposals prepared by the Department of Health and Human Services (DHHS) to revise and eliminate rules and requirements governing skilled nursing homes "would take us back 15 years when there was widespread abuse and neglect in America's nursing homes."

The Task Force for Regulatory Reform of the Health Care Financing Administration (HCFA) at DHHS has proposed a general revision of standards of care governing skilled nursing homes participating in the Medicare and Medicaid programs "as part of this administration's efforts to reduce the burden of federal regulations." Suggested changes would eliminate specific requirements for social and dental services, staff training and documentation of staffing patterns and several dietetic, sanitary and drug administration safeguards (see attached list.)

HCFA Director Carolayne Davis has been quoted as saying, "I start with the presumption that (nursing homes) are overregulated." Griesel criticized that focus, suggesting instead that "an analysis and overhaul of federal regulations should focus on the needs of residents, not the needs of providers for regulatory relief." She said the present administration's plans ignore the history of federal leadership in the development of nursing home regulations.

"Deregulation of nursing homes is totally inconsistent with the evidence that's been developed in the past 15 years from state and federal congressional hearings, scores of government studies and reports of voluntary organizations and the media. According to the Task Force for Regulatory Reform, current regulations exceed the actual intent of federal law.

over

"Yet, to our knowledge, none of the numerous congressional hearings during the last 15 years has ever raised the question if nursing home regulations are too strong. On the contrary, most hearings have raised issues regarding the need for strengthened regulations and a stronger enforcement system."

Griesel urged that congressional oversight hearings be held on the deregulation proposals because "the history and circumstances which led previous secretaries (of DHHS) to promulgate minimal regulations for the protection of the health and safety of residents seems to have been greatly ignored."

"The question becomes, what will (DHHS) Secretary Richard Schweiker do to continue to protect nursing home residents - the most vulnerable group in our society? Will he blindfold himself to the facts as they exist and to the history of abuses recognized by his predecessors?"

A three-year initiative of the federal government - completed in 1980 - to review, simplify and strengthen regulations appears to have been ignored by the Reagan administration, Griesel said. She also questioned the wastefulness of ignoring the three-year process and emphasized the haste and sloppiness with which the 1981 proposed draft was developed, causing confusion and ambiguity.

Although the NCCNHR and other organizations contend the 1980 proposals could have been even stronger, "they did reflect tremendous progress toward the advancement of the health and safety of nursing home residents - particularly in the area of patients' rights and quality of life," Griesel said. "In comparison, the 1981 draft rules reflect serious regression in several areas."

The Reagan administration, for example, would delete the current staff training requirement for an educational program on the problems and needs of the aged, ill and disabled, and inservice training on infection prevention and control, and fire and accident safety prevention. The draft proposal states: "We do not believe that it is necessary for Federal regulations to mandate staff development."

In comparison, the 1980 proposals would have required untrained or unlicensed personnel to complete 30 hours of training from a physician or licensed practical nurse within 30 days following employment in such specific areas as "communication disorders and skills, the importance of patients participating in decision-making and self-determination, application of federal and state regulations with special emphasis on patients' rights, and observation of physical or behavioral changes."

Griesel said the failure to mention resident councils is another example of how the present administration has ignored the comprehensive 1980 proposals, which had recommended a separate standard for the self-governing resident groups that comment on facility policies and programs and plan various activities as a vehicle to enhance personal self-determination

3-3-3
☆☆☆ Regarding an initial proposal to delete the standard for residents' rights, ☆☆☆
Griesel expressed "relief that the HCFA task force did change its course - perhaps because of intense public opposition - and retain residents' rights as a standard." She criticized the administration, however, for not adopting improvements proposed in 1980 to strengthen safeguards concerning involuntary transfers, chemical and physical restraints and accounting procedures used for residents' funds.

"The maintenance of the concept of a patient care management system, first proposed in 1980, also is praiseworthy," Griesel said. "However, the proposed regulations regrettably do not support the system.

"You need to require a minimal number of qualified staff, such as social workers, physical therapists, therapy aides, registered nurses and others, who are under the supervision of a full-time qualified health care professional if the system is to operate effectively and efficiently."

In a related development, the Health Care Financing Administration also is considering proposed regulations that would give states the option of certifying skilled Medicare and Medicaid nursing homes through a private agency rather than by state health licensing officials.

☆☆☆ Critics of the idea question how turning nursing home inspections over to the Joint ☆☆☆
Commission on Accreditation of Hospitals (JCAH) - a non-profit organization governed by other national health provider organizations - will save the government money, as proponents claim. Griesel also questioned the accountability of JCAH inspections and voiced concern that the HCFA would not require JCAH inspection reports to be open to the public. The Association of (state) Health Facility Licensure and Certification Directors has expressed strong criticism of the JCAH proposal - a view echoed by The New York Times in a Dec. 26 editorial:

"The intention, apparently, is to turn regulation back over to the states and save Medicaid money by lowering standards. But state officials are worried that this would invite a relapse to the corrupt and cruel old days . . . An administration that would seriously relax regulation of this industry is asking for a mean kind of trouble."

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REGAN OFFICIALS SEEK TO EASE RULES ON NURSING HOMES

AGENCY IS DRAFTING PLAN

Proposals Include Repeal of Regulations on Sanitation, Safety and Contagion

By ROBERT PEAR

Special to The New York Times

WASHINGTON, Dec. 19 — Regan Administration officials want to relax rules governing nursing homes, the rights of patients and the qualifications of the staff in long-term care facilities. Proposals being drafted by the Department of Health and Human Services include repealing regulations of the industry at a time when many states have been forced to cut back on nursing home inspections because of a reduction in Federal money available for that purpose.

Affects 1.3 Million People

More than 1.3 million older Americans reside in nursing homes covered by Medicare and Medicaid. Among the rules being considered for repeal are those governing sanitation, safety, and the rights of patients. The rules also require nursing homes to maintain a safe, sanitary environment and must respect the privacy and dignity of patients. Several officials say that some of these rules are unnecessary or duplicate state regulations, but some critics contend that the proposed changes would weaken the industry and that a part of the Reagan Administration's overall effort to eliminate what it views as costly, unnecessary regulations. "It is a very delicate balance of regulation and deregulation," said Carolyn K. Davis, head of the Health Care Finance

EASED RULES URGED FOR NURSING HOMES

Continued From Page 1

ing Administration, which administers Medicaid and Medicare. In an interview this week, she said that her predecessors had been "overzealous" and had issued rules for which there was no basis. As an added benefit, she said, "Regulatory reform will save us money." She noted that the Government's budget deficit is the largest in the history of the country and that the industry is incurring huge costs in complying with Federal rules.

But the health industry, represented by a coalition of 200 groups, is fighting at an annual rate of about 15 percent for the last five years. The Federal Government has been cutting back on Medicaid, of which nearly half was for long-term care.

Consumer groups and state licensing officials say that the proposed changes would weaken the industry and that any reduction in standards could jeopardize the health and safety of patients. The industry, however, says that the proposed changes would help the industry to help eliminate rules that need to be revised or eliminated. She noted that the industry is incurring huge costs in complying with Federal rules.

However, congressional members of the House of Representatives are pushing for a repeal of rules relating to the quality of care, including those standards for infection control, and the quality of care, including those standards for infection control, and the quality of care, including those standards for infection control.

Others must be "a safe and sanitary environment for patients and staff," said a spokesman for the industry. "We must ensure that the industry is incurring huge costs in complying with Federal rules."

Officials of the Health Care Financing Administration, which administers Medicaid and Medicare, are pushing for a repeal of rules relating to the quality of care, including those standards for infection control, and the quality of care, including those standards for infection control.

See Duplicate of Regulations
Federal officials say that the proposed changes would be given an opportunity to comment on the proposals before they are adopted. The industry is incurring huge costs in complying with Federal rules.

New York and other states registered their rules after the industry's fight that they would be forced to register their rules. The industry is incurring huge costs in complying with Federal rules.

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Nursing home policing shift urged

By William Recktenwald

A FEDERAL TASK force has recommended that the U.S. government stop inspecting nursing homes and instead rely on the health care industry to supervise them, The Tribune has learned.

If this proposal by a task force of the federal Health Care Financing Administration is adopted, U.S. funding for state inspections of nursing homes would end.

State and local governments could continue to inspect the facilities, but would have to bear the costs themselves.

"I must say that I'm astounded," said U.S. Sen. David Pryor (D., Ark.), a minority member of the Senate Committee on Aging.

"WE ARE FACED right now with the very unfortunate situation of fighting for (existing) standards that we do not think are adequate. Those people (in nursing homes) are very, very vulnerable, and relaxing the rules will hurt them."

Elma Griesel, executive director of the National Citizens Coalition for Nursing Home Reform, said, "It might take a year or two, but we'll wind up with some really deplorable situations in nursing homes."

The Health Care Financing Administration is an agency of the Department of Health and Human Services assigned to oversee the federal Medicaid and Medicare programs.

Sen. David Pryor:

"Those people (in nursing homes) are very, very vulnerable, and relaxing the rules will hurt them."



The bills of many nursing home patients are paid by these two programs.

UNDER THE proposal, nursing homes and home health agencies would be treated the same as hospitals when it comes to meeting Medicaid and Medicare conditions.

That means if a facility is deemed to meet Medicare conditions by complying with standards of the Joint Commission for the Accreditation of Hospitals, it no longer would be subject to periodic federal certification checks. Instead, the facility would monitor its own performance.

Before this recommendation can be adopted, it first must be published in the Federal Register, and comments must be considered. The process takes about a year.

Supporters of the proposal said it would reduce the cost of making regular checks and eliminate federal regulatory burdens on participating facilities.

"WE VERY MUCH support 'deemed' status (for nursing homes)," said Julie Trocchio, director of the Office of Standards and Operations for the American Health Care Association in Washington.

"Part of the reason is we think it's only fair since that's the kind of situation hospitals have . . . and this would mean working with the (facility's) staff on its own policies and procedures as opposed to going in with a 500-item checklist, which is what the federal and state people do now."

Richard Druggin, director of public information for the hospital accreditation committee, said his organization has a staff of 230 that surveys 6,400 facilities in the U.S.

The proposed additional workload caused by surveying more than 10,000 nursing homes before they are deemed would not be a problem, he said.

"We do not conduct inspections," he said. "Inspection is an involuntary thing. We survey. We impose no sanctions. We act as consultants. It is a self-evaluation process. We try to help the facility."

UNDER PRESENT rules, the state inspects every nursing home. Federal teams also inspect some homes. The hospital accreditation committee surveys long-term facilities once every two years

and hospitals every three.

If the federal government follows the recommendation, it will reverse a commitment it made last year to create a plan to allow for inspections of all federally-supported nursing homes and a random sampling of patients to determine whether they were receiving adequate care.

The Health and Human Services Department agreed to those inspections to win a 17-month stay of action in a class-action suit filed in Denver that challenged the way nursing home inspections were conducted. That stay expires Dec. 31, allowing the government to pursue other courses of action after Jan. 1.

"IF THE GOVERNMENT proceeds with deemed status, it means deregulation in a nutshell," said John Holland, attorney for the plaintiffs in the Denver suit. "Here the system was just on the edge of being reformed, and now they're going to expose already seriously vulnerable people to the mercy of their keepers in a way that's entirely unregulated. It's a government abdication of government responsibility."

"You don't take an industry plagued with massive problems and scandals and ask it to police itself," said Holland, long a critic of nursing homes.

"The government," he said, "is ignoring the consequences it may be visiting on those very people that it recently said, at the National Conference on Aging, it hadn't forgotten."

THE WASHINGTON POST

Sunday, December 20, 1981

U.S. Task Force Co-Eased Nursing-Home

Associated Press

A federal task force is considering a shift in state nursing home inspections with good records, the task force said yesterday.

Such relief would permit the state to concentrate on nursing homes with poor records, the task force said.

The states are reimbursed by HCFA. Those funds are 10 percent from last year, Willging said, stimulating efforts to reorganize.

Patient ambush

When President Reagan addressed the White House Conference on Aging on Dec. 1, his speech included a plaintive appeal to older Americans: "Maybe you can understand my frustration over the last couple of years," he said, "... to be portrayed as somehow an enemy of my own generation." The President went on to say flatly that while cutting spending, "We have safeguarded services to those poor and elderly who depend on the government."

Perhaps Mr. Reagan, the oldest man ever elected President, did not know that "one" of the "last couple of years" he referred to was the year he was elected into what is happening in the U. S. Department of Health and Human Services.

IN ALL THIS LAND there is no group more dependent upon government than the nursing home patients on Medicaid, the federal program that helps pay for nursing home care for the poor. One might think that Mr. Reagan would have a special feeling toward this needy people, many of whom are women of his age.

But Mr. Reagan has no special feelings are reflected in his actions of his administration. It is drifting proposals to repeal the following federal regulations:

- ✓ Rules saying that a nursing home patient must be "treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs, requiring nursing homes to have a policy of communitable disease or infection that prohibits nursing homes with symptomatic infectious diseases from accepting new patients."
- ✓ Federal requirements that nursing homes must maintain "a safe and sanitary environment for patients and personnel."

- ✓ The rule that a home must hire an outside consultant if its own staff does not include qualified persons in medical record keeping, nu-

Florida: still trying

The state Medicaid program will pick up a \$200-million tab this year to support half the patients in Florida nursing homes. Taxpayers have little assurance, however, that their money is buying quality health care for elderly Floridians too frail to care for themselves.

The 1980 Florida Legislature gave the state's nursing home patients some overdue but welcome attention. A reform package designed to improve homes for the aged, including a tougher rating system and a patients' bill of rights, was signed into law. But almost two years later, the rating system that was sup-

ported and social work.

Federal officials gave two reasons for the proposals. The regulations duplicate state licensing rules. The changes would amount to deregulation of the nursing home industry in accordance with the President's economic program.

Perhaps the federal regulations do duplicate rules in some states. But the application of the rules is uneven. For example, the rating system in some states is so lax that it might result in lower quality of care for even a few patients in old nursing homes.

FOR THE 748,000 RESIDENTS of nursing homes, the nursing home industry needs stricter regulation, not a freer hand. Certainly that is true in Florida (see editorial below). Despite the belated efforts of the Legislature, state inspection of nursing homes never has been adequate even with the existing federal regulations. The for-profit nursing home industry is cheating the more. That segment of the industry includes those homes that are profiting from the misery of some neglected patients. A representative of the nonprofit part of the industry, which includes the church and other group-affiliated homes that frequently offer the best care, expressed the fear that federal "deregulation" would lower standards.

For the Reagan administration to "deregulate" the nursing home industry is to give some elements of the industry the opportunity to impose more neglect and more abuse upon patients who in some homes already are abused and neglected.

IS THAT HOW the President thinks he can earn praise and support as a friend of older Americans? Is that how he is safeguarding services to the poor and elderly who depend most on the government? Is it any wonder that the President's own generation worries when he promises to "reform" Social Security?

posed to distinguish the good homes from the bad has not been implemented. Now, it's scheduled to take effect in April, 1982.

SOME OF Florida's 349 nursing homes are excellent. Others are not. The files of these nursing homes are filled with stories documenting nursing home atrocities, neglect, abuse, filth, vermin, malnutrition, bed sores, stretch, sitting and degradation.

Under current Medicare methods of payment, bad homes can collect as much money as good ones. There is no incentive in this often

calculus industry to improve the quality of patient care.

It's encouraging that Gov. Bob Graham is supporting a plan to focus the state's financing of nursing home care. The governor's revised budget for 1982-1983 includes an additional \$1.8 million in state and federal funds for Medicaid payments to nursing homes.

In theory, some of the extra money would be used to provide an incentive for better care by linking payments to the new rating system that is supposed to go into effect in four months. Under the new system, a home will be rated "superior" if it exceeds minimum standards, "unrated" if it simply meets minimum standards and "conditional" if it is substandard. Homes that earn a superior rating would be paid more per patient than homes that are unrated or have a conditional rating.

In practice, the extra \$4.9 million will be available only if the rating system is anything less than regressive.

FRAN SUTCLIFFE, a Pinellas County resident who probably has contributed more to reforms in the state's nursing home laws than any other Floridian, is pessimistic about the new rating system.

The idea for a new rating system, she was mandating, and the incentive behind it were all gone, she says. Unfortunately, the system that now is being written to implement the rating system are not very good, she adds.

She attributes the watering down of the rating system to lobbying by the nursing home industry.

"A nursing home could have serious deficiencies and still receive a superior rating," Mrs. Sutcliffe contends. "It remains to be seen what happens, but I don't have a great deal of confidence in the new rating system. It is of no more benefit to consumers than the old one."

Originally, the legislators intended that only homes exceeding the minimum requirements in 14 vital aspects of patient care would receive a superior rating. Under the rules written to carry out the law, each of those 14 standards is broken into nine requirements. A home that meets five of the nine requirements would be designated as exceeding the minimum standard. "That means if a home meets just over 50 percent of the requirements, it would receive a superior rating," Mrs. Sutcliffe complains.

IT'S GOV. GRAHAM'S responsibility to make sure that the new rating system is as tough as the legislators intended and that it is enforced rigidly. The system will be worthless unless consumers have confidence that the care provided at home with a superior rating really is excellent.

Unless Graham can guarantee the toughness of the new rating system, it would be an outrage to reward nursing homes that might have serious deficiencies. Would you want it any other way if you had to spend your last days in a nursing home?

In Nursing Home

RONALD Reagan continues to war against his own contemporaries. First he went after Social Security, as if he personally represented all Americans who insisted on living as long as he has. Now the objects of his attack are those who live in nursing homes.

and sanity of its old people in nursing homes. So he appointed Carolyn K. Davis to head the Health Care Financing Administration, which oversees Medicaid and Medicare. She told a reporter, "I started with the presumption that we are overregulated," Her predecessors were "overzealous," she said, but she "will save money. Reagan! It's all very peculiar. Reagan!

Reagan's young people, however, drew up a plan to deregulate the nursing-home industry. There are more than 1.3 million Americans in these homes who are covered by Medicare and Medicaid programs. Since taxpayers are helping to support such health care, the Fed should have a say in how the nursing homes are operated. More than a say; a duty.

70, the people who will be harmed by his proposals were young, whereas he was young. They raised families while he raised his families. They were not the people who were being asked to give up their families. They didn't have a group of 100 businessmen to handle their affairs. Today, their children have no room for them, or no interest in them. Does this mean they don't deserve

But the Reagan crowd says none of the Government's business. They want to repeal Federal law that forbids nursing homes to employ people with communicable diseases. They also want to get rid of laws requiring nursing homes to have a sanitary and operators to respect the privacy and dignity of patients. These are not outrageous laws.

to live in safety and comfort for as long as they can?

Make no mistake: If the nursing homes are regulated by their own operators, human beings will die before their time. And if Reagan lets that happen, we shall all be witnessing the triumph of the obscene.

NYT Special Feature

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Nursing Homes Still Require

Some Watching

In its meekness and to get the government off our backs, the Federal administration's attack on the nursing home industry has been too far in some areas. It is one thing to require that nursing homes be operated by persons who are not on the Federal government's blacklist, but it is a different matter to require that nursing homes be operated by persons who are not on the Federal government's blacklist.

One area where the administration's enthusiasm for deregulation may have gotten out of hand is the Federal government's attack on the nursing home industry. The Federal government's attack on the nursing home industry is one thing, but it is a different matter to require that nursing homes be operated by persons who are not on the Federal government's blacklist.

Many nursing home operators cleared up their act after revelations in the 1950s and 1970s that the industry had put profit above compassion for the elderly. The industry's reputation for neglect and abuse was so bad that it was common to hear the words "nursing home" and "abuse" used interchangeably. The industry's reputation for neglect and abuse was so bad that it was common to hear the words "nursing home" and "abuse" used interchangeably.

In New York state, for example, evidence has been turned up that at least 43 nursing homes are owned or

operated by felons, many of them convicted of billing the government on Medicaid payments. In Texas, the state has indicted Autumn Hills Convalescent Center Inc. of Houston for murder by neglect and for fraud—an unprecedented prosecution.

Despite such evidence, the President's Task Force for Regulatory Relief is busy drawing up a list of nursing home regulations that administration zealots feel will never be missed. The regulations targeted for extinction are spelled out in an internal process report dated Oct. 15 by Thomas G. Donohue, chief of the Federal Health Services Administration.

The document regulations do not deal specifically with the nursing home industry, but they do deal with the industry's reputation for neglect and abuse. The document regulations do not deal specifically with the nursing home industry, but they do deal with the industry's reputation for neglect and abuse.

The task force has decided to abolish requirements that nursing homes furnish state inspectors with information on their staffing levels. It has also decided there's no need for nursing homes to put in writing their policies for control of contagious diseases and for protection of health care workers and their employees from communicable diseases.

In addition, the task force apparently thinks it's not necessary to make nursing home operators give their personnel training in control of infection, fire prevention and safety, accident, prevention and confidence.

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SATURDAY, DECEMBER 26, 1931

Asking for Nursing Home Trouble

"Social legislation of the aged poor" is the bureau-cent's term for a problem most families are bound to meet sooner or later. It is the problem of the aged poor, and it is the problem of the aged poor who are no longer able to take care of herself on a meager pension or Social Security.

In the 1890's, the Great Society sought to help by expanding Federal health benefits in a way that encouraged private entrepreneurs to open nursing homes. The flood of money succeeded in stimulating care for the aged, but it also produced a dizzying amount of greed. Only belated state and Federal regulation has since been able to curb the industry. Now the Federal Administration evidently wants to relax Federal regulation. If so, there is good reason to fear a new proliferation of abuse.

The nation's nursing home capacity has increased since 1923 from 500,000 to 1.3 million. The care of these patients costs \$200 million, of which the Federal Government pays about \$100 million, the largest chunk by Medicaid. To qualify, nursing homes must persuade state officials that they meet minimum Federal standards.

In the early days of the boom, some operators exhibited a startling capacity. They made McChesney Jamieson, president of the National's medical "practice," inspect, dilapidated, and even billed Washington for the care in their offices.

The profits were large enough to buy legal and political defenses, so for a few years the operators were able to get away with a great deal of what they were doing. But now they are being forced to reform, and they are being forced to reform publicly in the Senate and Congress, required stricter accountability.

Some of the damage, however, was not easily repaired. According to Bruce Vladeck, author of a study of the subject, the lax requirements in the early years means that we can't get a hard core of steady operators who are permitted to grow up in the industry, and it will take a stable foundation of long experience to build a new industry.

It has been clear that how the Federal Health Care Financing Administration proposes to relax Federal regulation, but its task force is reported to be studying the industry's requirements and special standards, and it is also considering whether recreation of nursing homes can be left to an industry group.

The industry group, apparently, is to turn regulation back over to the states and save Medicaid money by lowering standards. But state officials are worried that this would invite a relapse to the corrupt and cruel old days.

Nursing homes used to provide a solid example of failed partnership between bureaucratic and entrepreneurial. An Administration that would seriously relax regulation of this industry is asking for a much kind of trouble.

Don't retreat on nursing homes

Until a few years ago the 1.7 million Americans confined to nursing homes were helpless to assert their most basic rights and interests. Those who lived in decent nursing homes needed no special protection. But others — more, by far — were prisoners in facilities that routinely trampled over basic rights: withholding medical records, prohibiting visits by friends, ignoring privacy, punishing individualistic behavior, even padding bills. Conditions were often unsanitary, diets inadequate, nursing spotty.

Despite recent progress, many nursing homes still fail to meet even minimal standards. A 1979 survey commissioned by the federal government documented the need for much further improvement. Nevertheless, overall gains recorded since the mid-1970s have been encouraging. In a few states such as Illinois, improvements have been heartening.

Today these gains are in peril. Propelled by the regulatory relief mandate it claims, the Reagan administration has targeted nursing homes for particular relief. If the administration's proposals go into effect, the hard-won improvements will disappear and further progress will be stymied. Nursing homes will go back to square one.

Largely responsible for the gains of the last five or 12 years has been federal legislation and an agency with which most people are probably unfamiliar. Called the Health Care Financing Administration, the agency is responsible for running two massive government health-care programs — Medicaid, which pays for the nursing-home care of about 1.5 million people, and Medicare, which finances care for another 200,000.

This agency, with explicit authority granted by Congress, has laid down certain conditions that must be met by nursing homes that provide care to residents on Medicaid or Medicare. Among the conditions are minimal standards for housing, medicine, nursing, nutrition, pharmaceuticals and rehabilitation. The agency pays the states to ensure compliance with the standards. States are free to expand on these minimal standards, and some, under prodding by advocacy groups and federal officials, have indeed gone beyond them. Illinois is one. Last year the enactment of a comprehensive nursing-home reform law, along with a companion law authorizing suspension or revocation of a nursing home's license for its

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Arlington Heights, Ill.

operator's involvement in other substandard or illegal nursing homes, marked a turning point in the care for 100,000 Illinoisans in nursing homes. Provisions of Illinois's law are trailblazing: mandatory yearly surprise inspections of all nursing homes, creation of an extensive "bill of rights" for residents, required formal training for nurse aides, imposition of fines against deficient facilities, permission for public-fee residents to file suit against nursing-home operators, and more.

Very likely none of this would have been instituted without the federal government's leadership — and this leadership is what the Reagan administration desires to turn around. It intends to propose the repeal or relaxation of the Health Care Financing Administration's most worrisome regulations. An internal task force on regulatory reform (not to be confused with the Reagan administration's government-wide interagency task force on regulatory relief, headed by Vice President Bush) has been meeting secretly to formulate its proposals on nursing homes.

Although the specific proposals are not yet publicly known, their tenor is plain. Last week the Health Care Financing Administration's director was quoted as saying, "I start with the presumption that we are overregulated." More worrisome yet, the confidential minutes of the task force show that key regulations targeted for extinction include the long-sought requirements for "a safe and sanitary environment for patients and personnel," the control of communicable diseases carried by employees, and the "consideration, respect and full recognition of dignity and privacy" of residents.

Excessive regulation is undoubtedly a burden in the productive sector of the economy, and Reagan appointees in those fields have good reason to begin with the presumption of overregulation. It is another story in the social-service sector. There the presumption should be starkly different: that within the federal government's forcible grasp and leadership, persons who cannot protect their own interests would be helpless. Nowhere is this to be feared more than in America's nursing homes.