

**WEST VIRGINIA  
SECRETARY OF STATE  
BETTY IRELAND  
ADMINISTRATIVE LAW DIVISION**

Form #2

Do Not Mark In This Box

2008 JUL 17 PM 3:13

**NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE**

AGENCY: DHHR Office of Health Facility Licensure and Certification TITLE NUMBER: 64

RULE TYPE: Nursing Home Rule Legislative CITE AUTHORITY: W. V. Code §§ 16-1-4 and 16-5C-5

AMENDMENT TO AN EXISTING RULE: YES  NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 13

TITLE OF RULE BEING AMENDED: Nursing Home Licensure Rule

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: \_\_\_\_\_

TITLE OF RULE BEING PROPOSED: \_\_\_\_\_

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON 7/18/08 AT NOON ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Deanna Kramer, RN, MS, NHA; Nursing Home Program  
Aimee Silva Jackson, Paralegal  
BPH-OHFLAC, 1 Davis Square, Ste 101  
Charleston, WV 25301-1799

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Martha Yager Parker  
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

\$22.50

## FISCAL NOTE FOR PROPOSED RULES

Rule Title: Title 64, Series 13, the Nursing Home Licensure Rule

Type of Rule:                      X   Legislative                           Interpretive                           Procedural

Agency: HEALTH AND HUMAN RESOURCES

Address: Office of Health Facility Licensure and Certification  
1 Davis Square, Suite 101  
Charleston, West Virginia 25301-1799

Phone Number: 304-558-0050                    Email: diannakramer@wvdhhr.org

### Fiscal Note Summary

Summarize in a clear and concise manner what effect this measure will have on costs and revenues of state government.

1. Arnett & Foster, P.L.L.C. was engaged by the Office of Health Facility Licensure and Certification to estimate the financial impact of the proposed changes in Section 10 of the licensure rule. The proposed rule increases the minimum nursing staffing level from 2.25 hours per patient per day (ppd) to 2.79 hours ppd. Based on the results of their review, 14 nursing homes do not currently meet or exceed the proposed 2.79 hours ppd. **The estimated annual cost to raise the nursing staffing levels of these 14 nursing homes to the proposed 2.79 hours ppd, in 2009 dollars, is \$652,461.** Of the 2.79 hours ppd, the proposed rule requires 1.50 hours ppd be provided by qualified nurse aides. Only 4 nursing homes do not currently meet or exceed the proposed 1.50 hours ppd for nurse aides. **The annual estimated cost for meeting this requirement, in 2009 dollars, is \$35,623.**
  
2. The proposed rule increases the entry-level educational requirement for activity directors from a 45-hour course to a 90-hour course with a 90-hour practicum. A financial study revealed 16 nursing homes in WV do not currently employ an activity director possessing at least this minimum qualification. **The estimated direct cost for having 1 activity director from each of these 16 nursing homes complete the required training is \$19,040.** The proposed rule requires activity directors to obtain 10 hours of activity-related continuing education annually. A financial study revealed activity directors at 34 nursing homes will need to obtain this continuing education annually. **The estimated annual direct cost for having 1 activity director from each of the 34 affected nursing homes obtain this continuing education is \$17,000.**
  
3. The proposed rule requires nursing homes with 120 or more licensed beds to employ a second qualified full-time social worker. A financial study found that 16 nursing homes in WV may experience a financial impact from the proposed change ranging from a facility-specific minimum amount of \$4,160 to a maximum amount of \$46,800. **Overall, the maximum financial impact of this requirement is estimated to be \$595,920.**

### Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

Effect of Proposal	Fiscal Year		
	2008 Increase/Decrease (use "-" )	2009 Increase/Decrease (use "-" )	Fiscal Year (Upon Full Implementation)
<b>1. Estimated Total Cost</b>	0	0	#####
Personal Services			
Current Expenses			
Repairs and Alterations			
Equipment			
Other			#####
<b>2. Estimated Total Revenues</b>			

**3. Explanation of above estimates (including long-range effect):**

Please include any increase or decrease in fees in your estimated total revenues.

- 1.) In determining the fiscal impact, Arnett and Foster utilized hours reported in the Medicaid cost reports filed for the 6 month period ending 12-31-06. Amounts derived from this analysis were inflated 4% per year to represent 2009 dollars. From this amount, \$701,530 would not be subject to Medicaid reimbursement for the 14 nursing homes identified as below the 2.79 proposed standard. A Medicaid utilization rate of 72.7% was applied in determining the overall fiscal impact to Medicaid.
- 2.) The estimated annual cost for meeting the proposed continuing education requirement was \$500 based on the assumption that two classes per year would be needed. The annual estimate does not include any related expense for travel, lodging or other expenses. There are 2 individuals residing in WV who are qualified to teach the 90-hour activity director course. The proposed rule allows an 18-month period after the effective date for persons to acquire this training. It is unlikely that out-of-state travel would be required for the affected nursing homes to meet this requirement.

**Memorandum**

Please identify any areas of vagueness, technical defects, reasons the proposed rule would not have a fiscal impact, and/or any special issues not captured elsewhere on this form.

[Empty box for memorandum content]

Date

6-16-08

Agency

Department of Health and Human Resources

Authorized Representative

Martha Heager Walker

Martha Heager Walker  
Secretary

## **Brief Summary and State of Circumstances with Require the Proposed Rule**

### **Brief Summary of the Proposed Rule:**

The Office of Health Facility Licensure and Certification (OHFLAC) submits this proposed legislative rule for the purpose of repealing and replacing Title 64, Series 13, the Nursing Home Licensure Rule.

### **Statement of Circumstances which Require the Proposed Rule:**

The proposed rule:

- Clarifies the existing licensing requirements for nursing homes (for which there are no interpretative guidelines), brings these requirements in line with current Centers for Medicare & Medicaid Services (CMS) regulations and current national standards and practices with respect to patient safety (including medication errors and other adverse events), infection control, and disaster preparedness, and enhances Resident Rights (including the right to effective pain control) and Quality of Life, including granting additional protections to those residents affected by a nursing home's downsizing or closure.
- Where the State licensure rule mirrors the CMS regulations, this does not increase the regulatory burden on nursing homes that already participate in Medicare and/or Medicaid, as these facilities are already required to comply with all of the CMS regulations. Nor does increase a nursing home's risk for receiving penalties for noncompliance with both State licensure and Federal certification; according to 16-5C-10(d), "... (T)he director may not assess a penalty under state licensure for the same deficiency or violation cited under federal law..." By reiterating all (instead of only some) of the CMS requirements within the State licensure rule, those nursing homes that choose not to participate in Medicare and/or Medicaid or that lose their ability to participate in Medicare and/or Medicaid will not be held to a lower standard of performance than the rest of the nursing homes in this State.
- To address Quality of Life issues, the proposed rule includes measures to facilitate resident empowerment through "resident-directed care", increases the number of social workers in nursing homes with 120 or more beds, and raises the entry-level qualifications for activity directors.
- Attributes specific duties and responsibilities to the governing body of the nursing home, as well as to key personnel, in order to increase accountability, especially in such instances when the governing body is remotely removed from the direct operations of a nursing home, such as with a private equity group (e.g., the Carlyle Group). Throughout existing rule, actions are attributed to "the nursing home", an inanimate object. [Example: "The governing body shall be responsible for ensuring that the nursing home's administrator is empowered to employ sufficient qualified staff and utilize the nursing home's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."]

## **Brief Summary and State of Circumstances with Require the Proposed Rule**

- Increases the current minimum nursing staffing level from 2.25 hours of direct care staff per patient per day (ppd) to 2.79 hours ppd (of which 1.50 hours ppd must be provided by nurse aides), to address the higher acuity of today's nursing home residents.
- Clarifies and simplifies the process by which a new, previously unlicensed facility may receive an initial license under this rule, including providing a definition in the rule for "substantial compliance" [the standard established in W. Va. Code 16-5C-6(b)(3) which must be met before a license may be issued] and a mechanism for classifying deficiencies to identify when substantial compliance is achieved.
- Corrects deficits in the existing rule, which does not address all requirements specified in W. Va. Code 16-5C-5(b)(1) and (2). The proposed rule also corrects errors in the existing rule. Many of these errors occurred when the previous version of the existing rule (effective July 1, 2001) was written in active voice, and an "action" required in the rule was attributed to the wrong "actor". [Example: In the existing rule, the nursing home (not the director of OHFLAC) is required to investigate complaints reported to OHFLAC against nursing homes.]
- More fully addresses, throughout the rule, the needs of residents with Alzheimer's disease and other cognitive impairments, including the need to conduct a comprehensive assessment of a resident's behavior (including collecting specific information about a resident's customary routine) prior to using psychoactive medications and/or physical restraints to control that behavior, and the need to train staff in identifying and assessing for pain in a cognitively impaired resident.
- Specifically addresses the coordination of services between nursing homes and hospices and/or outpatient hemodialysis centers, to improve the continuity of resident care between these types of health care providers when such relationships exist.
- Adds the requirement that residents who meet certain criteria receive information regarding hospice-palliative care.
- Adds definitions for terms utilized, but not specifically defined, in the existing rule.
- Removes existing barriers to providers, including but not limited to: (1) permitting a nursing home to recruit and train a new dietary manager without incurring a deficient practice; (2) distinguishing between grievances (which do not need to be reported to State agencies) and complaints alleging resident abuse, neglect, and/or misappropriation of resident property (which must be reported to State agencies); (3) clarifying a nursing home's responsibilities with respect to resident admission, transfer, and discharges, including discharges against medical advice; (4) allowing student nurses to administer medications to residents under the direct supervision of a member of the school faculty; and (5) allowing nurse aides, under the general supervision of a licensed nurse, to apply nonprescription topical lotions, creams, or ointments to a resident's skin under certain circumstances.

64CSR13

TITLE 64  
LEGISLATIVE RULES  
WEST VIRGINIA DIVISION OF HEALTH

2007 JUN 17 PM 3:14

SERIES 13  
NURSING HOME LICENSURE RULE

§64-13-1. General Provisions.

1.1. Scope. -- It is the purpose of this rule to implement state and federal law governing the licensing, operation, and standard of care in nursing homes located in the state of West Virginia. Compliance with this rule will help each resident attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with a comprehensive assessment and plan of care and prevailing standards of care in a living environment, to the extent practicable, that approximates a normal home environment, and will promote a standard of care that assures that the ability of each resident to perform activities of daily living does not diminish unless the resident's ability is diminished solely as a result of a change in the resident's clinical condition.

1.2. Authority. -- W. Va. Code §§16-1-4 and 16-5C-5.

1.3. Filing Date. -- ?????

1.4. Effective Date. -- ?????

1.5. Repeal of Former Rule. -- This legislative rule repeals and replaces "Nursing Home Licensure Rule" W. Va. 64CSR13, effective July 1, 2007.

§64-13-2. Definitions.

2.1. Abuse. -- The willful infliction of injury, unreasonable confinement, intimidation, or punishment, which results in pain, mental anguish or physical harm, even if the resident is unaware that the harm has occurred.

2.1.a. Involuntary seclusion. -- Separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

2.1.b. Physical Abuse. -- Abuse resulting from resident contact including but not limited to striking the resident with a body part or with an object; shoving, pushing, pulling, tugging or pinching or twisting any of the resident's body with fingers, fingernails, or objects; burning or sticking the resident with an object; engaging in physical contact that knowingly,

intentionally, recklessly or through carelessness causes or is likely to cause death, physical injury, pain or psychological harm to the resident; inappropriate or improper use of restraints or isolation; acts of retaliation even in response to a physical attack by the resident.

2.1.c. Psychological and Emotional Abuse. -- Humiliating, harassing, teasing or threatening a resident with punishment or deprivation; not considering a resident's wishes; restricting a resident's contact with family, friends or others; ignoring a resident's needs for verbal and emotional contact; or violating a resident's right to confidentiality.

2.1.d. Sexual Abuse. -- Sexual harassment, sexual coercion, or sexual assault of a resident; sexual interaction with a non-consenting resident; or inciting any type of sexual activity.

2.1.e. Verbal Abuse. -- Statements made to, or in the presence of, a resident that result in ridicule or humiliation of the resident; the use of oral, written or gestured language that includes cursing; the use of demeaning, derogatory references to or descriptions of a resident or his or her family.

2.2. Administrator. -- A person licensed in the state of West Virginia as a nursing home administrator who is responsible for the day to day operation of the nursing home.

2.3. Advance Directive. -- A written instruction of an individual, such as a living will, a medical power of attorney, or other written directive recognized under state law and relating to the provision of health care when the individual is unable to direct his or her own health care. (Note that a POST form is not an advance directive.)

2.4. Adverse Consequences. -- An effect that is due to or associated with a medication and that is manifested as an unpleasant symptom, or that impairs or causes a decline in an individual's health, physical condition, or functional or psychosocial status. It may include various types of adverse drug reactions and interactions.

2.5. Adverse Drug Reaction (ADR). -- A type of adverse consequence that is a secondary effect of a medication, which is undesirable and different from the helpful and therapeutic effects of the medication. It may include a side effect, hypersensitivity, idiosyncratic response, toxic reaction or medication interaction.

2.6. Annual Inspection. -- For the purpose of this rule, annual inspection is defined as occurring during a time frame of nine (9) to fifteen (15) months.

2.7. Applicant. --

2.7.a. Applicant for a Nursing Home License. -- A person who submits an application for a license or renewal of a license to operate a nursing home.

2.7.b. Applicant for Employment. -- A person who submits an application for employment in a nursing home.

2.7.c. Applicant for Admission. -- A person who is applying for admission to become a resident of a nursing home.

2.8. Bed Capacity. -- The maximum number of beds the nursing home is currently licensed to offer for resident occupancy.

2.9. Behavioral Intervention. -- A type of non-pharmacologic approach to try to influence or redirect behavior; for example, by talking with the individual, restructuring the environment, discussing and enforcing limits on acceptable behavior, or various psychosocial and activities interventions.

2.10. Biologicals. -- Products isolated from a variety of natural sources – human, animal, or microorganism – or produced by biotechnology methods and other cutting-edge technologies and may include a wide variety of products such as vaccine, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins.

2.11. Capacity to make decisions. -- The ability to comprehend and retain information which is material to a decision, especially as to the likely consequences of that decision; the ability to use the information and weigh it in the balance as part of the process of arriving at a decision and the ability to communicate the decision in an unambiguous manner.

2.12. Care Plan. -- A document, prepared by the interdisciplinary care team in conjunction with the resident, that specifically identifies measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial strengths and needs identified through a comprehensive assessment. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of the right to refuse treatment, as set forth in subdivision 4.7.a. of this rule.

2.13. Causal Factors. -- Any stimulus that affects the behavior of a resident either positively or negatively.

2.14. CMS. -- The centers for medicare and medicaid services, within the United States department of health and human services.

2.15. Change of Ownership. -- Any transaction that results in a change of control over the capital assets of a nursing home including, but not limited to, a conditional sale, a sale, a lease or a transfer of title or controlling stock.

2.16. Complaint. -- An allegation of resident abuse, neglect, or misappropriation of resident property.

2.17. Convenience. -- Any action taken by the nursing home to control a resident's behavior or maintain a resident's behavior with a lesser amount of effort and that is not in the resident's best interest.

2.18. Current Standards of Practice. -- Approaches to care, procedures, techniques, treatments, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

2.19. Customary Routine. -- The resident's usual community lifestyle and daily routine in the year prior to the resident's date of initial entry into a nursing home. If the resident is being admitted from another nursing home, then the admitting / new nursing home should gather information regarding the resident's routine during the last year that the resident lived in the community. An assessment of a resident's customary routine shall include, but not be limited to an assessment of the resident's:

2.19.a. Sleeping habits, including what times the resident would routinely go to bed and awaken; whether the resident typically napped during the day and at what times these naps took place; any rituals in which the resident routinely engaged prior to going to sleep; the resident's preference with respect to sleep wear; and what furniture the resident used when sleeping or napping;

2.19.b. Dietary preference and eating habits, including customary meal times and whether the resident routinely consumed three (3) meals each day versus an alternate meal pattern;

2.19.c. Bathing habits, including frequency of bathing; preferences with respect to bathing in the morning or evening; and whether the resident typically used a shower, bathtub, or basin for bathing; and

2.19.d. Usual social activities, participation in religious activities, and presence of animal companionship.

2.20. Deemed Status. -- Special consideration granted to a nursing home that receives accreditation from an accrediting organization, whereby an accreditation report may be used in place of an annual licensing inspection by the state if the standards of the accrediting organization recognized by CMS are comparable to the medicare standards.

2.21. Deficiency. -- An entry made on the West Virginia department of health and human resources STATE FORM that describes the specific requirements of the rule with which the nursing home failed to comply, an explicit statement that the requirement was not met, and the evidence to support the determination of non-compliance.

2.22. Department. -- The West Virginia department of health and human resources.

2.23. Director. -- The secretary of the West Virginia department of health and human resources or his or her designee.

2.24. Discharge. -- Moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care.

2.25. Discipline. -- Any action taken by the nursing home for the purpose of punishing or penalizing a resident.

2.26. Dose. -- The total amount, strength, and/or concentration of a medication given at one (1) time or over a period of time. The individual dose is the amount, strength, and/or concentration received at each administration. The amount received over a twenty-four (24) hour period may be referred to as the daily dose.

2.26.a. Excessive Dose (including Duplicate Therapy). -- When the total amount of any medication given at one time or over a period of time that is greater than the amount recommended by the manufacturer's label or package insert, or by standards of practice for a resident's age and condition; there is no evidence of a review for the continued necessity of the dose or of attempts at, or consideration of the possibility of, tapering a medication; and there is no documented clinical rationale for the benefit or necessity for the dose or the use of multiple medications from the same class.

2.27. Drug Regimen Review (DRR). -- A comprehensive assessment of the medication regimen of a resident, with a goal of promoting positive outcomes and minimizing adverse drug / medication outcomes or adverse drug reactions. The review includes preventing, identifying, reporting, and resolving medication related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary care team. A drug regimen review may also be referred to as a medication regimen review.

2.28. Duration. -- When used in the context of medication administration, duration means the total length of time the medication is being received.

2.28.a. Excessive Duration. -- When the medication is administered beyond the manufacturer's recommended time frames or facility-established stop order policies; beyond the length of time advised by current standards of practice; or when there is no additional therapeutic benefit being derived and no clear clinical factors that warrant the indefinite use of the medication.

2.29. Employee. -- Any person who performs personal services for the nursing home in exchange for monetary compensation where such personal services, including the results to be accomplished as well as the details and the means by which the results are accomplished, are controlled and directed by the nursing home, where monetary compensation is effected through the nursing home's payroll system.

2.30. Enabler. -- Any device that allows the resident to accomplish tasks that otherwise he or she could not accomplish and that maintains and improves the resident's ability to function. (Note that a device may be both an enabler and a physical restraint.)

2.31. Experimental Research. -- Development and testing of clinical treatments, such as an investigational drug or therapy, that involve treatment or control groups or both. For example, a clinical trial of an investigational drug is experimental research.

2.32. Family Council. -- A group of persons, family members or responsible parties of the residents, meeting as a group and having the right to express grievances in relation to the well-being of the residents in general and the right to make recommendations concerning the nursing home's policies and procedures.

2.33. Governing Body. -- The person, or group of persons with the ultimate responsibility and authority for the conduct of the nursing home.

2.34. Gradual Dose Reduction (GDR). -- The stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

2.35. Grievance. -- Any concern dealing with an issue other than an allegation of resident abuse, neglect, or misappropriation of resident property.

2.36. Harm. -- Non-compliance with this rule that has negatively affected the resident such that the resident's physical, mental or psychosocial well-being has been compromised and is not transient in nature.

2.37. Health Unit Coordinator. -- Also known as a "unit clerk", "ward clerk", "unit secretary", or "health information assistant", the health unit coordinator may be assigned non-nursing clerical duties as well as health record management duties. At a minimum, this individual must have a high school diploma or its equivalent and evidence of having successfully completed a training course in medical terminology.

2.38. Immediate Jeopardy. -- A situation in which the nursing home's non-compliance with one (1) or more requirements of this rule has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident.

2.39. Incompetent Person. -- An adult individual, eighteen (18) years of age or older, who has been found by a court to need the assistance or protection of a guardian and/or a conservator.

2.40. Independent Health Contractor. -- A licensed, certified, and/or registered health care provider who performs personal services for the nursing home in exchange for monetary compensation, where the nursing home has the right to specify the results to be accomplished by the work, but not the means and methods by which the result is accomplished.

2.41. Indication for Use. -- The identified, documented clinical rationale for administering a medication based upon an assessment of the resident's condition and therapeutic goals and on manufacturer's recommendation.

2.42. Interdisciplinary care team. -- A team consisting of at least a registered professional nurse and other professional disciplines as appropriate, including the resident's physician, working together with the resident or the resident's representative, if applicable, to attain or maintain the resident at his or her highest practicable level of physical, mental and psychosocial well-being.

2.43. Institutional Setting. -- Any health care facility.

2.44. Irregularity. -- Any event related to the ordering, acquiring, dispensing, receiving, storing, controlling, timing, administration, documentation, reporting or monitoring of a medication, which can actually or potentially interfere with the intended outcome for a resident and can include, but is not limited to a medication related problem.

2.45. Legal Representative. -- A person appointed by an individual or by a duly authorized agency or court, or otherwise authorized by law to exercise some degree of control over a resident's affairs. Each type of legal representative has specific duties and decision-making authority. Not all legal representatives have the lawful authority to act on behalf of the residents in all matters requiring action by a legal representative. Legal representatives include one (1) of the following most appropriate to the decision to be made:

2.45.a. A conservator, temporary conservator or limited conservator appointed pursuant to the West Virginia Legal Guardianship and Conservatorship Act, W.V.C. §44-1-1- et seq., within the limits set by the appointing order;

2.45.b. A guardian, temporary guardian or limited guardian appointed pursuant to the West Virginia Legal Guardianship and Conservatorship Act, W.V.C. §44-1-1-et seq., within the limits set by the appointing order;

2.45.c. A person appointed as committee or guardian prior to June 9, 1994, within limits set by the appointing order and W.V.C. §44A-1-2-(d);

2.45.d. A person having medical power of attorney pursuant to the West Virginia Health Care Decisions Act, W.V.C. §16-30-1 et seq., within the limits set by the law and the appointment;

2.45.e. A representative payee under the U.S. Social Security Act, Title 42 U.S.C. §301 et seq., within the limits of the payee's legal authority;

2.45.f. A health care surrogate appointed pursuant to the West Virginia Health Care Decisions Act, W.V.C. §16-30-1 et seq., within the limits set by the appointment;

2.45.g. A person having a durable power of attorney pursuant to W.V.C. §39-4-1 or a power of attorney under common law, within the limits of the appointment;

2.45.h. A person identified pursuant to the W.V.C. §16-3C-4, to grant consent for HIV related testing and for the authorization of the release of the results;

2.45.i. A parent or guardian of a minor; or

2.45.j. A person lawfully appointed in a similar or like relationship of responsibility for a resident under the laws of this state, or another state or legal jurisdiction, within the limits of the applicable statute and appointing authority.

2.46. License. -- The document issued by the secretary that is the licensee's authority to receive residents and perform services included within the scope of this rule.

2.47. Licensed or Registered.

2.47.a. Person. -- Licensed or registered by the proper authority to follow a profession in the state of West Virginia.

2.47.b. Nursing home. -- A nursing home licensed by the department.

2.48. Licensee. -- A person, or persons, holding a license to operate a nursing home who is responsible for compliance with all rules and minimum standards.

2.49. Medicaid. -- The medical assistance program established pursuant to title nineteen of the Social Security Act [42 U.S.C. §1396 et seq.].

2.50. Medical Director. -- A physician, licensed by the West Virginia board of medicine or the West Virginia board of osteopathy, who oversees the medical care and other designated care and services in a nursing home. Under this rule, the medical director is responsible for coordinating medical care and helping develop, implement, evaluate, and revise resident care policies and procedures that reflect current standards of practice.

2.51. Medical symptom. -- An indication or characteristic of a physical or psychological condition.

2.52. Medicare. -- The medical insurance program established pursuant to title eighteen of the Social Security Act [42 U.S.C. §1395 et seq.].

2.53. Misappropriation of Property. -- The deliberate misplacement, exploitation or wrongful misuse of a resident's belongings or money.

2.54. Monitoring. -- The ongoing collection and analysis of information (including observation and diagnostic test results, etc.) and comparison to baseline data in order to: (a) ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal and detection of any complications or adverse consequences of the condition or of the treatments; and (b) support decisions about modifying, discontinuing, or justifying the continuation of an intervention.

2.55. Neglect. -- The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

2.56. Next of Kin. -- In descending order of priority;

2.56.a. The resident's spouse;

2.56.b. The resident's adult children;

2.56.c. The resident's parents;

2.56.d. The resident's adult siblings;

2.56.e. The resident's adult grandchildren;

2.56.f. The resident's close friends; and

2.56.g. Any other person or entity, including guardians, public officials and private corporations and other persons or entities which the department may from time to time designate in rules promulgated pursuant to chapter twenty-nine of the West Virginia Code.

2.57. Non-compliance. -- Any deficient practice or nonconformity that causes a nursing home to not be in substantial compliance with this rule.

2.58. Non-pharmacologic Interventions. -- Approaches to care that do not involve medications, generally directed towards stabilizing or improving a resident's condition and/or behavior. Examples of such approaches include but are not limited to: alternate or complementary therapies to address pain; identifying and reducing environmental and psychosocial stressors; basing daily care on customary or life-long routines; encouraging involvement in person-appropriate activities; and using sleep hygiene techniques.

2.59. Nourishing Snack. -- Two (2) or more food items from the basic food groups plus a beverage of milk, juice or the resident's preference.

2.60. Nurse Aide. -- Any individual who is not a licensed health care provider or registered dietitian or volunteer who provides nursing or nursing related services for hire to residents in a nursing home after successfully completing a state-approved training and competency evaluation program.

2.61. Nursing Home. -- Any institution, or any part or unit of an institution, 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 (24) hours, for four (4) 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 an illness or incapacitation.

2.62. Nursing Personnel. -- The director of nursing, the charge nurse and all employees under the direct supervision of the director of nursing or charge nurse who attend to resident-oriented nursing functions, including registered professional nurses, licensed practical nurses and nurse aides, but excluding:

2.62.a. Ancillary personnel who are assigned to the nursing department but who do not perform nursing or nursing-related services, including but not limited to supply clerks, health information management personnel, paid feeding assistants and other assistive personnel by any title (e.g., "hospitality aide" and "resident valet"), and

2.62.b. Employees engaged in administration, dietetics, social services, activity staff, housekeeping, laundry and maintenance.

2.63. Ombudsman. -- Any person or organization designated by the state long-term care ombudsman as part of the West Virginia long-term care ombudsman program.

2.64. Paid Feeding Assistant. -- A person who has successfully completed a state-approved training course and is paid by a nursing home to feed residents, or who is used under an arrangement with another agency or organization to feed residents in a nursing home. Paid feeding assistants are not considered nursing personnel and may not be used to satisfy the minimum hours of nursing services staffing requirements.

2.65. Plan of Care. -- The overall profile of services and expected outcomes of care that may include those plans to meet the resident's needs after discharge to the community. This includes all care and services outlined in the resident's medical record. The care plan document is part of the resident's overall plan of care.

2.66. Physician Orders for Scope of Treatment (POST) Form. -- The POST form is a short summary of treatment preferences and a clear, current and active physician's order for care in an emergency situation. The POST form is not intended to replace a living will or medical power of attorney form, and it is not an expression of a resident's advance directives.

2.67. Poor Performer. -- A nursing home which has repeat deficiencies that resulted in harm or greater whereby the nursing home cannot avoid an enforcement action by correction of the deficiency.

2.68. Premises. -- A tract of land, together with all buildings, equipment, fixtures and facilities erected, constructed or situated on the land, 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 nursing home.

2.69. The Protection and Advocacy Network. -- The system established to protect and advocate the rights of persons with developmental disabilities specified in the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §15001 et seq., and the protection and

advocacy system established under the Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C. §10801 et seq.,.

2.70. Reasonable Accommodations of Individual Needs and Preferences. -- The nursing home's efforts to individualize the resident's environment to assist the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own preferences and unique needs and based on his or her assessment and care plan.

2.70.a. "Individualizing the resident's environment" may include actions such as modifying the arrangement of the resident's room to enable the resident to maintain unassisted functioning, providing adaptive equipment, based on a comprehensive assessment of the resident, to facilitate unassisted functioning, ensuring that staff uses appropriate measures to facilitate communication with residents who have cognitive impairments and/or communication deficits, based on a comprehensive assessment of the resident, and adjusting the schedule on which care and services are providing, in consideration of the resident's customary routine, based on a comprehensive assessment of the resident.

2.71. Qualified. -- The capacity of a person who is licensed, certified, or registered to perform a duty or a task in accordance with applicable state law and other accrediting bodies.

2.72. Quality Assessment and Assurance. -- Systematic activities performed to determine the extent to which clinical practice meets specified standards and values with regard to such things as: the appropriateness of service assessment and duration; the appropriateness of facilities and resources utilized; and the adequacy and clinical soundness of care rendered. Such activities include the establishment of facility-wide goals for resident care, the assessment of the procedures used to achieve the goals, and the proposal of solutions in attaining those goals.

2.73. Receiving Medication. -- The process of accepting a medication from a source (e.g., vending pharmacy delivery agent, VA, family member).

2.74. Regulatory Grouping. -- A set of directly-related regulatory requirements.

2.75. Repeat Deficiency. -- A deficiency that: 1) is cited on the current inspection; 2) was cited on the previous inspection or any intervening inspection between the current inspection and the previous inspection; 3) has had a plan of correction submitted for the previous inspection or any intervening inspection that was accepted by the director; and 4) is cited based on the same regulatory grouping.

2.76. Resident. -- A person who is admitted to a licensed nursing home for observation, treatment, and/or care for illness, disease, injury or other disability.

2.77. Resident Care Committee. -- A committee, comprised of no less than the administrator, the director of nursing, and the medical director, whose members are responsible for developing, reviewing, and revising as necessary the resident care policies and procedures.

2.78. Resident Care Policies and Procedures.

2.78.a. Resident Care Policies. -- The nursing home's overall goals, directives, and governing statements that direct the delivery of care and services to its residents

2.78.b. Resident Care Procedures. -- The processes by which the nursing home provides care to its residents in a manner consistent with current standards of practice and the nursing home's policies.

2.79. Resident Council. -- A group of residents having the right to meet as a group and to express grievances in relation to the well-being of residents in general and to make recommendations concerning the nursing home's policies and procedures.

2.80. Restraint. -- Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the person cannot remove at will and which restricts freedom from movement or normal access to one's body, or any drug used to limit movement by a resident or to limit the mental capacity of a resident beyond the requirements of therapeutic treatment.

2.81. Routine Dental Service. -- A service consisting of an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings, minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures such as impressions of dentures and fitting of dentures.

2.82. Secretary. -- The secretary of the West Virginia department of health and human resources.

2.83. Side Effect. -- An expected, known reaction that occurs with a predictable frequency and is less intense or problematic than an ADR. Side effects of minimal impact or duration do not necessarily constitute adverse consequences. Consideration of side effects may be a key factor in selecting particular medications.

2.84. Staff. -- Any person or persons who perform personal services for the nursing home in exchange for monetary compensation where such personal services, including the results to be accomplished as well as the details and the means by which the results are to be accomplished, are controlled and directed by the nursing home, regardless of whether monetary compensation is effected through the nursing home's payroll system or the nursing home's accounts payable system.

2.85. State Board of Review. -- The board within the West Virginia department of health and human resources designated by state law through which a resident may appeal a discharge from a nursing home.

2.86. Standard Quality of Care. -- Substantial compliance with this rule.

2.87. Substantial Compliance. -- A level of compliance with the requirements of this rule such that any identified deficiencies pose no greater a risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with the requirements of this rule.

2.88. Transfer. -- Moving the resident from the nursing home to another legally responsible institutional setting.

2.89. Treatment. -- Care provided for the purposes of maintaining and/or restoring health, improving functional levels, or relieving symptoms.

2.90. Unforeseeable Emergency. -- An unusual, unpredictable or unforeseen circumstance including, but not limited to, an outbreak of infectious disease, adverse weather conditions or natural disasters. An unforeseeable emergency does not include situations in which the nursing home has reasonable knowledge of increased resident census or decreased availability of staff, including, but not limited to, holidays, scheduled vacations and scheduled medical leave.

2.91. Volunteer. -- A person who works in or is used by a nursing home and who does not receive or expect to receive any form of compensation for services the individual performs.

#### §64-13-3. State Administrative Procedures.

##### 3.1. General Licensure Provisions.

3.1.a. No person may establish, operate, maintain, offer or advertise a nursing home, as defined in this rule within the state of West Virginia, unless that person obtains a valid license.

3.1.b. A separate license is required for nursing homes maintained or operated on separate premises even though maintained or operated under the same ownership or management.

3.1.c. Separate buildings on the same premises, operated under the same ownership and management, are one (1) nursing home unless the director determines otherwise.

3.1.d. Neither an original nor a renewal license shall be issued under this rule for a project reviewable under W.V.C. §16-2D-1 et seq. unless the state health planning and development agency 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. Evidence of compliance shall be supplied with licensure applications.

3.1.e. A license is valid only for the premises and persons named in the application.

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

3.1.g. If the ownership of a nursing home with a valid unexpired license changes, the new owner shall apply for a new license as soon as practicable after the change in ownership has been approved by the West Virginia health care authority.

3.1.h. The application for a license by the new owner has the effect of a valid license for three (3) months from the date the application is received by the director.

3.1.i. The governing body shall be responsible for obtaining approval from the director and submitting an application with applicable fees to the state licensing agency prior to changing the name, physical address, ownership and/or bed capacity of a nursing home.

3.1.j. The words "clinic," "hospital," "sanitarium," or any other word that suggests a type of institution other than the proposed or existing nursing home shall not appear in the name.

3.1.k. A license shall state:

3.1.k.1. The name of the nursing home to which it applies;

3.1.k.2. The name of the applicant who is the licensee;

3.1.k.3. The maximum bed capacity for which it is granted;

3.1.k.4. The date of issuance of the license;

3.1.k.5. The expiration date of the license; and

3.1.k.6. The physical address of the nursing home.

3.1.l. The name on the license shall be that used in the application which specifically identifies the nursing home.

3.2. Exceptions.

3.2.a. Nothing contained in this rule applies to:

3.2.a.1. A hospital as defined in W.V.C. §16-5B-1;

3.2.a.2. Institutions as defined in W.V.C. §§27-1-6 and 25-1-3;

3.2.a.3. A federally operated institution;

3.2.a.4. Institutions operated for the care and treatment of alcoholic patients;

3.2.a.5. Offices of physicians;

3.2.a.6. Hotels;

3.2.a.7. Extended care facilities operated in conjunction with a hospital;

3.2.a.8. Facilities, including intermediate care facilities for the mentally retarded required to be licensed under W.V.C. §27-9-1;

3.2.a.9. Assisted Living Residences as defined under W.V.C. §16-5D-2;

3.2.a.10. Residential Care Communities as defined under W.V.C. §16-5N-2;

3.2.a.11. Homes or asylums operated by fraternal orders pursuant to W.V.C. §35-3-1 et seq.; and

3.2.a.12. Hospices as defined under W.V.C. §16-5I-2.

3.2.b. 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 or her spouse, does not constitute a nursing home within the meaning of this rule.

### 3.3. Initial License.

3.3.a. An applicant shall submit an application to the director or designee, on a form prescribed by the director, containing information sufficient to demonstrate that the nursing home is in compliance with the standards for nursing homes established in W.V.C. §16-5C-1 et seq., and this rule.

3.3.b. The applicant shall file the initial licensure application not less than thirty (30) days and not more than ninety (90) days prior to the date proposed for commencement of operation.

3.3.c. Before an applicant for initial licensure may request an initial licensure inspection, the governing body shall be responsible for:

3.3.c.1. Submit to the director for review and approval copies of:

3.3.c.1.A. All policy and procedure manuals, which shall be organized by department or discipline;

3.3.c.1.A.1. Policies and procedures within each manual shall be numbered and organized in accordance with a table of contents.

3.3.c.1.B.2. The policies and procedures shall include as a minimum all policies and procedures required by this rule.

3.3.c.1.B. All contracts, including but not limited to consultant contracts, service agreements, maintenance agreements, and transfer agreements;

3.3.c.1.C. All information provided to an applicant for admission, including but not limited to the admission agreement, any information regarding a resident's rights and responsibilities, any information regarding the management and protection of a resident's personal funds, the bed hold policy, and the names, addresses, and telephone numbers of all associated state agencies, including those of the protection and advocacy agencies for residents with developmental disabilities and/or mental illness, and the state and regional ombudsmen programs; and

3.3.c.1.D. Evidence of the assurance of financial security as required by subdivision 4.15.g. of this rule.

3.3.c.2. Upon notification by the director, admit not more than three (3) residents and render care to them in accordance with the requirements of this rule for a minimum of thirty (30) days calendar prior to requesting of the director in writing an initial licensure inspection.

3.3.c.2.A. The governing body shall be responsible for notifying the director in writing within twenty-four (24) hours of admission of the first resident.

3.3.c.2.B. If the governing body does not request in writing an initial licensure inspection within forty-five (45) calendar days after admitting its first resident, the director shall presume that the facility is ready for its initial licensure inspection.

3.3.c.3. The director shall conduct an unannounced on-site initial inspection to determine whether the facility demonstrates substantial compliance with this rule.

3.3.c.3.A. For any deficient practices identified during the initial licensure inspection, the director shall provide a written report on the STATE FORM listing each deficiency reflecting the facility's non-compliance with specific statutes and rules within ten (10) working of the last day of the inspection.

3.3.c.3.B. For each deficient practice cited, the governing body shall be responsible for providing a written plan of correction on the STATE FORM within ten (10) calendar days of receipt of the STATE FORM.

3.3.c.3.B.1. An acceptable plan of correction shall meet the criteria established in subsection 21.4. of this rule.

3.3.c.4. Upon approval of an acceptable plan of correction, the director shall conduct a follow-up inspection to determine whether the facility corrected the previously cited deficient practices and demonstrated substantial compliance with this rule.

3.3.c.4.A. This unannounced follow-up inspection shall not occur before the latest date of completion specified on the plan of correction.

3.3.c.4.B. For any deficient practices cited during a follow-up inspection, an inspection report and a plan of correction shall be required in accordance with paragraph 3.3.c.3. of this rule.

3.3.c.5. Any applicant for licensure that is unable to demonstrate substantial compliance with this rule within one hundred eighty (180) calendar days of the last day of the initial licensure inspection shall be required to submit a new application for licensure.

3.3.d. The director shall issue an initial license after conducting an initial licensure inspection, during which the governing body demonstrated substantial compliance with this rule.

3.3.d.1. The governing body may not admit more than three (3) residents until after the director has issued the initial license.

#### 3.4. Renewal License.

3.4.a. The administrator shall submit an application for a renewal license to the director or designee on the form prescribed by the director.

3.4.b. A completed application for renewal of a license shall be submitted not less than thirty (30) days and not more than ninety (90) days prior to the expiration date of the current license.

3.4.c. The fee for renewal of a license, as determined by the director pursuant to W.V.C. §16-5C-6(e), shall accompany the license renewal application.

3.4.d. The director shall renew an original license when the following conditions are met:

3.4.d.1. The director finds the nursing home in substantial compliance with the provisions of W.V.C. §16-5C-1 et seq., and with this rule;

3.4.d.2. The licensee applied for a renewal within the time period specified in this subsection; and

3.4.d.3. The licensee submitted the correct renewal fee with the application.

3.4.e. A renewal license is valid for fifteen (15) months from the date of issuance.

#### 3.5. Provisional License.

3.5.a. If, at the time a nursing home's license needs to be renewed, the director finds that a nursing home is not in substantial compliance with the requirements of this rule and the provisions of W.V.C. §16-5C-1 et seq., the director may, at his or her discretion, issue a provisional license to the governing body.

3.5.b. A provisional license may be issued only when the director makes the following findings:

3.5.b.1. That the care given in the nursing home does not pose a substantial threat to the health and safety of residents; and

3.5.b.2. That the nursing home has demonstrated improvement and potential for substantial compliance within the term of the license for which renewal is requested.

3.5.c. A provisional license shall not be issued for a period greater than six (6) months.

3.5.d. No extensions or renewals shall be granted on provisional licenses.

3.6. Inspections of Licensed and Unlicensed Nursing Homes.

3.6.a. Before licensing a nursing home, the director shall inspect the nursing home.

3.6.b. The director shall conduct at least one (1) unannounced inspection annually, or in accordance with section 21. of this rule on deemed status of a licensed nursing home, to determine compliance with the provisions of W.V.C. §16-5C-1 et seq., and this rule.

3.6.c. In accordance with W.V.C. §16-5C-9, the director or designee has the right to enter the premises of a nursing home that the director has reason to believe is being operated or maintained as a nursing home without a license.

3.6.d. If the owner or person in charge of an unlicensed nursing home refuses entry pursuant to this subsection, the director shall apply to the circuit court of the county in which the nursing home is located or in the circuit court of Kanawha County for a warrant authorizing inspection.

3.6.e. If the director finds, on the basis of the inspection, that the governing body is operating a nursing home without a license, the governing body shall be responsible for applying for a license within ten (10) days in accordance with the provisions of this rule or shall reduce the number of residents to three (3) or fewer.

3.6.f. The governing body of a nursing home that fails to apply for a license is subject to the penalties established in sections 21. and 22. of this rule.

3.6.g. The director shall file an inspection report according to this rule and shall keep the report on file for four (4) years.

3.6.h. An inspection report shall list each deficiency reflecting the nursing home's non-compliance with specific statutes and rules.

3.6.i. The director shall send a copy of the report of an inspection to the administrator of the nursing home.

3.7. License; Posting; Licensed Capacity.

3.7.a. The administrator shall ensure the nursing home's license is posted in a conspicuous place on the licensed premises.

3.7.b. The department, on behalf of the state of West Virginia, shall maintain ownership of each license certificate issued to a licensee; upon the suspension or revocation of the license, or upon discontinuing operation of the home by voluntary action of the licensee, the governing body shall be responsible for returning each license certificate to the director immediately.

3.7.c. The number of residents in a nursing home may not at any time exceed the licensed capacity of the home as shown on the license, unless the director authorizes the governing body to temporarily exceed the licensed capacity in the event of an emergency.

3.7.c.1. Such authorization to exceed the licensed capacity in the event of an emergency shall be for a time-limited period and shall be issued in writing.

3.8. Change in Status Necessitating Discharge or Transfer of Residents.

3.8.a. Whenever a licensee plans to temporarily or permanently discontinue all or part of its operation, to include a temporary or permanent reduction in the nursing home's overall occupancy or licensed bed capacity, or to change its ownership or location, and the change in status would necessitate the discharge or transfer of residents, the governing body shall be responsible for notifying the director at least one hundred-twenty (120) days prior to the proposed date of the change in status.

3.8.a.1. In the event of an impending labor strike necessitating the temporary transfer of residents to ensure continuity of care, the governing body or designee may submit a written request to the director to waive the time frames for implementing the requirements found under subdivision 3.8.b. of this rule.

3.8.b. For a governing body planning a change in status as described in subdivision 3.8.a. of this rule:

3.8.b.1. This rule remains fully applicable until all affected residents have been discharged or transferred.

3.8.b.2. At least ninety (90) days prior to the proposed implementation date of the planned change in status, the governing body or designee shall provide the director with a detailed written transfer plan, subject to approval by the director. This plan shall include the following:

3.8.b.2.A. Credible evidence that adequate staff and resident care will be provided during the implementation phase;

3.8.b.2.B. A detailed plan for the identification, based solely on objective criteria, of those residents who may be transferred or discharged as a result of the change in status;

3.8.b.2.C. A detailed plan for communicating the reason(s) for the change in status and an explanation of the objective criteria being used to identify those residents who may be affected by this change in status, both orally and in writing, to all residents and their legal representatives;

3.8.b.2.C.1. Such notification, upon approval of the plan by the director, shall take place no less than sixty (60) days prior to the implementation date of the change in status and shall be comprised of:

3.8.b.2.C.1.(a). At least one (1) group meeting arranged by the governing body or designee, with written invitations provided at least ten (10) calendar days in advance of the meeting date to all potentially affected parties, including all residents, legal representatives for both health and financial decision making, the state and regional long-term care ombudsmen, the director of the state licensure and certification agency, and the director of the long-term care unit of the state medicaid plan.

3.8.b.2.C.1.(b). Issuance of written transfer or discharge notices at least thirty (30) days in advance of the proposed effective date of each individual resident's date of transfer or discharge, to all affected residents and their legal representatives for health and financial decision making, in the case of incapacity. The contents of each notice shall comply with all requirements set for in subsection 5.1. of this rule.

3.8.b.2.D. A detailed plan for providing medically-related social services to assist all affected residents and their legal representatives in identifying, and facilitating the transfer or discharge of the affected residents, to alternative placements suitable to meet the physical, mental, and psychosocial needs of the residents.

3.8.b.2.E. A detailed plan to offer and provide medically-related social services to those residents and/or their legal representatives who remain in the nursing home after the proposed implementation date, to identify and address any psychosocial and emotional needs arising from the transfer and/or discharge of the affected residents.

3.8.b.2.F. A detailed plan of the licensee's arrangements to make an orderly transfer of each resident affected, including but not limited to:

3.8.b.2.F.1. Specifying how the governing body plans to minimize the health risks associated with transfer trauma;

3.8.b.2.F.2. Specifying how the governing body or designee will ensure that the resident's personal belongings, as well as all pertinent medical and financial records, are transferred with the resident;

3.8.b.2.F.3. Identifying and providing assistance, as necessary, to those residents whose nursing home stays are being covered by the West Virginia state medicaid plan, to facilitate the establishment of eligibility for coverage by another state's title nineteen plan prior to a resident's transfer to a receiving health facility in the other state;

3.8.b.2.F.4. Identifying and providing assistance, as necessary, to residents with legal representatives or surrogate decision-makers for health care and/or financial decisions that were designated or appointed under West Virginia state law, to ensure that, if a resident transfers to a health care facility in another state, a legal representative is available and willing to serve as the resident's surrogate decision maker in the other state; and

3.8.b.2.F.5. Specifying how the governing body or designee will ensure that residents are involved in the discharge planning process as required by subdivision 5.1.e. of this rule.

3.8.b.3. The governing body or designee, upon request, shall provide the state licensure and certification agency with any additional information related to the transfer plan as well as follow-up reports regarding specific placement action.

3.8.b.4. The licensee shall not admit new residents into the nursing home after the date of the written notice provided to the director as set forth in subdivision 3.8.a. of this rule.

### 3.9. Availability of Reports and Records.

3.9.a. The director shall make available for public inspection and, upon request, provide hard copies at a cost of twenty-five cents (\$0.25) per page or electronically at a nominal cost, of the following documents:

3.9.a.1. Applications and exhibits;

3.9.a.2. Inspection reports;

3.9.a.3. Reports of investigations conducted in response to complaints; and

3.9.a.4. Any other reports filed with or issued by the director pertaining to the compliance of a nursing home with applicable laws, and rules.

3.9.b. If the director determines it is in the best interest of the public, the director may provide copies of records and reports free of charge to nonprofit community organizations upon written request.

3.9.c. The director shall treat a report of inspection of a nursing home as public information from the time an acceptable plan of correction is approved.

3.9.d. If the governing body or designee does not submit an acceptable written plan of correction within the time specified by the director pursuant to subsection 21.4. of this rule, reports pertaining to the nursing home shall be made public at the expiration of the specified time.

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

3.9.f. 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 resident.

3.9.g. Before releasing a report or record considered to be public information, the director shall delete any confidential information regarding a resident that reasonably permits identification of the resident.

3.9.h. The director shall delete from complaints made available to the public under this section any information required to be held confidential under subdivision 4.5.a. of this rule.

### 3.10. Nursing Home Licensing Advisory Council.

3.10.a. The director shall establish a licensing advisory council composed of licensed nursing home administrators, representatives of appropriate government agencies and consumers.

3.10.b. The composition of the council shall be determined by the director and be comprised of no less than ten (10) members and no more than fifteen (15) members.

3.10.b.1. The nursing home licensing advisory council shall be composed of:

3.10.b.1.A. Not more than two (2) members who are currently employed as administrators of licensed nursing homes with sixty (60) or fewer beds;

3.10.b.1.B. Not more than two (2) members who are currently employed as administrators of licensed nursing homes with between sixty-one (61) and ninety (90) beds;

3.10.b.1.C. Not more than two (2) members who are currently employed as administrators of licensed nursing homes with greater than ninety (90) beds;

3.10.b.1.D. One (1) member who is currently employed as an administrator of a state-operated licensed nursing home;

3.10.b.1.E. One (1) member who represents the bureau of senior services;

3.10.b.1.F. One (1) member who represents the adult protective service unit of the office of social services;

3.10.b.1.G. One (1) member who represents the long-term care unit of the bureau for medical services;

3.10.b.1.H. One (1) member who represents the entity serving as the state's quality improvement organization;

3.10.b.1.I. One (1) member who represents the state long-term care ombudsman;  
and

3.10.b.1.J. Not more than three (3) consumers who personally have or have had a close family member as a resident in a nursing home in this state. Consumer members of the advisory council shall not profit in any way, either directly or indirectly, from nursing homes (or assisted living facilities operated in association with nursing homes) or be employed by any of the state agencies listed in subparagraphs 3.10.b.1.E., 3.10.a.1.F., 3.10.a.1.G., or 3.10.a.1.I of this rule.

3.10.c. The purpose of the council is to make recommendations to the director about regulatory issues and improvement of nursing home services.

3.10.d. The council shall hold a meeting not less than semiannually, at least one (1) of which shall be held in a public setting and receive input from the public.

3.10.e. The members of the nursing home advisory council shall be appointed by the director for four (4) year terms.

3.10.e.1. A member of the advisory council may request and receive approval, at the discretion of the director, to serve one (1) additional consecutive four (4) year term.

3.10.f. The appointments of individual members of the council shall be staggered such that the terms of approximately fifty percent (50%) of the council's membership shall expire every two (2) years.

### 3.11. Interpretive Guidelines.

3.11.a. The department may issue interpretive guidelines related to this rule and prior to the adoption and implementation of the guidelines, shall provide notice of a public comment period to all affected parties.

### §64-13-4. Residents' Rights.

4.1. Exercise of Rights. Each resident has the right to exercise his or her rights as a resident of the nursing home and as a citizen or resident of the United States. The resident has the right to

be free of interference, coercion, discrimination, and reprisal from the nursing home in exercising his or her rights.

#### 4.2. Nursing Home Policies and Procedures.

4.2.a. The resident care committee of a nursing home shall establish written policies and procedures regarding the rights and responsibilities of residents. The policies adopted shall be consistent with the provisions of this rule.

4.2.b. Through the administrator, the resident care committee is responsible for on-going development of and adherence to procedures implementing policies regarding the rights and responsibilities of residents.

4.2.c. The administrator or designee shall make the nursing home's policies and procedures available upon request to:

4.2.c.1. Residents or potential residents; and

4.2.c.2. Legal representatives.

#### 4.3. Duties of Staff.

4.3.a. All members of the nursing home staff shall ensure that every resident under their care is accorded all rights set forth in sections 4., 5., and 7. of this rule.

4.3.b. The administrator or designee shall ensure that all staff, upon hire and at least annually thereafter, receive training in the proper implementation of residents' rights policies as set forth in subdivision 20.4.d. of this rule.

4.3.c. When the nursing home staff limits or restricts the rights of a resident for medical reasons, the staff will document the specific reasons for the limitation or restriction in the resident's medical record and the specific period of time the limitation or restriction will be in place. The resident, or in the case of the resident's incapacity the resident's legal representative for health care decision making, shall authorize the limitation or restriction in writing.

#### 4.4. Rights of Legal Representatives.

4.4.a. The rights and obligations established under this rule devolve to a resident's legal representative if, in accordance with applicable state law, the resident lacks capacity to exercise his or her rights and obligations.

4.4.a.1. If a legal representative has been appointed for, or designated by, any resident as having the authority to exercise on behalf of the resident one or more of the resident's rights under this rule, the administrator shall afford the legal representative the full opportunity to exercise that authority within the limits of the legal representative's scope of authority as set by the appointing order and/or applicable state law.

4.4.a.1.A. The administrator or designee shall inform the resident's legal representative of the limits of the legal representative's decision-making scope of authority as set by the appointing order and/or applicable state law, to include the distinction between health care decisions, financial decisions, and daily decisions (including lifestyle choices) that constitute neither health care nor financial decisions and over which the legal representative may have no authority.

4.4.a.2. A legal representative shall exercise his or her authority in conformance with state and federal law.

4.4.a.3. Nothing in this rule shall in any way be construed to diminish or deprive any person of any rights other than specifically provided in this rule.

4.4.b. If a resident is adjudged incompetent by the court or determined to lack the capacity to make informed health care decisions in accordance with state law, the interdisciplinary care team shall notify the resident's legal representative for health care decision making to act on the resident's behalf;

4.4.c. The interdisciplinary care team shall make every reasonable effort to communicate the rights and obligations established under this rule directly to the resident.

4.4.d. If the rights of a resident have devolved to another person, the interdisciplinary care team shall maintain documentation of the determination of incapacity, or the adjudication of incompetence, in the resident's medical record.

4.4.e. The interdisciplinary care team shall maintain in the resident's medical record verification of the authority of the legal representative for health care decision making.

4.4.f. If the resident regains his or her capacity, the powers of the medical power of attorney representative or health care surrogate shall cease immediately.

#### 4.5. Confidentiality and Access to Records and Information.

4.5.a. Confidential Treatment. The administrator or designee shall assure confidential treatment of each resident's personal and medical records and may approve or refuse their release to any person outside the nursing home, except in the case of his or her transfer to another health care institution, as required by law, or for a third party payment contract.

4.5.b. Access to Records. Upon an oral or written request, the administrator or designee shall provide to each resident access to all of his or her records, including current clinical records, within twenty-four (24) hours of the request (excluding weekends and holidays).

4.5.c. A resident may purchase, at a cost not to exceed twenty-five cents (\$0.25) per page, photocopies of the records or any portions of them, upon oral or written request to the nursing home.

4.5.c.1. The administrator or designee will provide the photocopied materials to the resident within two (2) working days of the request (excluding weekends and holidays).

4.5.d. Access to Inspection and Inspection Reports. Any person shall have the right to review the most recent and past state and federal inspection and complaint reports with the nursing home's plan of correction.

4.5.d.1. The administrator or designee shall make the results of inspections and inspections, as well as plans of correction, available for examination in a place readily accessible to residents and shall post a notice of their availability.

4.5.d.2. The administrator or designee may charge an amount not to exceed twenty-five cents (\$0.25) per page for copies of reports requested by any person.

4.5.e. The resident care committee shall adopt policies and procedures that will protect the confidentiality of the resident as it relates to use of the resident's name and photographs.

4.6. Right for information. The administrator or designee shall:

4.6.a. Inform a resident of his or her rights and responsibilities under this rule and all rules governing resident conduct, prior to or at the time of admission and within thirty (30) days of any changes to the rules regarding residents' rights, and the resident shall acknowledge receipt of this information in writing.

4.6.a.1. The administrator or designee shall notify a resident, or the resident legal representative in the case of incapacity, in writing of any changes to the nursing home's policies governing resident conduct at least thirty (30) days in advance of the projected implementation date of the policy change, and the resident shall acknowledge receipt of this information in writing.

4.6.b. Prominently display a copy of the residents' rights and responsibilities, the names, addresses, and telephone numbers of all associated state agencies including licensing agencies, and state and local ombudsmen programs.

4.6.c. Reasonably accommodate residents with special communication needs such as hearing impairments and a primary language other than English to inform residents of their rights.

4.6.d. Inform a resident about:

4.6.d.1. The resident's medical condition; if a resident is determined to lack capacity to make informed health care decisions, the resident's legal representative for health care decision making shall be informed.

4.6.d.2. The resident's care and treatment; if a resident is determined to lack capacity to make informed health care decisions, the resident's legal representative for health care decision making shall also be informed.

4.6.e. Inform a resident of the right to voice all grievances and complaints without fear of discrimination or reprisal and of the right to be apprised of the nursing home's active efforts towards resolution of the resident's grievance and/or complaint.

4.5.f. Hospice palliative care required to be offered.

4.5.f.1. When the health status of a resident declines to the state of terminal illness or when the resident receives a physician's order for "comfort measures only", the interdisciplinary care team shall provide the resident with information about the option of receiving hospice palliative care. If a resident has been determined to lack the capacity to make informed health care decisions, the interdisciplinary care team shall also provide the resident's legal representative for health care decision making with information stating that the resident has the option of receiving hospice palliative care.

4.5.f.2. The interdisciplinary care team shall document that the resident and legal representative have received information about the option of hospice palliative care and shall maintain the documentation for inspection, so that the director may verify the nursing home's compliance with this requirement.

4.7. Refusal of Treatment and Experimental Research.

4.7.a. Refusal of Treatment. A resident has the right to refuse treatment and to refuse to participate in experimental research.

4.7.a.1. As provided under state law, a resident who has the capacity to make informed health care decisions, and who either withholds consent to treatment or makes an explicit refusal of treatment, either directly or through an advance directive, shall not be treated against his or her wishes.

4.7.a.1.A. If the resident is unable to make informed health care decisions, a decision by the resident's legal representative for health care decision making to forego treatment is, subject to state law, equally binding on the nursing home.

4.7.a.1.B. When a refusal of treatment occurs, the interdisciplinary care team shall:

4.7.a.1.B.1. Assess the reasons for the resident's refusal, to include making the determination whether the resident is refusing the treatment or merely refusing the conditions or circumstances under which the treatment is being offered or provided;

4.7.a.1.B.2 Inform the resident, and in the case of incapacity, the resident's legal representative for health care decision making, as to the consequences of the refusal;

4.7.a.1.B.3. Offer alternative treatments; and

4.7.a.1.B.4. Continue to provide all other services.

4.7.a.1.C. The interdisciplinary care team shall maintain documentation in the resident's medical record of the resident's refusal and the actions taken.

4.7.a.2. Refusal of Experimental Research. The resident shall have the right to refuse to participate in experimental research.

4.7.a.2.A. The interdisciplinary care team shall ensure that a resident, being considered for participation in experimental research, is informed of the nature of the experiment and of the possible consequences for participation.

4.7.b. The administrator shall not transfer or discharge a resident for refusing treatment unless criteria for transfer or discharge are met under subsection 5.1. of this rule.

4.8. Written Information. The administrator or designee shall provide to each resident a written description of the legal rights of the resident, which includes:

4.8.a. A description of the manner of protecting personal funds, under subdivision 4.15.g. of this rule;

4.8.b. A description of the resident's financial obligation as explained to the residents prior to or at the time of admission, including charges to the resident for services available, charges not covered under the state medicaid plan, or charges not included in the nursing home's basic rate;

4.8.c. A description of the requirements and procedures for medicaid eligibility, including information about the availability of asset assessments upon request at the county department office;

4.8.d. A list of names, addresses, and telephone numbers of the director, the medicaid fraud control unit, and all related state client advocacy groups such as the ombudsmen program and the protection and advocacy network; and

4.8.e. A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property in the nursing home, and non-compliance with the advance directives requirements.

4.9. Advance Directives.

4.9.a. The resident has the right to execute an advance directive, including a medical power of attorney, living will, combined medical power of attorney and/or living will.

4.9.b. The resident care committee shall develop and maintain written policies and procedures regarding advance directives including:

4.9.b.1. Provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, execute an advance directive; and

4.9.b.2. A written description of the nursing home's policies implementing advance directives.

4.9.c. The administrator shall only admit residents for which the nursing home has the capacity to administer care in accordance with the resident's advance directives, but the administrator cannot require a resident to execute an advance directive as a condition of admission.

4.9.c.1. In the event that a resident executes an advance directive after admission to the nursing home and the nursing home does not have the capacity to administer care in accordance with that advance directive, the administrator or designee shall:

4.9.c.1.A. Notify the resident orally and in writing of its inability to honor the resident's advance directive, and

4.9.c.1.B. Assist the resident in finding appropriate alternative placement, if the resident so desires.

#### 4.10. Right to Choose a Personal Physician.

4.10.a. The resident has the right to choose a personal physician, who has privileges at the nursing home, and to request and receive a second opinion from a physician of the resident's choice, where significant alternatives for care or treatment exist or when the resident requests information concerning care or treatment alternatives.

4.10.a.1. The resident shall receive the information from his or her doctor or the administrator or his or her designee, as appropriate.

4.10.b. Upon admission, the administrator or designee shall provide the resident with the names of all physicians who have attending privileges at the nursing home.

4.10.c. The administrator or designee shall provide written notice to the resident of the name, address, telephone number, and specialty of his or her attending physician at the time of admission and when any change in physician is made.

#### 4.11. Right to Choose a Pharmacy.

4.11.a. The resident has the right to obtain prescription medications from a source other than the nursing home's contract pharmacy, provided that the alternate source complies with the rules and regulations of the board of pharmacy, 15CSR1.

4.12. Privacy and Confidentiality. A resident has the right to personal privacy regarding accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the nursing home to provide a private room for each resident.

4.12.a. The resident has the right to associate and communicate privately with persons of his or her own choice.

4.13. Right to Effective Pain Control. The resident has the right to effective management of both acute and chronic pain.

4.13.a. The resident care committee shall develop and maintain written policies and procedures that facilitate the recognition, assessment, treatment, and monitoring of pain, to ensure that all residents are properly assessed for pain and that all residents who have pain receive effective treatment.

4.13.a.1. The written policies and procedures shall address the use of appropriate tools to assess for the presence of pain in all resident populations, including residents with cognitive impairments and/or communication deficits.

4.13.a.2. The director of nursing or designee shall train all nursing staff in the recognition and reporting of signs and symptoms of pain upon hire and at least annually thereafter, as set forth in subdivision 20.4.d. of this rule.

4.13.b. The director of nursing or designee shall assess each resident for pain:

4.13.b.1. On admission;

4.13.b.2. At each quarterly review, as set forth in subdivision 8.3.d. of this rule;

4.13.b.3. At any time that a change in the resident's condition prompts a comprehensive assessment, as set forth in paragraph 8.3.c.2. of this rule;

4.13.b.4. When a resident exhibits a change in behavior, including but not limited to resisting certain movements during care, combativeness, increasing or recurring restlessness, and/or increasing or recurring agitation;

4.13.b.5. At any time the resident is suspected of experiencing pain; and

4.13.b.6. At any time the resident has vital signs taken.

4.13.c. The interdisciplinary care team shall maintain documentation in the resident's medical record of:

4.13.c.1. Assessments for underlying cause(s) of pain and the impact of the pain on the resident's physical, mental, and psychosocial well-being;

4.13.c.2. Interdisciplinary care plan goals and approaches to pain management, including pharmacologic and non-pharmacologic interventions, to decrease the resident's pain and to improve the resident's quality of life;

4.13.c.3. Evidence of ongoing monitoring of the effectiveness of these interventions in controlling the resident's pain; and

4.13.c.4. Evidence of reassessment of and adjustments made to the resident's pain management plan at a frequency based on the resident's needs.

4.14. Grievance and Complaint Procedures.

4.14.a. The resident care committee shall develop and implement written policies and procedures for receiving, registering, thoroughly investigating, and responding to all grievances and complaints made by residents, their legal representatives and the public.

4.14.a.1. The resident care committee shall designate an employee to be responsible for receiving all grievances and complaints.

4.14.a.2. The resident care committee shall establish a process for thoroughly investigating and assessing the validity of all grievances and complaints.

4.14.a.3. The resident care committee shall provide a mechanism to record all grievances and complaints received, and any action(s) taken on them, and to communicate the findings or outcomes in writing to the individual(s) making the grievance and complaint.

4.14.a.4. The resident care committee shall establish a method to promptly inform the administrator in writing of all grievances and complaints received by the nursing home, and the administrator shall acknowledge having reviewed each grievance and complaint by signing and dating the grievance or complaint record.

4.14.b. The administrator shall assure that careful consideration is given to each and every grievance and complaint, even when it has been made by a person who often makes grievances and complaints having no valid basis.

4.14.c. The administrator or designee shall inform, both orally and in writing, all staff, volunteers, and persons used by the nursing home on a contractual basis of the nursing home's grievance and complaint policies and procedures during the individual's initial orientation to the nursing home and at least annually thereafter, as set forth in subsection 20.4. of this rule.

4.14.d. The administrator or designee shall inform, both orally and in writing, all residents and their legal representatives of the nursing home's grievance and complaint policies and procedures upon admission to the nursing home and at least annually thereafter.

4.14.e. Complaints Alleging Resident Mistreatment, Neglect, or Abuse or Misappropriation of Resident Property.

4.14.e.1. With respect to allegations of resident mistreatment, neglect, or abuse, and misappropriation of resident property, the written policies and procedures, in addition to complying with the requirements set forth in subdivisions 4.14.a. through 4.14.d. of this rule, shall specify the process by which the administrator or designee shall:

4.14.e.1.A. Ensure that all complaints alleging resident mistreatment, neglect, or abuse, and misappropriation of resident property, are reported immediately to the administrator of the nursing home and to other officials in accordance with state and federal laws, rules and regulations, (including the state licensure and certification agency);

4.14.e.1.A.1. "Immediately" is defined here as meaning within twenty-four (24) hours of a staff member of the nursing home receiving an allegation or otherwise becoming aware of an instance of resident mistreatment, neglect or abuse or misappropriation of resident property.

4.14.e.1.B. Thoroughly investigate all allegations of resident mistreatment, neglect, or abuse, and misappropriation of resident property;

4.14.e.1.C. Prevent further potential abuse while the investigation is in progress;

4.14.e.1.D. Report the results of all investigations, including any corrective actions taken, to the administrator and to other officials in accordance with state and federal laws, rules, and regulations (including the state inspection and certification agency) within five (5) working days of the incident.

4.15. Management of Residents' Personal Funds.

4.15.a. The resident has the right to manage his or her own financial affairs, and the nursing home shall not require residents to deposit their personal funds with the nursing home.

4.15.b. Upon written authorization of a resident or a determination that the resident's income and assets are within the limits set forth in W.V.C §44A-1-8(k) and there is no other person willing to serve, the administrator or designee shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the nursing home as specified in subdivisions 4.15.c. through 4.15.f. of this rule.

4.15.c. Deposit of funds.

4.15.c.1. Funds in excess of fifty dollars (\$50).

4.15.c.1.A. The administrator or designee shall deposit any resident's personal funds in excess of fifty dollars (\$50) in an interest-bearing account (or accounts) that is (are) separate from any of the nursing home's operating accounts and that credits all interest earned on a resident's funds to that account.

4.15.c.1.B. In pooled accounts, there shall be a separate accounting for each resident's share.

4.15.c.2. Funds less than fifty dollars (\$50).

4.15.c.2.A. The administrator or designee shall maintain a resident's personal funds that do not exceed fifty dollars (\$50) in a non-interest bearing account, interest-bearing account, or petty cash fund.

4.15.d. Accounting and records:

4.15.d.1. The administrator or designee shall establish and maintain a system that assures a complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home.

4.15.d.2. The system shall preclude any co-mingling of a resident's funds with the nursing home's funds or with the funds of any person other than another resident.

4.15.d.3. The administrator or designee shall provide a written accounting of each resident's funds through quarterly statements and upon request, to the resident and his or her legal financial representative.

4.15.d.3.A. For any transaction from a resident's account, the administrator or designee shall provide the resident, or the resident's financial legal representative, with a receipt and retain a copy of the receipt.

4.15.d.3.B. The administrator or designee shall administer the funds on behalf of the resident only as directed by the resident or the resident's legal financial representative.

4.15.d.3.C. When the interdisciplinary care team determines, on the basis of professional judgment, that a resident is unable to manage his or her financial affairs and does not have a legal financial representative, the administrator or designee shall notify the resident's next of kin to initiate conservatorship proceedings. If the resident has no next of kin, or if the next of kin, once notified, fails to act, the administrator or designee may initiate conservatorship proceedings.

4.15.e. Notice of certain balances.

4.15.e.1. The administrator or designee shall notify in writing each resident who receives medicaid benefits:

4.15.e.1.A. When the amount in the resident's account reaches two hundred dollars (\$200) less than the supplemental security income (SSI) resource limit for one (1) person; and

4.15.e.1.B. When the amount in the resident's account, in addition to the value of the resident's other non-exempt resources, reaches the SSI resource limit for one (1) person, the resident may lose eligibility for medicaid or SSI.

4.15.f. Conveyance upon death or discharge.

4.15.f.1. Upon the discharge of a resident with personal funds deposited with the nursing home, the administrator or designee shall convey the resident's funds and a final accounting of those funds to the discharged resident within thirty (30) days of discharge.

4.15.f.2. Upon the death of a resident with a will and with personal funds deposited with the nursing home, the administrator or designee shall convey the resident's funds and a final accounting of those funds to the clerk of the county court having jurisdiction to grant administration of the resident's will, within sixty (60) days of the resident's death.

4.15.f.3. Upon the death of a resident without a will and with personal funds deposited with the nursing home, the administrator or designee shall convey the resident's funds and a final accounting of those funds to the clerk of the county court which would have jurisdiction as to the probate of the resident's will, if there were one, within sixty (60) days of the resident's death.

4.15.g. Assurance of financial security.

4.15.g.1. The governing body shall be responsible for purchasing a bond or obtain and maintain commercial insurance with a company licensed in the state of West Virginia if the nursing home in any one month handles an amount greater than thirty-five dollars (\$35) per resident per month in the aggregate.

4.15.g.1.A. The sum of the bond or insurance shall be at least one and twenty-five one-hundredths (1.25) times the average amount of residents' funds deposited with the nursing home during the nursing home's previous fiscal year. Reference table 64-13B of this rule.

4.15.g.1.B. The insurance policy shall specifically designate the resident as the primary beneficiary or payee for reimbursement of lost funds.

4.15.g.1.C. The administrator or designee shall reimburse the resident, within thirty (30) days, for any losses and seek its reimbursement through the bond or insurance.

4.15.g.1.D. The administrator or designee is responsible for any insurance deductible.

4.15.g.1.E. The director may require the governing body of a nursing home to file an additional bond or purchase additional insurance in the following circumstances:

4.15.g.1.E.1. When the director determines that the amount of the bond or insurance is insufficient to protect the residents' money; or

4.15.g.1.E.2. When the amount of the bond or insurance is impaired by recovery against it.

4.15.g.1.F. When a nursing home ceases to handle personal funds of residents in amounts that require a bond or insurance, the director shall allow the release of the bond or insurance upon the administrator or designee providing an accounting to the residents.

4.15.g.1.G. An employee of a nursing home, or a person or his or her spouse having a financial interest in the nursing home, shall not serve as a resident's legal financial representative unless the employee or person is related to the resident within the degree of consanguinity of second cousin or unless the nursing home has been named temporary legal representative payee.

#### 4.16. Resident Work.

4.16.a. A resident has the right to refuse to perform services for the nursing home, and a resident has the right to perform services for the nursing home if he or she chooses when:

4.16.a.1. The interdisciplinary care team has documented the need or desire for work in the resident's care plan;

4.16.a.2. The resident's care plan specifies the nature of the services to be performed and whether the services are voluntary or paid;

4.16.a.3. Compensation for paid services is at or above prevailing rates for the services; and

4.16.a.4. The resident agrees to the work arrangement described in the resident's care plan.

4.17. Mail. The resident has the right to privacy in written communications, including the right to:

4.17.a. Send and receive his or her personal mail unopened, unless a request to the contrary has been made to the staff by the resident.

4.17.b. Have access to stationery, postage, and writing implements at the resident's own expense.

4.18. Access and Visitation Rights.

4.18.a. Access.

4.18.a.1. The resident has the right and the administrator or designee shall provide immediate access to any resident by the following:

4.18.a.1.A. A representative of a government agency with jurisdiction over some aspect of the nursing home;

4.18.a.1.B. The resident's individual physician;

4.18.a.1.C. The state long-term care ombudsman or designee;

4.18.a.1.D. The agency responsible for the protection and advocacy system for individuals with mental retardation / developmental disability;

4.18.a.1.E. The agency responsible for the protection and advocacy system for individuals with mental illness; and

4.18.a.1.F. Subject to the resident's right to deny or withdraw consent at any time, any other individual, whether the individual is a relative or a non-relative, of the resident's choosing;

4.18.a.2. The administrator or designee shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

4.18.a.3. The administrator or designee shall allow representatives of the state long term care ombudsman to examine a resident's clinical records with the permission of the resident or, in the case of incapacity the resident's legal representative for health care decision making, and consistent with state law.

4.18.a.4. A person entering a nursing home, other than a representative of the director, who has not been invited by a resident or a resident's legal representative shall:

4.18.a.4.A. Promptly advise the administrator or other available agent of the nursing home of his or her presence;

4.18.a.4.B. Not enter the living area of a resident without identifying him or herself to the resident and without receiving the resident's permission to enter;

4.18.a.4.C. Terminate a visit with a resident upon request of the resident;

4.18.a.4.D. Not disclose communications with a resident unless the resident authorizes disclosure;

4.18.a.4.E. Be permitted to visit all areas of the nursing home except:

4.18.a.4.E.1. Living areas of a resident who objects;

4.18.a.4.E.2. Business records of the nursing home unless the administrator consents;

4.18.a.4.E.3. Personal and medical records of the resident, unless the resident or, in case of incapacity, the resident's legal representative for health care decision making, consents in writing and/or in accordance with state law;

4.18.a.4.E.4. Food service areas requiring sanitary conditions;

4.18.a.4.E.5. A pharmaceutical or secure area; or

4.18.a.4.E.6. Any other areas where inspection might endanger any person or might invade the privacy of any employee or resident.

4.18.a.5. The administrator shall establish visiting hours consisting of at least eight (8) hours per day between 8:00 a.m. and 8:00 p.m., seven (7) days a week.

4.18.a.5.A. Visiting hours shall be posted conspicuously in a public place in the nursing home.

4.18.a.6. Relatives, non-relatives of the resident's choosing, and members of the clergy shall be permitted to visit a resident without restriction to the extent possible.

4.18.b. Resident's Refusal.

4.18.b.1. The resident has the right to refuse a visit and the visit shall be terminated upon the resident's request.

4.18.b.2. In the case of an incapacitated resident, the legal representative may refuse visitors, other than those enumerated in subparagraphs 4.18.a.1.A through 4.18.a.1.E., only if the legal representative demonstrates that such visits have a harmful effect on the resident. All relevant information shall be documented in the resident's medical record.

4.18.c. Administration's Exclusion.

4.18.c.1. The administrator or designee in charge of the nursing home may refuse a visitor access or require the visitor to leave only if:

4.18.c.1.A. In the judgment of the administrator, or his or her designee, the presence of the visitor is detrimental to the health, safety, or welfare of the resident or other residents or the visitor or the functioning of the nursing home;

4.18.c.1.B. Access is sought for financial solicitation or commercial purposes, or;

4.18.c.1.C. A resident does not wish the visitor to stay.

4.18.c.2. The restriction and the reasons for it shall be documented and kept on file.

4.19. Telephone. A resident shall be assured reasonable access to a telephone located in a quiet area where the resident can conduct a private conversation without being overheard or disturbed by others.

4.19.a. "Reasonable access to a telephone" includes placing telephones at a height accessible to residents who use wheelchairs and adapting telephones for use by residents with impaired hearing.

4.20. Personal Property. The resident shall have the exclusive right to use and enjoy his or her personal property, and the property shall not be used by other residents or staff without the express permission of the resident.

4.21. Married Couples. A married resident shall be assured privacy for visits by his or her spouse. A resident has the right to share a room with his or her spouse when married residents live in the same nursing home and both spouses consent to the arrangement.

4.22. Self-Administration of Drugs. A resident may self-administer drugs if the interdisciplinary care team determines that self administration is safe. The interdisciplinary care team shall review the resident's physical and cognitive ability to safely self-administer medications upon admission, at least quarterly and upon identification of a significant change in the resident's condition.

4.23. Refusal of Certain Transfers.

4.23.a. A resident has the right to refuse a transfer to another room within the nursing home, if the purpose of the transfer is to obtain medicare or medicaid eligibility by relocating:

4.23.a.1. A resident occupying a medicare-certified bed from the part of the nursing home that is medicare-certified to a part of the nursing home that is not medicare-certified; or

4.23.a.2. A resident occupying a medicaid-certified bed from the part of the nursing home that is medicaid-certified to a part of the nursing home that is medicare-certified.

§64-13-5. Admission, Transfer and Discharge.

5.1. Admission, Transfer and Discharge.

5.1.a. Transfer and discharge requirements. The administrator shall permit each resident to remain in the nursing home, unless:

5.1.a.1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;

5.1.a.2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home;

5.1.a.3. The health or safety of persons in the nursing home is endangered;

5.1.a.4. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the nursing home;

5.1.a.4.A. If the interdisciplinary care team determines, on the basis of professional judgment, that a resident is unable to manage his or her financial affairs and does not have a legal financial representative, prior to initiating an involuntary discharge based on non-payment, the administrator or designee shall notify the resident's next of kin to initiate conservatorship proceedings.

5.1.a.4.A.1. The administrator or designee shall initiate conservatorship proceedings on behalf of the resident if the resident has no next of kin or if the next of kin, once notified, fails to act.

5.1.a.4.B. If the interdisciplinary care team determines, on the basis of professional judgment, that a resident is unable to manage his or her financial affairs and his or her financial representative is not using the resident's funds to pay for the resident's stay, prior to initiating an involuntary discharge based on non-payment, the administrator or designee shall:

5.1.a.4.B.1. Notify the appropriate authorities, including but not limited to the adult protective services agency and the state medicaid fraud control unit, and

5.1.a.4.B.2. Initiate conservatorship proceedings on behalf of the resident.

5.1.a.5. Or, the nursing home ceases to operate.

5.1.b. Documentation.

5.1.b.1. When the administrator or designee transfers or discharges a resident, the interdisciplinary care team shall document in the resident's clinical record the reason for the transfer or discharge.

5.1.b.1.A. This requirement applies to transfers or discharges that are initiated by the administrator or designee, not by the resident. Whether or not a resident agrees to the transfer or discharge decision, these requirements apply whenever the administrator or designee initiates the transfer or discharge.

5.1.b.2. The documentation shall be made by the resident's physician when transfer or discharge is necessary under paragraphs 5.1.a.1. through 5.1.a.3. of this rule.

5.1.c. Notice before transfer or discharge. Before the administrator or designee transfers or discharges a resident, the administrator or designee shall:

5.1.c.1. Provide written notice to the resident, and/or his or her legal representative as appropriate, of the transfer or discharge. The notice shall be in a language the resident understands and shall include the following:

5.1.c.1.A. The reason for the proposed transfer or discharge;

5.1.c.1.B. The effective date of the proposed transfer or discharge;

5.1.c.1.C. The location or other nursing home to which the resident is being transferred or discharged;

5.1.c.1.D. A statement that the resident has the right to appeal the action to the state board of review, with the appropriate information regarding how to do so;

5.1.c.1.E. The name, address and telephone number of the state long-term care ombudsman;

5.1.c.1.F. For nursing home residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of persons with developmental disabilities; and

5.1.c.1.G. For nursing home residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of persons with mental illness.

5.1.d. Time of notice. The notice of transfer or discharge shall be made by the administrator or designee at least thirty (30) days before the resident is discharged or transferred, except the notice shall be made as soon as practicable before a transfer or discharge when:

5.1.d.1. The discharge is to a community setting or lower level of care in accordance with subdivision 5.1.g. of this rule;

5.1.d.2. The safety of persons in the nursing home would be endangered;

5.1.d.3. The health of persons in the nursing home would be endangered;

5.1.d.4. The resident's health improves sufficiently to allow a more immediate transfer or discharge;

5.1.d.5. An immediate transfer or discharge is required by the resident's urgent medical needs; or

5.1.d.6. A resident has not resided in the nursing home for thirty (30) days.

5.1.e. Orientation for Transfer or Discharge.

5.1.e.1. The interdisciplinary care team shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the nursing home.

5.1.e.2. Involuntary Transfer or Discharge. In the event of an involuntary transfer or discharge, the interdisciplinary care team shall assist the resident, the resident's legal representative or both, in finding a reasonably appropriate alternative placement prior to the proposed transfer or discharge and by developing a plan designed to minimize any transfer trauma to the resident.

5.1.e.2.A. The plan shall include providing information, both orally and in writing to the resident, or the resident's legal representative or both, regarding available community resources, offering assistance with arranging for support services based on the resident's known care needs, and taking steps under the interdisciplinary care team's control to assure safe relocation.

5.1.e.3. Regardless of whether a transfer or discharge is voluntary or involuntary, the interdisciplinary care team shall actively involve, to the greatest extent possible, the resident and the resident's legal representative in selecting the new residence and in the development of a post-discharge plan of care.

5.1.e.3.A. If the resident and/or the resident's legal representative is unable or unwilling to participate in the selection of the new residence and/or the development of the post-discharge plan of care, the interdisciplinary care team shall document the reason(s) for the lack of participation, if known, in the resident's medical record.

5.1.e.4. Discharge of Married Residents. If two (2) residents in a nursing home are married and the administrator or designee proposes to discharge one (1) spouse to another nursing home, the administrator or designee shall give the other spouse notice of his or her right to be discharged to the same nursing home.

5.1.f. Discharge Against Medical Advice.

5.1.f.1. In the event that the resident, or the resident's legal representative on behalf of the resident who lacks the capacity to make informed health care decisions, chooses to discharge from the nursing home to a residence that does not provide the level of care or services required to maintain the resident's health and/or safety, the interdisciplinary care team shall:

5.1.f.1.A. Inform the resident's attending physician immediately;

5.1.f.1.B. Inform the resident, or the resident's legal representative or both of the possible consequences for discharging to an inappropriate placement;

5.1.f.1.C. Provide information orally and in writing to the resident, or the resident's legal representative or both, regarding available community resources and offer to arrange for support services based on the resident's known care needs;

5.1.f.1.D. Make a referral, as appropriate, to the adult protective services agency to promote resident safety;

5.1.f.1.E. Document the resident's reason for discharging against medical advice, if known; and

5.1.f.1.F. Document all actions taken and the responses by the resident and/or legal representative in the resident's medical record.

5.1.g. Discharge to a Community Setting or a Lower Level of Care.

5.1.g.1. The administrator or designee shall not discharge a resident requiring the level of care and services provided by a nursing home to a community setting or a lower level of care against his or her will.

5.1.g.2. For a resident who wishes to voluntarily discharge to a community setting or lower level of care, the interdisciplinary care team shall inform the resident, or the resident's legal representative or both, of all available options for care and encourage the resident's participation in the development of his or her post-discharge plan of care.

5.2. Bed-hold Notice before Transfer.

5.2.a. Before the administrator or designee transfers a resident to the hospital or allows a resident to go on a therapeutic leave, the administrator or designee shall provide written information to the resident, the resident's legal representative or both, that specifies:

5.2.a.1. For a nursing home that participates in the state medicaid program, the duration of the bed-hold policy under the state medicaid plan, during which the resident is permitted to return and resume residence in the nursing home; and

5.2.b.2. The nursing home's policies regarding bed-hold periods, permitting a resident to return.

5.2.b. The nursing home's bed-hold policies apply to all residents. The administrator or designee may provide this notice of bed-hold policies well in advance of any transfer (e.g., upon admission). The administrator or designee shall reissue this notice to all residents if the bed-hold policy under the state medicaid plan or the nursing home's policy were to change.

5.3. **Bed-hold Notice upon Transfer.** At the time of transfer of a resident for hospitalization or therapeutic leave, the administrator or designee shall provide to the resident, the resident's legal representative or both, written notice which specifies the duration of the bed-hold policy described in subsection 5.2. of this rule.

5.3.a. "At the time of transfer" means that the resident, the resident's legal representative or both receive written notification within twenty-four (24) hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital.

5.4. **Permitting a Resident to Return.** For a nursing home that participates in the state medicaid program, the resident care committee shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state medicaid plan, is readmitted to the nursing home immediately upon the first availability of a bed in a semi-private room if the resident:

5.4.a. Requires the services provided by the nursing home; and

5.4.b. Is eligible for medicaid nursing facility services.

5.5. **Bed-Hold and Readmission Rights.**

5.5.a. Upon payment of the nursing home's bed-hold rate or, in the case of medicaid residents, in accordance with the policy and procedure currently prescribed by the state medicaid plan, a resident has the right to retain the same bed in which he or she is a resident. The administrator or designee shall notify a resident in writing, at the time of admission and hospitalization or leave of absence, of the nursing home's bed-hold policy.

5.5.b. After a hospitalization or a leave of absence for which there was no bed-hold, a former resident has the right to be re-admitted to the first available bed in a semi-private room in the nursing home from which he or she came, if the resident requires the services provided by the nursing home.

5.5.b.1. "Former resident" is defined here as meaning a resident who resided in the nursing home immediately prior to the resident's hospitalization or leave of absence for which there was no bed-hold.

5.5.b.2. If a former resident wishes to return to the nursing home and meets the requirements for coverage under the medicare program, the resident may be placed in a bed certified to participate in that program.

5.5.b.3. If the nursing home is not certified under the medicare program and the resident chooses placement in a nursing home providing medicare coverage, the administrator or designee shall place the resident on a waiting list for readmission to the nursing home after medicare coverage has ceased, if the nursing home can provide the necessary services to the former resident.

5.6. Equal Access to Quality Care.

5.6.a. Each resident or person requesting admission to a nursing home shall be free from discrimination during the application and admission process, unless the discrimination:

5.6.a.1. Is the result of the nursing home not being able to provide adequate and appropriate care, treatment and/or services to the resident or applicant due to the resident's or applicant's history of mental or physical disease or disability; and

5.6.a.2. Is not contrary to a federal or state law, regulation or rule that prohibits the discrimination or that requires the care to be provided if the nursing home participates in a financial program requiring the admittance or continued residence of the person.

5.6.b. The resident care committee shall establish and maintain identical policies and practices regarding admission, transfer, discharge and the provision of services for all persons regardless of source of payment.

5.6.b.1. "Identical policies and practices" concerning services means that the resident care committee shall not distinguish between residents based on their source of payment when providing services that are required to be provided under the law. All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities that are mandated by the law must be provided to residents according to residents' individual needs, as determined by assessments and care plan.

5.7. Civil Rights.

5.7.a. The administrator or designee shall not segregate a resident, give separate treatment, restrict the enjoyment of any advantage or privilege enjoyed by others in the nursing home, or provide any aid, care, services, or other benefits that are different from or are provided in a different manner from those provided to others in the nursing home on the grounds of race, color, religion or national origin, age, disability, sex or other protected status.

5.7.b. The administrator or designee shall not deny admission to a prospective resident on the grounds of race, religion or national origin, age, disability, sex or other protected status.

5.8. Admissions and Payment Policy.

5.8.a. The governing body of a nursing home shall not require:

5.8.a.1. Residents or potential residents to waive their rights to medicare or medicaid; and

5.8.a.2. Oral or written assurance that residents or potential residents are not eligible for, or will not apply for, medicare or medicaid benefits.

5.8.b. Third Party Guarantee. The governing body of a nursing home shall not require a third party guarantee of payment to the nursing home as a condition of admission or expedited admission, or continued stay in the nursing home.

5.8.b.1. The governing body of a nursing home may require, for admission or for continued stay of the resident, that a person, who has legal right and access to a resident's income or resources available to pay for the resident's care, sign a contract to provide payment from the resident's income or resources without incurring personal financial liability.

5.8.c. The administrator or designee shall fully inform each resident prior to or at the time of admission and during his or her stay, of services available in the nursing home and of related charges, including the existence of a contract with a hospice provider, and of any charge for services not covered under medicare or medicaid, or not covered by the nursing home's basic per diem rate, including the nursing home's policy on providing toiletries, adult briefs, wheelchairs, and all personal care and medical items.

5.8.d. The administrator or designee shall inform residents in writing about medicaid and medicare eligibility and what is covered under those programs including information on resource limits and allowable uses of the resident's income for items and services not covered by medicaid and medicare.

5.8.d.1. The administrator or designee shall inform medicaid residents and their legal representatives that, if they desire a private room, they may privately supplement the medicaid payment by directly paying the facility the difference between the nursing home's private-pay semi-private room rate and the nursing home's private-pay private room rate.

5.8.e. In the case of a person eligible for medicaid, the governing body of a medicaid / medicare-certified nursing home shall not charge, solicit or accept, or receive, in addition to any amount otherwise required to be paid under the state medicaid plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the nursing home.

5.8.e.1. The governing body of a nursing home may charge a resident who is eligible for medicaid for items and services the resident has requested and received, and that are not specified in the state medicaid plan as included in the term "nursing home services", if the administrator or designee gives proper notice of the availability and cost of these services to the resident and does not condition the resident's admission or continued stay on the request for or receipt of such additional services.

5.8.e.2. The governing body of a nursing home may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the nursing home for a medicaid eligible resident.

5.8.f. The administrator or designee shall give the resident a thirty (30) day notice when changes are made to items and services specified in subdivisions 5.8.c. and 5.8.d. of this rule.

§64-13-6. Resident Behavior and Facility Practice.

6.1. Restraints. Each resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

6.1.a. The following items shall not be considered as restraints whenever utilized for the purposes stated in this subdivision:

6.1.a.1. Devices that promote the improvement of an individual resident's functional status and that do not restrict the resident's freedom of movement and/or normal access to his or her body; and

6.1.a.2. Medications that are standard treatment, or a documented exception to standard treatment, for the resident's medical or psychiatric condition which assist an individual resident in attaining or maintaining his or her highest practicable physical, mental and psychosocial well-being.

6.1.a.3. Bed rails that are used solely to assist an individual resident in turning and/or to assist the resident in transferring out of bed.

6.1.b. The following items shall not be used under any circumstances: canvas jackets, canvas sheets, or canvas cuffs; leather belts, leather cuffs, or leather hand mitts; any device that requires the use of a lock and key; any device that cannot be quickly released.

6.1.c. Restraint Assessments. Restraints shall only be used in accordance with a comprehensive assessment and plan of care, which includes the development and implementation of a schedule or plan of rehabilitation training enabling the progressive removal or the progressive use of less restrictive restraints when appropriate; and as a last resort, after completing, implementing, and evaluating the resident's comprehensive assessment and plan of care, when the interdisciplinary care team has determined and thoroughly documented that less restrictive means have failed.

6.1.c.1. Except as provided in this paragraph, and in paragraph 6.1.h.1. of this rule for emergency situations, prior to authorizing the use of a physical restraint on any resident, the interdisciplinary care team shall ensure that:

6.1.c.1.A. The attending physician or authorized physician extender, as defined in subdivision 12.1.g. of this rule, makes a personal examination of the resident and documents an individualized determination of the need to use the restraint on that resident; and

6.1.c.1.B. The interdisciplinary care team, in conjunction with the resident, the resident's legal representative for health care decision making in the case of the resident's

incapacity, and the attending physician or authorized physician extender, conducts an individualized comprehensive assessment of the resident that shall:

6.1.c.1.B.1. Determine what specific medical symptom(s) and/or underlying cause(s) warrant the use of the restraint and how the use of a restraint would treat the medical symptom(s), protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being;

6.1.c.1.B.1.(a). In assessing for underlying causes, the interdisciplinary care team shall include a review of data collected during an assessment of the resident's customary routine, to determine whether the medical symptoms exhibited by the resident may be an expression of the resident's past routines, habits, and/or occupations.

6.1.c.1.B.2. Investigate and document what alternative interventions have been attempted and found to be unsuccessful;

6.1.c.1.B.3. Determine the least restrictive device that is most appropriate to meet the needs of the resident, taking into consideration any contraindications for its use;

6.1.c.1.C. If the comprehensive assessment indicates a need for a physical restraint, the interdisciplinary care team shall:

6.1.c.1.C.1. Fully inform the resident and, in the case of incapacity, the resident's legal representative for making health care decisions, of the reasons for using the restraint and the risks and benefits associated with the use of the restraint; and

6.1.c.1.C.2. Obtain written consent from the resident or, in the case of incapacity, the resident's legal representative for making health care decisions. Such consent shall be valid until the individual resident no longer needs the restraint or no longer than sixty (60) days, whichever is shorter.

6.1.d. Physician's order and care plan.

6.1.d.1. After a comprehensive restraint assessment indicates the need for a physical restraint, the resident's attending physician shall write an order specifying the precise type and size of physical restraint to be used, the specific circumstances under which the physical restraint is to be applied and/or removed (e.g., the restraint is removed during meal times and supervised activities), and the duration for which the restraint is to be applied.

6.1.d.1.A. The attending physician may order the use of the physical restraint for a period not to exceed sixty (60) days.

6.1.d.1.B. At the end of any sixty (60) day period of physical restraint use, the interdisciplinary care team shall:

6.1.d.1.B.1. Document in the resident's clinical record specifically how the use of the physical restraint improved the resident's functional abilities and/or enhanced the resident's quality of life;

6.1.d.1.B.2. Develop and implement a schedule or plan of rehabilitation training to enable the progressive removal or the progressive use of less restrictive restraints; and

6.1.d.1.B.3. Document the resident's response to efforts to progressively remove the physical restraint or progressively introduce less restrictive restraining devices.

6.1.d.1.C. If, after attempting to progressively remove or reduce a physical restraint to a less restrictive restraining device, the interdisciplinary care team determines that continued use of the physical restraint serves to maintain or improve the resident's functional abilities and/or enhance the resident's quality of life, the resident's attending physician or authorized physician extender may renew the order for the physical restraint for an additional period of time, not to exceed sixty (60) days, after complying with the requirements set forth in paragraph 6.1.c.1. of this rule.

6.1.d.1.D. No staff shall apply any restraint based on an "as needed" or PRN order.

6.1.d.2. The interdisciplinary care team shall develop a care plan for the resident, addressing at a minimum:

6.1.d.2.A. The type and size of restraint that is to be used;

6.1.d.2.B. When the restraint is to be used;

6.1.d.2.C. For physical restraints, a schedule of release time and what individualized activity is to be provided during that period of time; and

6.1.d.2.D. A systematic and gradual process to reduce the restraint or eliminate it, or both.

6.1.e. Application. Nursing home staff shall apply the physical restraints in accordance with the manufacturer's instructions and in a manner to allow for quick release.

6.1.e.1. Restraints shall be applied only by staff trained in their use.

6.1.f. Monitoring and release. Nursing home staff shall directly monitor a resident who has been restrained at least every half hour, and the resident shall be released from the restraint at least every two (2) hours, or more frequently based on the resident's needs, and provided exercise, toileting, and skin care.

6.1.g. Policies and procedures. The resident care committee shall establish and implement policies and procedures for restraint use.

6.1.h. Emergency.

6.1.h.1. In the case of an emergency, as when a resident exhibits behavior which becomes a threat to the health or safety of the resident or others, a registered professional nurse, who has been authorized in writing by the nursing home to do so, may order the use of a physical restraint for a specified and limited period of time not to exceed twenty-four (24) hours.

6.1.h.1.A. The resident care committee shall maintain a list of those registered professional nurses employed by the nursing home who have received written authorization to order the use of a physical restraint in the case of an emergency.

6.1.h.2. The director of nursing or designee shall immediately notify the resident's physician and legal representative or interested family member when a physical restraint has been applied as a temporary emergency measure.

6.1.h.3. Continued use of the physical restraint, beyond the limited period of time established in accordance with paragraph 6.1.h.1. of this rule, is subject to the requirements described in subdivisions 6.1.c. through 6.1.f. of this rule, including a personal examination of the resident by a the attending physician or authorized physician extender, in accordance with subparagraph 6.1.c.1.A. of this rule.

6.2. Involuntary Seclusion. Each resident has the right to be free from involuntary seclusion.

6.2.a. Placement of residents who are cognitively impaired in a specialized care unit that restricts their freedom of movement throughout the nursing home shall not be considered involuntary seclusion if:

6.2.a.1. The interdisciplinary care team has made the determination to place a resident in such a unit based on a comprehensive assessment of the resident;

6.2.a.2. The resident and the resident's legal representative for health care decision making participate in the placement decision and are involved in on-going care planning to assure that the resident's placement in the unit continues to meet the resident's needs and preferences.

6.2.a.3. Care and services are provided in accordance with each resident's needs and preferences, and the placement in such a unit is not for staff convenience;

6.2.a.4. The continuation of placement of a resident in the specialized care unit is reviewed during each periodic assessment required as set forth in subsection 8.3. of this rule.

6.2.b. The resident care committee shall ensure that a specialized care unit that is locked meets the requirements of all applicable state building and fire codes and that residents who are not cognitively impaired are able to enter and exit the unit without assistance.

6.2.c. No staff shall confine a resident to any room by locking or fastening the door from the outside.

6.3. Abuse.

6.3.a. A resident has the right to be free from verbal, sexual, physical, and mental abuse, financial exploitation, discrimination, denial of privileges, corporal punishment and involuntary seclusion.

6.3.b. Staff treatment of residents.

6.3.b.1. The resident care committee shall develop and implement written policies and procedures that prohibit neglect, abuse of residents, and misappropriation of resident property.

6.3.c. The administrator or designee shall not employ persons who have:

6.3.c.1. Been found guilty of abusing, neglecting, exploiting or mistreating residents, incapacitated adults or children by a court of law; or

6.3.c.2. Had a finding entered into the West Virginia nurse aide abuse registry or the West Virginia central abuse registry concerning abuse, neglect, exploitation or mistreatment of residents or misappropriation of their property.

6.3.d. The administrator or designee shall report any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a nurse aide or other nursing home staff to the West Virginia nurse aide abuse registry or the appropriate licensing authority and the director.

6.3.d.1. Actions by a court of law which indicate unfitness for service include a substantiated charge of abuse, neglect or exploitation against an employee, or conviction of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes related to public welfare, in any jurisdiction within or outside of the state of West Virginia.

6.3.e. Criminal Investigative Background Checks.

6.3.e.1. For all applicants who indicate current or past residence or employment in the state of West Virginia and who are being considered for employment, the administrator or designee shall obtain a statewide criminal investigative background check through the West Virginia state police.

6.3.e.2. For all applicants who indicate current or past residence or employment in any state other than West Virginia and who are being considered for employment, the administrator or designee shall obtain criminal investigative background checks as follows:

6.3.e.2.A. A statewide criminal investigative background check through the West Virginia state police, if the applicant has also indicated current or past residence or employment in the state of West Virginia, in addition to one (1) or more other states; and

6.3.e.2.B. A national criminal investigative background check through the national crime information center of the United States department of justice federal bureau of investigation.

6.3.e.3. After submitting the information required to initiate the criminal investigative background check(s), the administrator or designee may, in good faith, offer and begin employment of an applicant, pending the results of the criminal background check(s), provided:

6.3.e.3.A. The nursing home's policy permits starting a new employee pending the results of the criminal background check; and

6.3.e.3.B. The administrator or designee informs the applicant in advance that the applicant's continued employment is contingent upon receipt of satisfactory results of the criminal background check(s).

6.3.e.4. The administrator or designee shall not employ any applicant who has been convicted of a felony or misdemeanor involving abuse, neglect, or mistreatment of a minor child or incapacitated adult. Additionally, the administrator or designee shall ensure that:

6.3.e.4.A. Applicants having any other felony conviction in the preceding seven (7) years shall be disqualified for employment in a nursing home; and

6.3.e.4.B. Any applicant who is on the national sex offender public registry maintained by the United States department of justice shall be automatically disqualified for employment in a nursing home.

6.3.e.5. The administrator shall terminate the employment of any current employee found to be on the national sex offender public registry maintained by the United States department of justice, and shall notify the West Virginia nurse aide registry or the appropriate licensing board, if applicable.

6.3.f. The resident care committee shall develop and implement written policies and procedures that protect residents from mistreatment, abuse, neglect, and misappropriation of resident property. The policies and procedures shall address identifying, investigating, and reporting complaints alleging resident mistreatment, neglect, or abuse or misappropriation of resident property in accordance with subdivision 4.14.e. of this rule.

§64-13-7. Quality of Life.

7.1. The administrator or designee shall ensure that each resident receives care in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

7.2. Dignity.

7.2.a. Each resident shall be treated with consideration and respect and with full recognition of his or her dignity and individuality.

7.2.a.1. Nursing home staff shall interact with residents, when providing care and services, in such a manner as to maintain and enhance each resident's self-esteem and self-worth, to include but not limited to:

7.2.a.1.A. Grooming residents as they wish to be groomed;

7.2.a.1.B. Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences;

7.2.a.1.C. Assisting residents to attend activities of their own choosing, including but not limited to providing residents, as needed, verbal reminders of scheduled activities and assistance with transportation to and from the locations where the activities are being held;

7.2.a.1.D. Promoting independence and dignity in dining, including but not limited to avoidance of the routine use of disposable cutlery and/or dishware unless indicated to address an individual resident's assessed need, and ensuring that the atmosphere of each dining area is conducive to pleasant dining, with comfortable levels of lighting, temperature, and sound;

7.2.a.1.E. Respecting each resident's private space and property, including but not limited to knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting a resident's personal possessions without permission, and not changing a resident's television channel or radio station without the resident's permission;

7.2.a.1.F. Addressing each resident with a name of the resident's choice; and

7.2.a.1.G. Focusing on each resident as an individual when providing care and services, by talking and listening to the resident, not excluding the resident from conversations, and not discussing the resident in a public setting.

7.3. Self-Determination and Participation. The resident has the right to:

7.3.a. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

7.3.b. Interact with members of the community both inside and outside the nursing home; and

7.3.c. Make choices about aspects of his or her life in the nursing home that are significant to the resident.

7.3.d. Retain and use personal clothing and possessions and make his or her room as homelike as possible according to his or her individual tastes and desires, taking into consideration, space limitations, the rights of other residents, and safety and sanitation issues.

7.3.d.1. The resident shall have the exclusive right to use and enjoy his or her personal property, and the property shall not be used by other residents or staff without the express permission of the resident.

7.3.d.2. The governing body may specify in the admission contract the nursing home's liability for a resident's personal clothing and possessions;

7.3.e. Practice their religion and religious beliefs as they choose, as long as it does not impinge upon the rights of others; and

7.3.f. Participate in planning care and treatment.

7.4. Participation in Resident and Family Groups and Councils.

7.4.a. Residents have the right to organize, maintain, and participate in resident groups in the nursing home.

7.4.b. A resident's family has the right to meet in the nursing home with the families of other residents.

7.4.c. The administrator or designee shall provide a resident or family group, if one exists, with private space for meetings.

7.4.d. Staff or visitors may attend resident or family group meetings only at the group's invitation.

7.4.e. The administrator or designee shall provide assistance for resident or family group meetings, if requested, to include designating a staff person responsible for providing such assistance and for responding to written requests that result from group meetings.

7.4.f. The administrator or designee shall respond in writing to oral and written requests from resident and family council meetings. Resident councils and family councils shall be encouraged to make recommendations regarding nursing home policies.

7.4.g. When a resident or family group exists, the administrator or designee shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the nursing home.

7.4.g.1. "Act upon" means the administrator or designee shall seriously consider that group's recommendations and shall attempt to accommodate those recommendations, to the extent practicable, in developing and changing policies affecting resident care and life in the nursing home. "Act upon" does not mean that the administrator or designee must accede to all group recommendations.

7.5. Participation in Other Activities.

7.5.a. A resident has the right, at his or her discretion, to participate in social, religious, and community activities that do not interfere with the rights of other residents in the nursing home.

7.6. Accommodation of Needs.

7.6.a. A resident has the right to reside and receive services in the nursing home with reasonable accommodations of individual needs and preferences, except when the health or safety of the person or other residents would be endangered.

7.6.b. The governing body shall be responsible for providing sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by this rule and as identified in each resident's plan of care.

7.6.c. The governing body shall be responsible for providing each resident with: a separate bed of proper size and height for the convenience of the resident with a clean, comfortable mattress, and bedding appropriate to the weather and climate; functional furniture, including a chair, appropriate to the resident's needs; and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. Provided that, a resident may choose not to have any of these items in his/her room.

7.6.c.1. The governing body shall be responsible for permitting the use of at least a double size bed, upon the request of a married couple sharing a room, unless there is an overriding documented medical reason that puts one of the parties at risk for health and safety.

7.6.c.2. The governing body shall be responsible for allowing a resident to bring his or her own furnishings and other personal items into the resident's room to personalize his or her individual environment, provided the furnishings and items do not create a health or safety risk, are not medically inadvisable, and do not infringe upon the rights of any other resident who may share the same room.

7.6.c.2.A. Upon the request of the resident or, in the case of incapacity, the resident's legal representative, the governing body shall be responsible for permitting the resident to refuse the use of an individual bed and allowing the resident / legal representative to provide an alternative piece of furniture for sleeping in lieu of an individual bed (e.g., recliner or couch), provided:

7.6.c.2.A.1. The furniture is clean and free of pests,

7.6.c.2.A.2. The surface of the furniture is intact and can be readily cleaned and/or sanitized if it should become soiled, and

7.6.c.2.A.3. The size and/or placement of the furniture does not infringe upon the space of any other resident who may share the same room.

7.6.d. A resident has the right to receive notice before the resident's room or roommate in the nursing home is changed and to be informed of the reason for the change. The administrator or designee shall make efforts to assure that the changes are effected with the least disruption to the resident's life.

7.6.e. Intra-Facility Transfers.

7.6.e.1. A resident has the right to receive notice of an intended intra-facility transfer from one (1) room to another within the nursing home or a change in roommate, including a right to an informal hearing with the administrator prior to the transfer, as well as a written statement of the reason(s) for such transfer.

7.6.e.1.A. Neither the administrator nor a designee shall move a resident to a different bed or room in the facility if the relocation is arbitrary and capricious.

7.6.e.1.B. A transfer would not be considered arbitrary and capricious if a nursing home can document a clinical necessity for relocating the resident (e.g., a need for isolation or to address a behavior management concern) or if there is a hardship to an applicant for admission through a delay caused by inefficient distribution of beds by gender.

7.6.e.2. If an intra-facility transfer is required, the administrator or designee shall give notice to the resident at least two (2) days before relocation, except when:

7.6.e.2.A. The safety of persons in the nursing home would be endangered;

7.6.e.2.B. The health of persons in the nursing home would be endangered;

7.6.e.2.C. The resident's health improves sufficiently to allow a more immediate transfer; or

7.6.e.2.D. An immediate transfer is required by the resident's urgent medical needs.

7.6.e.3. The written notice of an intra-facility transfer shall include:

7.6.e.3.A. Reason(s) for transfer;

7.6.e.3.B. Effective date of transfer;

7.6.e.3.C. Location to which the resident will be transferred;

7.6.e.3.D. Name, address, and telephone number of the state and regional long-term care ombudsmen; and

7.6.e.3.E. For residents with mental retardation / developmental disabilities or mental illness, the mailing address and telephone number of the agency responsible for protection and advocacy of such persons.

7.6.e.4. The resident has the right to waive the two (2) day notice.

7.7. Animals. The resident care committee shall develop and implement policies and procedures that assure the general well-being of residents in a nursing home where animals visit or are boarded. The policies and procedures shall comply with local health ordinances.

7.8. Activities.

7.8.a. The administrator shall employ a full-time qualified professional to direct the activities program who:

7.8.a.1. Is certified by the national certification council for activity professionals (NCCAP), through any of the NCCAP's approved certification tracks, as an activity director certified (ADC); or

7.8.a.2. Has two (2) years of experience in a social or recreational program within the last five (5) years, one (1) of which was full-time in a resident activities program in a health care setting; or

7.8.a.3. Is an occupational therapist or occupational therapy assistant currently licensed to practice in the state of West Virginia; or

7.8.a.4. Has demonstrated the ability to provide for an ongoing program of activities designed to meet, in accordance with a comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident and has completed a NCCAP-approved 90-hour modular education program for activity professionals (MEPAP) (part I) and the 90-hour practicum (basic education course).

7.8.a.4.A. Commencing one hundred eighty (180) days from the effective date of this rule, any person employed as an activity director in a nursing home as of the effective date of this rule, and who is qualified for the position pursuant to paragraph 7.8.a.2. of this rule, shall be required to enroll in a NCCAP-approved 90-hour MEPAP (part I) and complete the coursework and the 90-hour practicum (basic education course) within twelve (12) months of enrollment.

7.8.a.4.B. No person having completed less than a NCCAP-approved 90-hour MEPAP (part I) and the 90-hour practicum (basic education course) shall be “grandfathered” to satisfy this requirement.

7.8.a.5. An activity director, who is qualified by virtue of having completed a NCCAP-approved training course and practicum as specified in paragraph 7.8.a.4. of this rule, shall be required to complete ten (10) hours of activity-related continuing education annually. Evidence of having completed the continuing education shall be maintained in the activity director’s personnel file.

7.8.b. If the intended activity director does not meet the requirements above, he or she shall be required to enroll in a NCCAP-approved 90-hour MEPAP (part I) and complete the coursework and the 90-hour practicum (basic education course) within twelve (12) months of enrollment.

7.8.b.1. Until the intended activity director has completed the required training, the nursing home shall arrange for the intended activity director to receive regularly scheduled consultation by a person who meets the qualifications described in paragraph 7.8.b.2. of this rule. The consultation by a qualified consultant may continue for such time as the candidate can meet the required qualifications, but not for more than a period of twelve (12) months from the date of hire.

7.8.b.2. A qualified activity consultant is a certified by the NCCAP, through any of the NCCAP’s approved certification tracks, as an activity consultant certified (ACC). This person shall:

7.8.b.2.A. Visit the nursing home as indicated by the needs of the nursing home and its residents, but not less than eight (8) hours quarterly; and

7.8.b.2.B. Provide a written, dated report, containing the time and duration of the visit and a summary of the findings with recommendations for improvements in the program to the administrator and the activity director, within ten (10) working days of the completion of the onsite visit.

7.8.c. The activity director shall provide for an ongoing program of activities designed to meet, in accordance with a comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The ongoing program of activities shall provide for evening and weekend activities.

7.8.d. The duties of the activity director shall include:

7.8.d.1. Developing the nursing home’s recreational and activities plan; organizing and directing the program, developing and implementing a written monthly activities calendar at least one (1) month in advance; completing an accurate resident assessment and care plan; and documenting participation or nonparticipation in activities and reasons for nonparticipation as it relates to the resident’s care plan; and

7.8.d.2. Designing an activities program to restore, maintain, and improve functioning and well-being in conjunction with the care plan for the individual resident.

7.9. Social Services.

7.9.a. The administrator of a nursing home with sixty (60) or more beds shall employ a qualified social worker on a full-time basis to perform social service functions, exclusive of non-social service duties such as sales and marketing activities.

7.9.b. The administrator of a nursing home with one hundred twenty (120) or more beds shall employ two (2) qualified social workers on a full-time basis to perform social service functions, exclusive of non-social service duties such as sales and marketing activities.

7.9.c. A qualified social worker is a person with:

7.9.c.1. A license to practice social work in the state of West Virginia, and

7.9.c.2. Who has a demonstrated ability to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

7.9.d. The social worker shall ensure that medically-related social services are provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

7.9.d.1. Medically-Related Social Services to be Provided. Medically-related social services shall include, but are not limited to, identifying and meeting, either directly or through contracted services, a resident's social, psychosocial, emotional and cultural needs related to:

7.9.d.1.A. Illness, treatment, and the resident's stay in the nursing home;

7.9.d.1.B. Stress;

7.9.d.1.C. Family and community relationships; and

7.9.d.1.D. Loss, bereavement, death and dying.

7.9.d.2. Community Resources. The social worker or designee shall maintain a current list of available social service agencies and community resources including, but not limited to, agencies that offer assistance in facilitating a resident's safe return to the community, if the resident expresses an interest in discharging to a community setting.

7.9.d.3. Sales and marketing activities do not constitute medically-related social services.

§64-13-8. Resident Assessment.

8.1. Admission Orders.

8.1.a. At the time each resident is admitted, and upon return from an inpatient hospital stay, the director of nursing or designee shall have physician orders for the resident's immediate care.

8.2. The interdisciplinary care team shall conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity.

8.3. Comprehensive Assessments.

8.3.a. The interdisciplinary care team shall make a comprehensive assessment of a resident's needs which:

8.3.a.1. Is based on a uniform data set and instrument specified by the director; and

8.3.a.2. Describes the resident's capability to perform daily life functions and any significant impairments in functional capacity.

8.3.b. A comprehensive assessment shall include the resident's:

8.3.b.1. Identification and demographic information;

8.3.b.2. Customary routine;

8.3.b.3. Cognitive patterns;

8.3.b.4. Communication;

8.3.b.5. Vision;

8.3.b.6. Mood and behavior patterns;

8.3.b.7. Psychosocial well-being;

8.3.b.8. Physical functioning and structural problems;

8.3.b.9. Continence;

8.3.b.10. Disease diagnosis and health conditions;

8.3.b.11. Dental and nutritional status;

8.3.b.12. Skin conditions;

8.3.b.13. Activity pursuit;

8.3.b.14. Medications;

8.3.b.15. Special treatments and procedures;

8.3.b.16. Discharge potential;

8.3.b.17. Documentation and summary information regarding the additional assessment performed through the resident assessment protocols.

8.3.b.18. Documentation of participation in assessment.

8.3.c. Frequency. Comprehensive assessments shall be conducted:

8.3.c.1. No later than fourteen (14) days after the date of admission;

8.3.c.2. Within fourteen (14) days after the facility determines, or should have determined that there has been a significant change in the resident's physical or mental condition; and

8.3.c.3. In no case less often than every three hundred sixty-six (366) days.

8.3.d. Review of Assessments. The interdisciplinary care team shall examine each resident no less than once every ninety-two (92) days, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

8.3.e. Use. The interdisciplinary care team shall use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care under subsection 8.5. of this rule.

8.3.f. Coordination. The interdisciplinary care team shall coordinate assessments with any state-required pre-admission screening program to the maximum extent practicable to avoid duplicative testing and effort.

8.4. Accuracy of Assessments.

8.4.a. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals.

8.4.b. Each assessment shall be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

8.4.c. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.

8.4.d. Civil money penalty for falsification.

8.4.d.1. A person who willfully and knowingly certifies (or causes another person to certify) a material and false statement in a resident assessment is subject to civil money penalties.

8.4.e. Use of independent assessors.

8.4.e.1. If the director determines, under an inspection or otherwise, that there has been a knowing and willful certification of false statements under subdivision 8.3.b. of this rule, the director may require (for a period specified by the director) that resident assessments under this section be conducted and certified by persons who are independent of the nursing home and who are approved by the director.

8.5. Comprehensive Care Plans.

8.5.a Development of the Care Plan. The interdisciplinary care team shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in a comprehensive assessment.

8.5.a.1. The resident has the right to participate planning care and treatment or changes to care or treatment, within the limits of his or her physical and/or cognitive abilities.

8.5.b. The comprehensive care plan shall describe the following:

8.5.b.1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under section 9. of this rule; and

8.5.b.2. Any services that would otherwise be required under sections 4. and 7. of this rule but are not provided, due to the resident's exercise of rights including the right to refuse treatment.

8.5.c. Timing of the Care Plan and Participation Requirements.

8.5.c.1. A comprehensive care plan shall be:

8.5.c.1.A. Developed within seven (7) days after the completion of a comprehensive assessment;

8.5.c.1.B. Prepared by the interdisciplinary care team, which includes the attending physician, a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident and the resident's family with the consent of the resident or the resident's legal representative; and

8.5.c.1.C. Periodically reviewed and revised by a team of appropriate persons after each assessment.

8.5.d. Services Provided Under a Care Plan.

8.5.d.1. The services provided or arranged by the nursing home shall:

8.5.d.1.A. Meet professional standards of quality; and

8.5.d.1.B. Be provided by qualified persons in accordance with each resident's written plan of care.

8.5.e. Care Plans and Medical Records.

8.5.e.1. Care Plans.

8.5.e.1.A. The interdisciplinary care team shall initiate a care plan for each resident upon admission, to be maintained by the nursing service in cooperation with all other disciplines.

8.5.e.1.B. The care plan shall provide a profile of the needs of the individual resident, identify the role of each service in meeting those needs, and the supportive measures each service will use to complement each other service in the accomplishment of the overall goal of care.

8.5.e.1.C. The interdisciplinary care team shall write a care plan that contains at least the following:

8.5.e.1.C.1. The goals to be accomplished;

8.5.e.1.C.2. Individually designed approaches or interventions that are designed to aid the resident in achieving the goals;

8.5.e.1.C.3. Therapies;

8.5.e.1.C.4. Treatments, including diet requirements; and

8.5.e.1.C.5. A statement of which discipline or professional service person is responsible for each element prescribed in the plan.

8.5.e.1.D. The resident care committee shall develop and maintain written policies and procedures to ensure that, through the interdisciplinary care team conferences or other means of coordination, the resident's care plan shall be reviewed and revised as needed, but at least quarterly. The review shall be noted in the medical record.

8.5.e.1.E. Policies and procedures shall delineate the roles and responsibilities of each service in relation to the resident care plan.

8.5.e.1.F. The resident's care plan shall be available for use by all personnel caring for the resident.

8.5.e.1.G. Relevant information from the resident's care plan shall be made available with other information that is conveyed when the resident is transferred to another nursing home, an acute care facility or referred for continuing care by other agencies upon discharge to the community.

8.5.e.2. Coordination of the Resident's Care with Hospice.

8.5.e.2.A. When a nursing home resident is also a patient of a hospice, the nursing home's interdisciplinary care team and the hospice must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual resident's needs and unique living situation in the nursing home. This coordinated plan of care must, at a minimum:

8.5.e.2.A.1. Reflect the participation of the hospice, the nursing home's interdisciplinary care team and the resident to the extent possible;

8.5.e.2.A.2. Include directives for managing pain and other uncomfortable symptoms;

8.5.e.2.A.3. Identify what services, supplies, and equipment are to be provided by nursing home staff to meet the day-to-day needs of the resident; and

8.5.e.2.A.4. Identify what services, supplies and equipment are to be provided by the hospice for the palliation and management of the resident's terminal illness and related conditions.

8.5.e.2.B. The nursing home's interdisciplinary care team and the hospice shall communicate with each other when any changes are indicated to the resident's plan of care.

8.5.e.2.C. The nursing home's interdisciplinary care team and the hospice shall be aware of the other's responsibilities in implementing the plan of care.

8.5.e.2.D. The nursing home's interdisciplinary care team shall allow the hospice to retain overall professional management responsibility for directing the implementation of the resident's plan of care related to the terminal illness

8.5.e.3. Coordination of the Resident's Care with Dialysis.

8.5.e.3.A. When a resident leaves the nursing home to obtain dialysis, the nursing home's interdisciplinary care team and the dialysis provider shall communicate and coordinate

services based on an assessment of the individual resident's needs, and the nursing home's interdisciplinary care team shall develop a care plan to ensure that nursing personnel assess and monitor all aspects of the resident's condition related to end stage renal disease. The care plan must address at least the following:

8.5.e.3.A.1. Routine assessment of the resident's vascular access for signs and symptoms of dysfunction and/or infection, and when and how to contact the dialysis center regarding abnormal findings;

8.5.e.3.A.2. Routine care of the resident's vascular access, including any cautions that should be communicated to direct care staff, such as not obtaining blood pressures from the arm in which a resident has an arteriovenous graft;

8.5.e.3.A.3. What times medications are to be administered, with respect to the resident's dialysis treatments, for maximum effect;

8.5.e.3.A.4. Any infection control issues unique to the resident;

8.5.e.3.A.5. What days and times the resident routinely receives dialysis treatments, what arrangements have been made to transport the resident to and from the dialysis center, and what arrangements have been made to provide meals to the resident before or during the dialysis treatments;

8.5.e.3.A.6. The nature and management of end-stage renal disease, including nutritional needs, psychosocial and emotional needs, and aspects to monitor; and

8.5.e.3.B. The nursing home's interdisciplinary care team and the dialysis provider shall communicate with each other regarding significant events that may indicate a change is needed in the resident's plan of care.

#### 8.5.f. Discharge Planning.

8.5.f.1. The nursing home's interdisciplinary care team shall assist each resident in the development of a discharge plan, based on the resident's wishes and a comprehensive assessment of the resident's needs. Discharge planning shall include at least the following:

8.5.f.1.A. Informing the resident, or the legal representative for health care decision making in the case of incapacity, of options available in the community that would facilitate the resident's ability to return home or to transfer to a lesser level of care, based on the resident's wishes and assessed needs. Summaries of discussions and assistance offered or provided to facilitate discharge planning shall be documented in the resident's medical record.

8.5.f.1.B. Assessing the resident's discharge potential, preferences, and goals, upon admission or within seven (7) days of admission and updated as needed upon completion of the initial comprehensive assessment.

8.5.f.1.C. Developing a written discharge plan which shall include information concerning such areas as nursing assessment, social history, rehabilitation potential, resident's needs at discharge, available community resources; the agreement or disagreement of the resident and/or legal representative for health care decision making; and

8.5.f.1.D. Periodically reviewing and revising the discharge plan on a monthly basis for the first three (3) months after admission and then at least quarterly thereafter, or more frequently upon request by the resident or legal representative.

8.5.g. Discharge.

8.5.g.1. General. When a resident is discharged to another nursing home or location or to his or her home, the nursing home's interdisciplinary care team shall prepare a discharge summary prior to the discharge. The summary shall be conveyed to the receiving nursing home or location at the time of discharge. The summary shall include:

8.5.g.1.A. The resident's name and identifying number;

8.5.g.1.B. The name of the attending physician;

8.5.g.1.C. The date of admission;

8.5.g.1.D. The date of discharge;

8.5.g.1.E. A provisional and final diagnosis;

8.5.g.1.F. The course of treatment and care in the nursing home;

8.5.g.1.G. Pertinent diagnostic findings;

8.5.g.1.H. Essential information regarding the resident's illness or problems;

8.5.g.1.I. Restorative procedures;

8.5.g.1.J. Medication instructions; and

8.5.g.1.K. The nursing home, agency or location to which the resident was discharged:

8.5.g.2. Anticipated Discharge. When a discharge is anticipated, the nursing home's interdisciplinary care team shall prepare for the resident a discharge summary that includes:

8.5.g.2.A. A recapitulation of the resident's stay;

8.5.g.2.B. A final summary of the resident's status to include items in subdivision 8.3.b. of this rule, prepared at the time of the discharge, that is available for release to authorized persons and agencies with the consent of the resident or legal representative;

8.5.g.2.C. Thirty (30) day notification of the discharge as appropriate and in compliance with other provisions of this rule; and

8.5.g.2.D. If the resident is discharged to his or her home, the resident shall be given appropriate information concerning his or her needs for care and medications including a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

8.5.g.3. The death of a resident shall be reported immediately to the attending physician and to the resident's legal representative and family as relevant.

8.5.g.3.A. The discharge summary shall include the requirements specified in this rule.

8.5.g.4. The administrator or designee shall immediately make a report to the county medical examiner or county coroner, or office of the chief medical examiner, of a resident's death, when that person's death:

8.5.g.4.A. Results either wholly, or in part, direct or indirectly, from accidental or other unnatural cause(s), or when suspected to be due to accidental or other unnatural cause(s), regardless of the interval between the underlying causative event and death;

8.5.g.4.B. Is suspected to constitute a public health hazard;

8.5.g.4.C. Occurs in association with a medical procedure, when death is not wholly explainable by pre-existing natural disease;

8.5.g.4.D. Occurs in association with suspected neglect or abuse.

8.5.g.4.E. All nursing home records pertaining to the decedent must be made available upon request to the medical examiner when investigating a death as required under W.V.C. §61-21-1 et seq.

8.5.g.5. The interdisciplinary care team shall complete medical records promptly within a time period specified in the nursing homes policies and procedures manual, not to exceed thirty (30) days after the resident is discharged.

8.5.g.5.A. The discharge summary shall contain a dated physician's signature.

§64-13-9. Quality of Care.

9.1. Each resident shall receive, and the interdisciplinary care team shall provide, the necessary care and services to attain or maintain the highest practicable physical, spiritual, mental, and psychosocial well-being of the resident, in accordance with the resident's comprehensive assessment and overall plan of care.

9.2. Activities of Daily Living. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

9.2.a. A resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. Activities of daily living include the resident's ability to:

9.2.a.1. Bathe, dress, and groom;

9.2.a.2. Transfer and ambulate;

9.2.a.3. Use the toilet;

9.2.a.4. Eat; and

9.2.a.5. Use speech, language, or other functional communication systems.

9.2.b. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in subdivision 9.2.a. of this rule.

9.2.b.1. Assistive devices and adaptive equipment. The interdisciplinary care team shall evaluate each resident to determine if he or she has the potential to benefit from the use of assistive devices and/or adaptive equipment.

9.2.b.1.A. The administrator or designee shall ensure that special eating equipment and utensils are provided for residents who need them.

9.2.b.1.B. The administrator or designee shall ensure that special communication devices are provided for residents who need them.

9.2.b.1.B.1. Such "special communication devices" may include hand-made picture cards or communication boards or portable dry erase boards. More sophisticated communication devices may be obtained upon a physician's order based on the recommendation of a speech-language pathologist licensed in the state of West Virginia.

9.2.b.1.C. For other types of assistive devices and/or adaptive equipment, the interdisciplinary care team shall assist the resident in obtaining alternate funding sources, including but not limited to obtaining resource adjustments and/or contacting community-based philanthropic organizations, in an effort to acquire the needed device / equipment.

9.2.c. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, in accordance with the individual resident's preferences and customary routine.

9.3. Vision and Hearing.

9.3.a. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the interdisciplinary care team shall, if necessary, assist the resident:

9.3.a.1. In making appointments;

9.3.a.2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices; and

9.3.a.3. In obtaining alternate funding sources, including but not limited to obtaining resource adjustments and/or contacting community-based philanthropic organizations, in an effort to acquire eye glasses and/or hearing aids.

9.3.a.4. The interdisciplinary care team shall offer to mark the eye glasses and/or hearing aids of each resident in such a manner as to readily identify the resident to whom they belong.

9.4. Pressure Sores. Based on a comprehensive assessment of a resident, the nursing home shall ensure that:

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

9.4.b. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

9.5. Urinary Incontinence. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

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

9.5.a.1. A resident who has an indwelling urinary catheter has a documented medical reason for the catheter.

9.5.b. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as

possible, unless the restoration of function is not possible due to the physical or cognitive condition of the resident.

9.6. Range of Motion. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

9.6.a. A resident who enters the nursing home without a limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

9.6.b. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in a range of motion.

9.7. Mental and Psychosocial Functioning. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

9.7.a. A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem; and

9.7.b. A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable.

9.8. Feeding Tubes. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

9.8.a. A resident who has been able to eat enough alone or with assistance is not fed by tube unless the resident's clinical condition demonstrates that use of a feeding tube is unavoidable; and

9.8.b. A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent secondary complications such as reflux, aspiration, aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities, and to restore, if possible, normal eating skills.

9.8.c. Tube feedings and parenteral nutrition shall be administered by the appropriate licensed health professionals in accordance with acceptable standards of practice.

9.8.d. Tube feedings and parenteral nutrition shall not be used for convenience of nursing home staff.

9.8.e. A resident who has a clinical condition that demonstrates the need for a feeding tube or parenteral nutrition will not have a feeding tube inserted or parenteral feeding administered if it contradicts his or her wishes expressed either directly or through advance

directives or by the resident's legal representative for health care decisions if this representative is empowered to do so.

9.9. Incidents and Accidents and Resident Safety.

9.9.a. The governing body and the administrator shall provide an environment that remains as free of accident hazards as possible; and

9.9.b. Where each resident receives adequate supervision and assistive devices to prevent accidents.

9.9.c. The administrator or designee shall complete a written report of any event – regardless of whether it is labeled an incident or an accident – in which a resident is involved, either inside or outside of the nursing home.

9.9.d. The event report shall include the:

9.9.d.1. Date of the occurrence;

9.9.d.2. Time of the occurrence;

9.9.d.3. Place of the occurrence;

9.9.d.4. Details of the occurrence;

9.9.d.5. A list of the names and contact information for all individuals, including residents, visitors, and staff, who were present or in the immediate vicinity when the event occurred;

9.9.d.5.A. The administrator or designee shall collect statements from each of the individuals identified in accordance with paragraph 9.9.d.5. of this rule, regarding their observations of the event; each statement will be dated and signed by the individual when the statement is collected.

9.9.d.6. Date and signature of the individual completing the event report; and

9.9.d.7. Date and signature of the reviewing physician.

9.9.e. The resident care committee shall establish and maintain a resident safety program designed to provide an environment that is safe and free from hazards over which the nursing home has control, to identify and analyze causal and/or contributing factors that place the residents at risk for harm, whether or not actual harm has yet occurred, and to implement preventative actions to reduce the likelihood of recurrence of an incident or accident involving the same or other residents.

9.9.e.1. Resident Safety Program. The resident care committee shall establish and implement a resident safety program under which it:

9.9.e.1.A. Reviews each individual event report generated pursuant to subdivisions 9.9.c. and 9.9.d. of this rule, regardless of whether the event resulted in actual harm to the resident, to identify and analyze factors that may have caused or contributed to the event;

9.9.e.1.B. Determines what corrective and/or preventative actions will be implemented to remove and/or mitigate those causal and/or contributing factors over which the nursing home has control, to prevent a recurrence of the event involving the same or other residents;

9.9.e.1.C. Maintains a record of events, investigations, and corrective actions taken; the records shall provide for analysis of causal factors and identification of preventative actions to be implemented; and

9.9.e.1.D. Ensures that, on at least a quarterly basis or more often as needed based on the numbers and types of events being reported, all event reports are reviewed in aggregate to identify and analyze for trends across units, shifts, and resident populations.

9.9.e.2. The effectiveness of the resident safety program shall be monitored quarterly or more frequently as determined by the nursing home's quality assessment and assurance committee.

9.10. Nutrition. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that a resident:

9.10.a. Maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible;

9.10.b. Receives a therapeutic diet when there is a nutritional problem; and

9.10.c. Who has an unplanned weight loss of ten percent (10%) or more in six (6) months, or a gradual progressive unexplained weight loss of ten percent (10%) or more below the person's admission body weight, shall have a thorough nutritional assessment, including appropriate laboratory studies.

9.11. Hydration. The interdisciplinary care team shall ensure each resident is provided sufficient fluids to maintain proper hydration and health.

9.11.a. Nursing home staff shall provide verbal cuing and/or physical assistance to residents requiring such assistance to promote fluid consumption.

9.11.b. A resident who has a clinical condition that demonstrates the need for intravenous fluids will not have intravenous fluids administered if it contradicts his or her wishes

expressed either directly or through advance directives or by the resident's legal representative for health care decisions if this representative is empowered to do so.

9.12. Special Needs. The interdisciplinary care team shall ensure that residents receive proper treatment and care for the following special needs:

- 9.12.a. Injections;
- 9.12.b. Parenteral and enteral fluids;
- 9.12.c. Colostomy, ureterostomy, or ileostomy care;
- 9.12.d. Tracheostomy care;
- 9.12.e. Tracheal suctioning;
- 9.12.f. Respiratory care;
- 9.12.g. Foot care;
- 9.12.h. Prostheses; and
- 9.12.i. Skin conditions.

9.13. Medications and Drugs.

9.13.a. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug used in any of the following circumstances or combinations of circumstances:

- 9.13.a.1. In excessive doses (including duplicate therapy);
- 9.13.a.2. For excessive duration;
- 9.13.a.3. Without adequate monitoring;
- 9.13.a.4. Without adequate indications for its use; or
- 9.13.a.5. In the presence of adverse consequences that indicate the dose should be reduced or discontinued.

9.13.b. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the interdisciplinary care team shall ensure that:

9.13.b.1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

9.13.b.2. Residents who use antipsychotic drugs receive gradual dose reductions and non-pharmacologic behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

9.13.c. Medication Errors. The director of nursing or designee shall ensure that:

9.13.c.1. The nursing home is free of medication error rates of five percent (5%) or greater; and

9.13.c.2. Residents are free of any significant medication errors.

9.13.d. Controlled Drugs Policy. The resident care committee shall establish and implement policies and procedures regarding the procurement, storage, dispensing, administration and disposition of controlled substances that conform to the Uniform Controlled Substances Act, W.V.C. §60A-1-1 et seq, federal regulations, and the rules of the West Virginia board of pharmacy.

9.14. Influenza and Pneumococcal Immunizations. The resident care committee shall establish and implement policies and procedures, consistent with current guidelines recommended by the U.S. department of health and human services centers for disease control and prevention (CDC), regarding the administration of influenza and pneumococcal immunizations to residents.

#### §64-13-10. Nursing Services.

10.1. The administrator and director of nursing shall ensure the nursing home has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Staffing shall not, other than during short unforeseeable emergencies, be less than an average of two and seventy-nine hundredths (2.79) hours of direct care nursing staff time per resident per day, of which not less than one and five-tenths (1.50) hours must be provided by nurse aides as described in subdivisions 10.2.b. and 10.2.c. of this rule.

10.1.a. Minimum hours of nursing staff to residents are outlined in table 64-13.A of this rule.

10.1.b. Facilities with fewer than fifty-one (51) beds are staffed at higher hours as outlined in table 64-13.A. of this rule.

10.1.c. The director may require staffing ratios above the specified minimum ratios if necessary to meet the assessed needs of the residents.

10.2. The administrator and director of nursing shall ensure the nursing home provides services by sufficient numbers of each of the following types of nursing staff on a twenty-four (24) hour basis to provide direct nursing care to all residents in accordance with each resident's care plan:

10.2.a. Licensed nurses who are directly responsible for resident care;

10.2.a.1. As used in this rule, "directly responsible for resident care" means that the licensed nurses are actually providing direct care to residents.

10.2.b. Nurse aides who are currently registered with the West Virginia nurse aide registry, after having successfully completed the required training and competency evaluation; and

10.2.c. Nurse aides who have completed the required training, are test-eligible, and who have not worked in a nursing home for more than four (4) months prior to successfully completing the competency evaluation.

10.2.d. Based on the assessed care needs of each resident and the nursing home services, the director of nursing or designee may determine the combination of licensed nurse time and nurse aide time if the total meets the minimum direct care nursing staffing requirements specified in subsection 10.1. of this rule.

10.2.e. The hours spent in an orientation or inservice training program shall not be counted in meeting the minimum nursing staffing requirements specified in subsection 10.1. of this rule.

10.2.f. At no time shall the combined ratio of nurse aides and licensed nurses on duty who are providing direct care to residents be less than one (1) nursing staff member to twenty (20) residents, providing the assessed care needs of the residents are met.

10.2.g. The director of nursing or designee shall establish a protocol for nursing staff coverage that includes coverage during vacations, long-term absences due to illness, emergency situations and other unexpected absences, and a contingency plan for back-up coverage.

10.3. Charge Nurse. The director of nursing or designee shall designate a licensed nurse to serve as a charge nurse on each shift;

10.4. Registered Professional Nurse. The administrator and director of nursing shall ensure the nursing home has a registered professional nurse on duty in the facility for at least eight (8) consecutive hours, seven (7) days a week.

10.4.a. In facilities with sixty (60) beds or fewer, the director of nursing may serve to meet this requirement.

10.4.b. When a registered professional nurse is on duty, nursing home staff shall immediately report any event (incident / accident) or change in a resident's condition to the registered professional nurse, who shall be responsible for assessing the resident and notifying the attending physician, the resident, and the resident's legal representative or interested family member, as relevant.

10.4.b.1. When there is not a registered professional nurse on duty, nursing home staff shall immediately report any event or change in a resident's condition to the registered professional nurse on call, as set forth in subsection 10.5. of this rule, who shall act on the information as appropriate which may include, as necessary, coming into the nursing home to personally assess the resident's condition.

10.5. Nurse on Call. If there is not a registered professional nurse on duty, the director of nursing or designee shall assign a registered professional nurse to be on call.

10.6. Director of Nursing. The administrator shall designate in writing a registered professional nurse to serve as the director of nursing services on a full-time basis, who shall be on duty at least five (5) days a week, eight (8) hours a day during the day shift.

10.6.a. The director of nursing shall be a registered professional nurse who has been graduated from an accredited school of nursing and who is currently licensed 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:

10.6.a.1. For a graduate of a two (2) year nursing program, three (3) years of nursing experience as a registered professional nurse, at least one (1) of which was in a supervisory capacity;

10.6.a.2. For a graduate of a three (3) year nursing program, two (2) years of nursing experience as a registered professional nurse, at least one (1) of which was in a supervisory capacity;

10.6.a.3. For a graduate of a four (4) year nursing program, at least one (1) year of nursing experience as a registered professional nurse, and at least one (1) year of experience in a supervisory capacity; or

10.6.a.4. For an individual with post-graduate education beyond a four (4) year nursing program, at least one (1) year of nursing experience as a registered professional nurse, and at least one (1) year of experience in a supervisory capacity.

10.6.b. The duties and responsibilities of the director of nursing shall include but are not limited to:

10.6.b.1. Developing and maintaining nursing service objectives, standards of practice, policy and procedure manuals, and job descriptions for each level of nursing personnel;

10.6.b.2. Recommending to the administrator the resources needed to carry out nursing services, including but not limited to equipment and supplies and the number and level of nursing personnel to be employed, based on the assessed needs of the resident population;

10.6.b.3. Ensuring that sufficient nursing personnel are scheduled and deployed across all units and shifts to meet the assessed needs of the current resident population.

10.6.b.4. Designating in writing:

10.6.b.4.A. A registered professional nurse on call when a registered professional nurse is not on duty in the nursing home;

10.6.b.4.B. A charge nurse on each shift, seven (7) days a week;

10.6.b.5. Participating in the employment of nursing personnel, including recruitment, selection, position assignment, orientation, inservice education, supervision, evaluation, and termination;

10.6.b.6. Participating, with the administrator and the medical director as the resident care committee, in the development and implementation of resident care policies and procedures;

10.6.b.7. Participating in the selection of prospective residents in terms of the nursing services they need and the nursing competencies available;

10.6.b.8. Assuring that each resident's comprehensive plan of care is maintained in conjunction with other disciplines;

10.6.b.9. Participating in the nursing home's quality assessment and assurance committee meetings, to identify issues and to develop and implement appropriate plans of action to correct identified problems;

10.6.b.10. Making daily rounds on resident floors, unless this duty has been delegated to another registered professional nurse; and

10.6.b.11. Recommending and coordinating the training needs of nursing staff with the individual responsible for staff development and inservice training.

10.6.c. In the event that the director of nursing is absent from the nursing home due to illness, vacation, training, or an emergency situation, the administrator shall designate another registered professional nurse in its employ to serve in the temporary absence of the director of nursing, so that there is the equivalent of a full-time director of nursing on duty for a minimum of seven (7) calendar days a week.

10.6.d. The administrator shall notify the director, in writing, within seven (7) calendar days of a vacancy in the director of nursing position. The written notice shall give the name and

West Virginia license number of the individual appointed to serve as the new director of nursing, and whether the appointment is permanent or temporary.

10.6.d.1. The director of nursing position shall not be held by a temporary designee for more than one hundred eighty (180) days, without prior approval by the director.

10.6.d.2. Written notification, giving the name and West Virginia license number of the individual, shall be sent to the director when a permanent appointment is made to the director of nursing position.

10.7. Posting of Nurse Staffing Information. The director of nursing or designee shall post the following information on a daily basis:

10.7.a. The name of the nursing home;

10.7.b. The current date;

10.7.c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

10.7.c.1. Registered nurses;

10.7.c.2. Licensed practical nurses;

10.7.c.3. Nurse aides; and

10.7.c.4. Current resident census.

10.7.d. Posting requirements. The director of nursing or designee shall post the nurse staffing data specified in subdivision 10.7.c. of this rule on a daily basis at the beginning of each shift.

10.7.e. The data shall be posted as follows:

10.7.e.1. In a clear and readable document; and

10.7.e.2. In a prominent place readily accessible to residents and visitors.

10.7.f. Public access to posted nurse staffing data. The director of nursing or designee shall make nursing staffing data available to the public for review. The director of nursing or designee shall, upon oral or written request, provide copies of nurse staffing data at a cost not to exceed twenty-five cents (\$0.25) per page.

10.7.g. Nursing home data retention requirements. The director of nursing or designee shall maintain the posted daily nurse staffing data for a minimum of eighteen (18) months.

§64-13-11. Dietary Services.

11.1. Dietary Staffing.

11.1.a. Dietitian. The administrator shall employ a qualified dietitian either full-time, part-time, or on a consultant basis.

11.1.a.1. A qualified dietitian is one who is registered by the commission on dietetic registration of the American dietetic association and licensed by the West Virginia board of licensed dietitians; or

11.1.a.2. Is qualified as defined by the West Virginia board of licensed dietitians, and is licensed by that board to provide professional nutritional services in West Virginia.

11.1.a.3. Consultation shall be based upon the residents' needs and shall occur at intervals of no less than every thirty (30) days and for no less than eight (8) hours.

11.1.a.3.A. A seven (7) day grace period may be permitted in order for the consultant dietitian's monthly visit to be considered timely. However, a consultant dietitian's monthly visit may not occur at an interval less than fourteen (14) days from the previous month's visit.

11.1.a.4. The dietitian's duties shall include the following:

11.1.a.4.A. Developing and/or approving all menus, including therapeutic diets prescribed by a resident's physician;

11.1.a.4.A.1. If the nursing home uses a menu developed by an outside resource, the administrator or designee is responsible for giving the dietitian any resident-suggested menu changes. The dietitian will then review and modify the menu plan as necessary to maintain nutritional adequacy based on resident preference.

11.1.a.4.A.2. Assisting in planning and conducting regularly scheduled inservice training that includes, but is not limited to:

11.1.a.4.A.2.(a). Therapeutic diets;

11.1.a.4.A.2.(b). Food preparation requirements; and

11.1.a.4.A.2.(c). Principles of sanitation.

11.1.a.4.A.3. And, visiting residents on a regular basis to discuss nutritional problems, depending upon their needs and level of care, and recommending appropriate interventions.

11.1.b. The administrator shall employ a full-time qualified dietary manager who shall be responsible for the management and supervision of the dietary service. The individual's authority and duties shall be defined in a written job description, and the dietary manager shall meet one of the following qualifications:

11.1.b.1. A dietitian who is registered by the commission on dietetic registration of the American dietetic association and is licensed by the West Virginia board of licensed dietitians or who is qualified as defined by the West Virginia board of licensed dietitians and is licensed by that board to provide professional nutritional services in West Virginia; or

11.1.b.2. A dietetic technician registered by the commission on dietetic registration of the American dietetic association; or

11.1.b.3. A certified dietary manager as certified by the certifying board of dietary managers of the dietary managers association; or

11.1.b.4. A graduate from an accredited college or university of an associate or baccalaureate degree program in foods and nutrition or food service management. The employee will be required, within fifteen (15) months from the date of employment in this position, to take and pass the certification exam to become a certified dietary manager; or

11.1.b.5. Have successfully completed a United States Armed Services course in food service supervision with an emphasis on nutrition and attained an E-5 grade. The employee will be required, within fifteen (15) months from the date of employment in this position, to take and pass the certification exam to become a certified dietary manager; or

11.1.b.6. Have documented evidence of at least one (1) year of satisfactory work experience in food service, and who is enrolled in an approved program within sixty (60) days of accepting responsibility for the position. This person shall successfully complete the program within eighteen (18) months of the date of enrollment and shall successfully pass the examination to become a certified dietary manager, as certified by the certifying board of dietary managers, within no more than nine (9) months following successful completion of the approved program.

11.1.b.6.A. The administrator shall ensure that the dietary manager candidate, who is enrolled in an approved program as specified in paragraph 11.1.b.6. of this rule, shall receive ongoing consultation, at least monthly and more often as needed, from a registered dietitian who meets the qualifications to provide guidance to the dietary manager on methods of maintaining the dietary service, planning of nutritionally balanced meals, and assessing the dietary needs of individual residents.

11.1.b.6.A.1. The dietitian serving as preceptor to the dietary manager candidate enrolled in the approved program shall monitor the candidate's progress toward completion of the program's requirements and shall report the candidate's progress on a monthly basis to the nursing home's administrator.

11.1.c. The dietary manager, in consultation with the dietitian, is responsible for the daily operation of the dietetic service;

11.2. Sufficient staff. The administrator shall ensure the dietary manager employs sufficient support personnel competent to carry out the functions of the dietary service.

11.3. Menus and Nutritional Adequacy.

11.3.a. The dietary manager, in consultation with the dietitian, shall meet the nutritional needs of residents in accordance with the recommended dietary allowances of the food and nutrition board of the national research council, national academy of sciences;

11.4. Food. The dietary manager, in consultation with the dietitian, shall provide each resident with:

11.4.a. Food prepared by methods that conserve nutritive value, flavor, and appearance.

11.4.a.1. Food items may be prepared a day in advance of the day of service.

11.4.a.2. Leftover food items may not be used as the basis for comprising an entire meal.

11.4.b. Food that is palatable, attractive, and at the proper temperature;

11.4.b.1. At the time of receipt by the resident, foods shall be at a temperature of no less than 120 degrees Fahrenheit for hot foods and at no more than 50 degrees Fahrenheit for cold foods;

11.4.c. Food prepared in a form designed to meet individual needs;

11.4.d. Food substitutes of similar nutritive value for food the resident refuses;

11.4.e. Food prepared with salt if called for in the food item's recipe, unless contraindicated by a physician's order; and

11.4.f. Iodized salt, if used.

11.5. Diets including regular diets. All residents shall have a physician's order for the specific type of diet he or she is to receive as set forth in the nursing home's diet manual.

11.5.a. Therapeutic and texture modified diets shall be served to residents in accordance with the physician's orders.

11.5.b. Nursing personnel shall advise food service in writing of each resident's diet order, and a copy of the order shall be kept on file for at least one (1) year.

11.5.c. Therapeutic Diets.

11.5.c.1. Therapeutic diets shall be prescribed by the attending physician. A current therapeutic diet manual that is not more than five (5) years old and is approved by the dietitian and the medical director and shall be maintained at each nursing station for ready access by nursing personnel and physicians.

11.5.d. Recognizing that the resident has the right to refuse medical treatment, all residents have the right to request substitute foods even when this violates the physician's orders.

11.5.d.1. The dietary manager, in consultation with the dietitian, shall provide education to the resident regarding the benefits of the prescribed diet and consequences of his or her refusal to eat the prescribed diet and shall otherwise comply with the requirements of subsection 4.7. of this rule.

11.5.d.2. The dietary manager or the dietitian shall document the informed decision in the resident's clinical record.

11.6. Frequency of meals.

11.6.a. The dietary manager, in consultation with the dietitian, shall provide at least three (3) meals daily at regular times, or in accordance with residents' preferences and customary routines.

11.6.a.1. Nothing in this rule shall prohibit or require the implementation of meal delivery systems such as home-style meals or buffet service.

11.6.b. No more than fourteen (14) hours shall elapse between a substantial evening meal and breakfast the following day.

11.6.b.1. Breakfast shall not be served before 7:00 a.m., unless by a resident's request.

11.6.c. The dietary manager, in consultation with the dietitian, shall offer to each resident a nourishing snack, as defined in section 2 of this rule, at bedtime daily, as determined by each resident's needs.

11.6.c.1. The nursing staff shall record the amount of the snack a resident consumes by percentage in the resident's medical record. If a resident refuses a snack, the nursing staff shall document the resident's refusal.

11.6.d. The nursing staff shall offer nutritional supplements to each resident in accordance with a physician's order.

11.6.d.1. Nursing staff shall record the amount of each supplement a resident consumes by percentage in the resident's medical record. If a resident refuses a supplement, the nursing staff shall document the resident's refusal.

11.7. Sanitary conditions. The dietary manager, in consultation with the dietitian, shall:

11.7.a. Procure food from sources approved or considered satisfactory by federal, state or local authorities;

11.7.b. Store, prepare, distribute, and serve food under sanitary conditions;

11.7.b.1. Hold hot foods above 140 degrees Fahrenheit and cold foods at or below 40 degrees Fahrenheit; and

11.7.c. Dispose of garbage and refuse properly.

11.8. The administrator shall maintain a dietetic service that is organized either directly by a nursing home or through a written agreement with a contractor who complies with the standards of this rule.

11.9. The dietetic service shall be in substantial compliance with the division of health rule, Food Establishments, 64CSR17.

11.10. Paid Feeding Assistants. Paid feeding assistants are authorized to feed residents who have no feeding complications, under the supervision of a registered professional nurse (RN) or a licensed practical nurse (LPN).

11.10.a. Paid feeding assistants may set up a resident's meal tray for dining, assist in feeding the resident, and record the resident's intake at the meal. Paid feeding assistants are to be used in accordance with the West Virginia department of health and human resources office of health facility licensure and certification guidelines for feeding assistants.

11.10.b. Paid feeding assistants are required to be at least sixteen (16) years of age.

11.10.c. Paid feeding assistants who are at least sixteen (16) years of age but less than eighteen (18) years of age must be directly supervised by a licensed nurse (RN or LPN) while feeding residents.

11.10.c.1. "Directly supervised by a licensed nurse" is defined here as the licensed nurse being physically present in the room where the feeding is being performed.

11.10.d. Paid feeding assistants are not considered nursing personnel and may not be used to satisfy the minimum nursing staffing requirements specified in subsection 10.1. of this rule.

11.10.e. **Volunteers Who Wish to Feed Residents.** The resident care committee may develop and implement policies and procedures to require volunteers who express a desire to feed residents to successfully complete the training course required of paid feeding assistants.

11.10.f. **Family Members Who Wish to Feed Residents.**

11.10.f.1. For residents who have been assessed as having no feeding complications, a nursing home shall not require the family member to complete a feeding assistant training course.

11.10.f.2. For residents who have been assessed as having feeding complications, the resident care committee may develop and implement policies and procedures to require the family member to complete a feeding assistant training course.

§64-13-12. **Physician Services.**

12.1. **Physician and Physician Extender Services.** A physician shall personally approve in writing a recommendation that a person be admitted to a nursing home. Each resident shall remain under the care of a physician.

12.1.a. **Physician supervision.** The resident care committee shall ensure that:

12.1.a.1. The medical care of each resident is supervised by a physician; and

12.1.a.2. Another physician supervises the medical care of residents when their attending physician is unavailable.

12.1.b. **Physician visits.** The physician shall:

12.1.a.1. Review the resident's total program of care, including medications and treatments, and examine the resident personally at each visit required by subdivision 12.1.c. of this rule;

12.1.a.2. Write, sign, and date progress notes at each visit; and

12.1.a.3. Sign and date all orders.

12.1.c. **Frequency of physician visits.** The resident shall be seen by a physician:

12.1.c.1. Within five (5) days prior to admission or within seventy-two (72) hours following admission, at which time the physician shall perform and document an admission history and physical examination, which shall include a current assessment of the resident's cognitive status, admitting diagnoses, an estimate of the resident's rehabilitation potential, and potential for discharge; and

12.1.c.2. At least every thirty (30) days for the first ninety (90) days after admission, and as the resident's condition warrants. The resident care committee shall assure that physician visits occur as clinically indicated for the resident.

12.1.c.3. After the ninety (90) day requirement has expired, the physician shall visit every sixty (60) days and as the resident's condition warrants.

12.1.d. Except as provided in subdivision 12.1.e. of this rule, all required physician visits shall be made by the physician personally.

12.1.e. Upon completing the visits in accordance with paragraph 12.1.c.2. of this rule, at the option of the physician, the required visit every sixty (60) days may be alternated between personal visits by the physician and visits by a physician's assistant, nurse practitioner or clinical nurse specialist in accordance with subdivision 12.1.g. of this rule.

12.1.f. Availability of physicians for emergency care. The resident care committee shall provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of an emergency.

12.1.g. Physician delegation of tasks to authorized physician extenders. Except as specified in paragraph 12.1.c.2. of this rule, a physician may delegate tasks to the following authorized physician extenders:

12.1.g.1. A physician assistant who is:

12.1.g.1.A. Licensed by the state;

12.1.g.1.B. Acting within the scope of practice as defined by W.V.C. §30-3-1 et seq.;

and

12.1.g.1.C. Under the supervision of the physician, or

12.1.g.2. A nurse practitioner or clinical nurse specialist who is:

12.1.g.2.A. Licensed by the state;

12.1.g.1.B. Acting within the scope of practice as defined by W.V.C. §30-7-1 et seq.;

and

12.1.g.1.C. Under the supervision of the physician.

12.1.h. If a resident is subject to an involuntary discharge due to the lack of an attending physician, and the resident appeals the discharge decision, the medical director shall supervise the medical care of the resident only for the duration of the appeal process.

12.2. Whenever a physician fails to comply with the requirements of paragraphs 12.1.c.2. and 12.1.c.3. and subdivision 12.1.e. of this rule regarding visits to residents, the resident care committee 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 arrangements or to make other arrangements for his or her resident within ten (10) calendar days, the resident care committee shall declare the resident to be abandoned and notify the director in writing of the abandonment. The director shall notify the West Virginia board of medicine or the West Virginia board of osteopathy, as appropriate. The resident care committee shall then seek other medical care for the resident.

§64-13-13. Rehabilitative Services.

13.1. Provision of Specialized Rehabilitative Services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and psychological or psychiatric rehabilitative services, are required in the resident's comprehensive plan of care, a nursing home shall:

13.1.a. Provide the required services; or

13.1.b. Obtain the required services from an outside resource, in accordance with subsection 20.3. of this rule, from a provider of specialized rehabilitative services.

13.2. Qualifications. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel as determined by licensing boards of those personnel.

§64-13-14. Dental Services.

14.1. The administrator shall ensure the nursing home provides or obtains from an outside resource in accordance with subsection 20.3. of this rule, the following dental services to meet the needs of each resident:

14.1.a. Routine dental services (to the extent the resident is covered under the state medicaid plan); and

14.1.b. Emergency dental services twenty-four (24) hours a day.

14.2. A nursing home shall assist a resident in need of dental services by:

14.2.a. Making dental appointments;

14.2.b. Arranging for transportation to and from the dentist's office; and

14.2.c. Referring residents with lost or damaged dentures to a dentist.

14.3. The interdisciplinary care team shall offer to mark the dentures of each resident in such a manner as to readily identify the resident to whom they belong.

§64-13-15. Pharmaceutical Services.

15.1. Provision of Pharmaceutical Services. The resident care committee shall develop and implement a system to accurately and safely provide or obtain (under an agreement described in subsection 20.3. of this rule) pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its residents.

15.1.a. The resident care committee shall assure that pharmaceutical services are provided in accordance with this rule and all other applicable federal, state and local laws and rules, and the rules of the West Virginia board of pharmacy.

15.2. Pharmaceutical Policies and Procedures. The resident care committee shall develop and implement written policies and procedures related to the provision of pharmaceutical services, including procedures that assure the accurate acquisition, receipt, dispensing, and administration of all medications and biologicals.

15.2.a. The administration of medications, biologicals and/or treatments to residents shall only be ordered by:

15.2.a.1. Physicians, dentists, and optometrists currently licensed to practice in the state of West Virginia;

15.2.a.2. Advanced nurse practitioners who are licensed and certified to practice in the state of West Virginia, within the limits of their prescriptive authority and in accordance with all applicable federal and state laws and the rules of the West Virginia board of examiners for registered professional nurses; and

15.2.a.3. Certified physician assistants who are licensed to practice in the state of West Virginia, within the limits of their prescriptive authority and in accordance with all applicable federal and state laws and the rules of the West Virginia board of medicine or the West Virginia board of osteopathy.

15.2.b. All orders for medications, biologicals and treatments for residents shall be issued in writing and signed and dated by the individual issuing the prescription. Provided that:

15.2.b.1. Written orders may be received by facsimile as permitted by applicable federal and state laws and rules.

15.2.b.2. All verbal or telephone orders shall be written immediately on the resident's order sheet, noted in the resident's permanent medical record, and signed by the accepting licensed nurse, pharmacist or certified physician assistant and shall be countersigned by the physician on his or her next visit to the resident or by mail if returned within ten (10) days.

15.2.b.2.A. Verbal or telephone orders for medications, biologicals and/or treatments shall be received only by a registered professional nurse, a licensed practical nurse, a pharmacist, a certified physician assistant, if identified as a responsibility in the physician assistant's job description and permitted by nursing home policy.

15.2.b.2.B. If permitted by nursing home policy, a health unit coordinator, as defined in section 2 of this rule, may be utilized to transcribe orders, after the orders have been reviewed and noted in accordance with subparagraph 15.2.b.2.A. of this rule.

15.2.c. The resident care committee shall develop and implement policies and procedures to:

15.2.c.1. Assure that, on a monthly basis, each resident's medication and treatment orders, including verbal and telephone orders, are reconciled to the resident's medication and treatment administration records and that all current orders are recapitulated, to reduce the potential for error;

15.2.c.1.A. The policy shall specify how and when the monthly reconciliation and recapitulation of orders shall occur and who may transcribe the orders and enter the orders onto the medication and treatment administration records.

15.2.c.2. Assure the timely acquisition of medications from the pharmacy, to include specifying when, how, and who may contact the pharmacy regarding acquisition of medications and the steps to follow for contacting the pharmacy for an original routine medication order, emergency medication order, and for refills;

15.2.c.3. Assure that the physician is contacted to verify or clarify an order or for direction when delivery of a medication will be delayed or the medication is not or will not be available, to include specifying when, how, and who may contact the physician;

15.2.c.4. Assure the administration of medications and biologicals, whether prescribed on a routine, emergency, or as needed (PRN) basis, to a resident in a timely manner in order to meet the needs of the resident;

15.2.c.5. Assure the availability of emergency medications, in accordance with the rules of the West Virginia board of pharmacy, to include specifying the types and categories of medications, amounts on hand, dosages to be provided, location of the supply, personnel authorized to access the supply, record keeping, monitoring for expiration dates, and the steps for replacing the supply when dosages are used;

15.2.c.6. Assure that emergency oxygen and tracheal suction devices are readily available and accessible.

15.2.c.7. Assure the coordination of pharmaceutical services, when a nursing home resident is also a patient of a hospice care program and the medications and/or biologicals

associated with treatment of the hospice patient's terminal condition are ordered and received from a source different from the nursing home's primary vendor pharmacy.

15.2.c.8. Assure that a resident's request for prescription medications from sources other than the contracted pharmacy is honored.

15.2.d. The resident care committee may choose to utilize a specialized dispensing system approved by the West Virginia board of pharmacy (e.g., unit dose, unit of use, punch card packaging, etc.), in lieu of the traditional bottle system for dispensing medications for oral administration. However, nothing in this rule shall prohibit the use of the traditional bottle system, if this is the only manner in which a pharmacy of the resident's choice, or a pharmacy of the hospice care program's choice, is able to dispense a resident's medications.

15.2.e. Medications, biologicals and treatments shall only be administered to a resident of a nursing home by:

15.2.e.1. Physicians, dentists, and optometrists who are currently licensed to practice in the state of West Virginia;

15.2.e.2. Registered professional nurses and licensed practical nurses who are currently licensed to practice in the state of West Virginia;

15.2.e.3. Student nurses of approved schools of nursing who are functioning under the direct supervision of a member of the school faculty who is physically present in the nursing home, in accordance the applicable rules of the West Virginia board of examiners for registered professional nurses and/or the West Virginia state board of examiners for licensed practical nurses;

15.2.e.4. Recent graduates of approved schools of nursing who possess valid temporary practice permits and who are functioning under the direct supervision of a registered professional nurse who is physically present in the nursing home, in accordance with the applicable rules of the West Virginia board of examiners for registered professional nurses and/or the West Virginia state board of examiners for licensed practical nurses; and

15.2.e.4.A. "Direct supervision" is defined here as the activity of a registered professional nurse with an unencumbered license in West Virginia being present at all times in the same assigned physical work area as the person being supervised.

15.2.e.5. Physician assistants who are currently licensed to practice in the state of West Virginia, if identified as a responsibility in the physician assistant's job description and permitted by nursing home policy.

15.2.e.6. Nurse aides are not authorized to administer any medications or perform any treatments or invasive procedures to a resident of a nursing home including, but not limited to, the administration of injections, enemas or suppositories and the insertion of indwelling urinary catheters.

15.2.e.6.A. Nurse aides, under the general supervision of a licensed nurse and as permitted by nursing home policy, may apply a nonprescription topical lotion, cream, or ointment to a resident's skin that is intact and free of rashes, excoriation, or other skin conditions requiring monitoring. The application of nonprescription topicals meeting these criteria shall not be considered an act of medication or treatment administration.

15.2.e.7. Residents who have been determined to have the ability to self-administer medications in accordance with subsection 4.22. of this rule.

15.2.e.8. Pharmacists administering immunizations to the extent authorized by W.V.C. §30-5-30.

15.2.f. Medications, biologicals and treatments shall be administered only to the individual resident for whom they are prescribed, shall be given in accordance with the directions of the prescription or the physician's orders, and the act of administration shall be recorded on the resident's medication and/or treatment administration record.

15.2.g. When a licensed nurse identifies a medication error and/or an adverse drug reaction, the licensed nurse shall immediately report the medication error and/or adverse drug reaction to the resident's physician verbally and document the occurrence in the resident's medical record.

15.2.g.1. The licensed nurse who identifies a medication error and/or an adverse drug reaction shall generate a written report of the occurrence and submit the report to the director of nursing, who shall be responsible for presenting all such reports to the quality assessment and assurance committee at its next scheduled meeting.

15.2.g.2. The quality assessment and assurance committee shall review in aggregate, on at least a quarterly basis, all reports of medication errors and adverse drug reactions received during that review period to:

15.2.g.2.A. Identify causal and/or contributing factors, and

15.2.g.2.B. Develop and implement measures to remove or mitigate those factors, in an effort to prevent or reduce future medication errors and/or adverse drug reactions.

15.2.h. The interdisciplinary care team shall ensure that an adverse drug reaction or allergy is documented in the resident's medical record and recorded inside the medical record in front of the contents (when paper-based medical records are in use).

15.2.i. The resident care committee shall ensure that an up-to-date medication information reference book, approved by the quality assessment and assurance committee, concerning prescription and nonprescription medications, their indications, actions, adverse reactions, interactions, contraindications, administration, precautions and dosages, is kept available at each nursing station.

15.2.j. The resident care committee shall ensure that medications not specifically limited as to time or number of doses when ordered by the physician are controlled by automatic stop orders in accordance with written policies and procedures established by the quality assessment and assurance committee.

15.2.k. Controlled Substances Policy. The resident care committee shall develop and implement policies and procedures regarding the procurement, storage, dispensing, administration and disposition of controlled substances that conform to the Uniform Controlled Substances Act, W.V.C. §60A-1-1 et seq, federal regulations and the rules of the West Virginia board of pharmacy.

15.3. Consultant Pharmacist.

15.3.a. The administrator shall employ or obtain the services of (under an agreement described in subsection 20.3. of this rule) a pharmacist who is licensed to practice in West Virginia and is currently registered as a consultant pharmacist with the West Virginia board of pharmacy.

15.3.a.1. Evidence of the pharmacist's current registration as a consultant pharmacist with the West Virginia board of pharmacy shall be maintained on the premises by the nursing home.

15.3.b. Responsibilities of the Consultant Pharmacist. A pharmacist providing pharmacy consulting services in a nursing home shall comply with all applicable federal, state and local laws and rules, and the rules of the West Virginia board of pharmacy, including the board of pharmacy's rules related to pharmacist consultants specified at 15CSR1-23.

15.3.b.1. The consultant pharmacist shall initiate and maintain, in the nursing home, appropriate records and procedures, as required by applicable federal, state and local laws, rules, and regulations, for the receipt, storage and disposition of all medications and biologicals.

15.3.b.2. The consultant pharmacist shall maintain a policy and procedure manual for pharmaceutical services in accordance with this rule and the rules of the West Virginia board of pharmacy. The manual shall be available to all nursing personnel for their guidance in drug handling and shall, at a minimum, contain policies and procedures to address all of the requirements specified by the rules of the West Virginia board of pharmacy at 15CSR1-23.4.3. et al, and:

15.3.b.2.A. The disposition, by the following means, of medications not totally consumed by the resident:

15.3.b.2.A.1. Return to the pharmacy for credit;

15.3.b.2.A.2. Destruction by the pharmacist in the presence of a registered professional nurse; and

15.3.b.2.A.3. Release, on written authorization of a physician, of medications to the resident upon a temporary leave, other than hospital leave, or upon discharge.

15.3.b.2.A.3.(a). Medications released to a resident shall be properly labeled and packaged by the pharmacist with directions for use in accordance with the rules of the West Virginia board of pharmacy.

15.3.b.2.A.3.(b). Documentation of medications released to a resident shall be entered in the resident's medical record.

15.3.b.3. The consultant pharmacist shall participate in the activities of the nursing home's quality assessment and assurance committee.

#### 15.4. Medication regimen review.

15.4.a. The consultant pharmacist shall review the medication regimen of each resident once a month or more frequently based on the resident's needs.

15.4.a.1. A seven (7) day grace period may be permitted in order for the medication regimen review to be considered timely. However, a monthly medication regimen review may not be completed at an interval less than fourteen (14) days from the date of the previous month's review.

15.4.b. The consultant pharmacist shall document the results of each resident's medication regimen review in the resident's medical record.

15.4.b.1. The consultant pharmacist shall document within the report either that no irregularity was identified or the nature of the irregularity(ies), if any were identified.

15.4.b.1.A. If no irregularities are identified during the review, the consultant pharmacist shall include a signed and dated statement to that effect.

15.4.b.1.B. The consultant pharmacist's report is considered part of each resident's individual clinical record; the results of each resident's medication regimen review shall be documented separately from that of another resident's review.

15.4.c. The medication regimen review shall include substances that are regarded as herbal products or dietary supplements.

15.4.d. The administrator or designee shall assure that the medication regimen review is conducted on the premises, except where complete electronic medical records are fully accessible to the pharmacist for review off-site.

15.4.e. The consultant pharmacist shall report any irregularities in the medication regimen review to the attending physician and the director of nursing, who shall act upon these reports.

15.4.e.1. The resident care committee shall develop and implement policies and procedures to address potential problem(s) requiring urgent attention by the physician, when identified by the consultant pharmacist through the medication regimen review, review of lab values and review of other reports, when the potential problem(s) may cause serious harm, injury or death if not addressed immediately.

15.5. Labeling of medications and biologicals.

15.5.a Medications and biologicals used in the nursing home shall be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, with the expiration date when applicable.

15.6. Storage of medications and biologicals.

15.6.a. In accordance with state and federal laws, the director of nursing or designee shall ensure that all medications and biologicals are stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

15.6.b. The director of nursing or designee shall provide separately locked, permanently affixed compartments for the storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, 42 U.S.C. §812, and other drugs subject to abuse, except when the nursing home uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

§64-13-16. Infection Control.

16.1. The resident care committee shall develop and implement an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

16.2. The resident care committee shall develop and implement policies and procedures consistent with current accepted standards of practice regarding the administration of pneumococcal vaccine, influenza vaccine, and screening for tuberculosis to meet the needs of each resident.

16.3. Infection control program.

16.3.a. The resident care committee shall develop and implement an infection control program under which it:

16.3.a.1. Develops prevention, surveillance, and control measures to protect residents, employees, and staff from facility-acquired infections;

16.3.a.2. Performs surveillance activities to monitor and investigate causes of infection and manner of spread in order to prevent infections in the nursing home;

16.3.a.3. Maintains a separate record of infection for each resident who has an infection;

16.3.a.4. Analyzes clusters of infections, changes in prevalent organisms, and any increase in the rate of infection in a timely manner;

16.3.a.5. Monitors community-acquired infections in residents newly admitted to the nursing home and develops control measures to protect other residents;

16.3.a.6. Develops procedures to be applied to certain individual residents, such as isolation;

16.3.a.7. Develops specific policies and procedures governing such activities as aseptic technique, outbreak investigation, wound care, catheter care, etc., based on the assessed needs of the residents;

16.3.a.8. Maintains records of incidents and corrective actions related to infection control; and

16.3.a.9. Reports and investigates diseases and outbreaks as required under 64CSR7, the reportable diseases, events and conditions rule.

16.3.b. The effectiveness of the infection control program shall be monitored quarterly or more frequently as determined by the nursing home's quality assessment and assurance committee.

16.3.c. The resident care committee shall designate an employee to serve as the infection control professional.

16.3.c.1. The infection control professional shall be a registered professional nurse, a licensed practical nurse under the direction of a registered professional nurse, or a licensed and certified clinical laboratory practitioner - medical technologist.

16.3.c.2. Within one hundred eighty (180) days of the effective date of this rule, the nursing home's infection control professional shall complete a basic infection control training program that is approved by the department's division of surveillance and disease control and the office of health facility licensure and certification.

16.3.c.2.A. Thereafter, an employee designated to serve as a nursing home's infection control professional shall complete the approved course within thirty (30) days of accepting the role of infection control professional.

16.3.c.3. The duties of the infection control professional shall include:

16.3.c.3.A. Performing surveillance to identify individual infections in residents, employees, and staff, and to identify clusters of infection;

16.3.c.3.B. Tracking trends in infections within the nursing home and reporting diseases, clusters and outbreaks as required under 64CSR7, the reportable diseases, events and conditions rule;

16.3.c.3.C. Identifying, documenting, investigating, and reporting infection control issues to the nursing home's quality assessment and assurance committee and making recommendations for corrective action;

16.3.c.3.D. Monitoring infection control practices and employee and staff compliance;

16.3.c.3.E. Developing and revising infection control policies and procedures and maintaining an infection control manual for all departments;

16.3.c.3.F. Conducting outbreak investigations and initiating control measures;

16.3.c.3.G. Providing orientation and continuing education related to infection control for all employees and staff;

16.3.c.3.H. Providing infection control consultation to all departments; and

16.3.c.3.I. Engaging in regular continuing education to upgrade knowledge and skills in infection control.

16.3.d. Isolation. When the interdisciplinary care team determines, in consultation with the infection control practitioner, that a resident needs isolation to prevent the spread of infection, the interdisciplinary care team shall isolate the resident or make arrangements to have the resident transferred to an appropriate health care facility which can better meet the needs of the resident, if the nursing home is unable to provide the required degree of isolation.

16.3.d.1. The interdisciplinary care team shall institute isolation procedures only to the degree required by the resident's condition and in accordance with current accepted standards of professional practice.

16.3.e. Staff restrictions. The administrator shall prohibit staff with a communicable disease or infected skin lesions from direct contact with other nursing home staff, residents or their food, if direct contact will transmit the disease.

16.3.f. Hand-washing. The administrator or designee shall require staff to wash their hands after each direct resident contact and after engaging in any activity for which hand washing is indicated by accepted standards of professional practice.

16.3.g. Linens. Staff shall handle, store, process and transport linens in order to prevent the spread of infection.

16.3.h. The infection control practitioner or designee shall ensure that environmental and terminal cleaning is completed in accordance with accepted standards of professional practice.

16.4. Prevention, Control and Surveillance of Mycobacterium Tuberculosis (TB).

16.4.a. The resident care committee shall develop and implement measures to reduce the risk for exposure to persons who might have TB disease, in accordance with current guidelines recommended by the U.S. department of health and human services centers for disease control and prevention (CDC).

16.4.b. TB Screening. The infection control practitioner or designee shall obtain a baseline TB status on all residents and staff, in accordance with current CDC guidelines.

16.4.c. The resident care committee shall review and revise these measures, in accordance with any changes in the CDC guidelines, not less than annually.

16.5. Occupational Health.

16.5.a. The resident care committee shall designate an employee to serve as the occupational health coordinator.

16.5.a.1. The occupational health coordinator shall be a registered professional nurse, a licensed practical nurse under the direction of a registered professional nurse, or a licensed and certified clinical laboratory practitioner - medical technologist.

16.5.a.2. Within one hundred eighty (180) days of the effective date of this rule, the nursing home's occupational health coordinator shall complete a basic infection control training program that is approved by the department's division of surveillance and disease control and the office of health facility licensure and certification.

16.5.a.2.A. Thereafter, an employee designated to serve as a nursing home's occupational health coordinator shall complete the approved course within thirty (30) days of accepting the role of occupational health coordinator.

16.5.b. The resident care committee shall develop and implement measures to promote occupational health, including a staff immunization program, in accordance with current CDC guidelines.

16.5.b.1. The resident care committee shall review and revise these measures, in accordance with any changes in the CDC guidelines, not less than annually.

16.5.c. The occupational health coordinator shall oversee:

16.5.c.1. Administration of post-employment physical examinations of newly hired staff within thirty (30) days of employment and annual physical examinations of staff in accordance with subdivision 20.5.d. of this rule.

16.5.c.2. Screening of all new staff for immunity to common childhood infections;

16.5.c.3. Management of the staff immunization program;

16.5.c.4. Management of the nursing home's exposure control plan for blood borne pathogens, in accordance with standards established by the United States department of labor occupational health and safety administration;

16.5.c.5. Management of staff health restrictions; and

16.5.c.6. Management of the tuberculin skin testing program for staff.

16.5.d. The occupational health coordinator shall screen new staff for immunity to common childhood infections such as mumps, rubella, measles, chicken pox (varicella), diphtheria, tetanus, and pertussis through the use of questionnaires, to be completed within thirty (30) days of beginning work at the nursing home.

16.5.d.1. If appropriate, the occupational health coordinator shall request new staff, whose immunity status is unknown, receive serologic testing for the presence of antibodies of these diseases, to prevent adult exposure of new employees to residents with communicable forms of such disease organisms.

16.5.d.2. The administrator or designee shall offer immunizations to staff in accordance with the current recommendations for immunization of health care workers, developed by the CDC's advisory committee on immunization practices (ACIP).

16.5.d.2.A. Staff may refuse to be immunized after being fully informed of the contraindications and precautions to vaccination and of the health risks of not being immunized.

16.5.d.2.B. If staff refuses to be immunized, the occupational health coordinator shall document the refusal.

16.5.e. The administrator or designee shall offer the Hepatitis B vaccine, free of charge, to previously unimmunized new staff who is at risk of exposure to blood borne pathogens, in accordance with current ACIP recommendations.

16.5.e.1. Staff may refuse to be immunized after being fully informed of the health risks of not being immunized.

16.5.e.2. If staff refuses to be immunized, the occupational health coordinator shall document the refusal.

16.5.f. The administrator or designee shall offer, free of charge, immunization for influenza to each staff on an annual basis.

16.5.f.1. Staff may refuse to be immunized after being fully informed of the contraindications and precautions to vaccination and of the health risks of not being immunized.

16.5.f.2. If staff refuses to be immunized, the occupational health coordinator shall document the refusal and shall conduct surveillance of non-immune staff during the recognized influenza season.

16.4.f. The occupational health coordinator shall make information available to all staff concerning other conditions in which pneumococcal vaccine may be of benefit for certain other underlying conditions.

§64-13-17. Physical Facilities.

17.1. Applicability; Construction, Additions; Renovations; Other Standards.

17.1.a. If the director determines that changes necessary for compliance with this section of this rule would create an undue hardship for a nursing home in existence at the time this rule becomes effective, the nursing home may be governed by rules which were in effect prior to the effective date of this rule.

17.1.b. The standard for new construction, renovations, and alterations are the relevant sections of the 2006 edition of the guidelines for design and construction of hospitals and health care facilities, as recognized by the American institute of architects, academy of architecture for health with assistance from the U. S. department of health and human services.

17.1.c. The governing body shall be responsible for ensuring the nursing home complies with the 2005 edition of the national fire protection association (NFPA) 99 standards for health care facilities.

17.1.d. The governing body shall be responsible for ensuring the nursing home complies with the West Virginia state building code, based on the international building code, 2003 edition.

17.1.e. The governing body shall be responsible for ensuring the nursing home complies with all applicable provisions of the Americans with Disabilities Act (ADA).

17.1.f. The governing body shall be responsible for submitting a complete set of architectural, structural, and mechanical drawings, drawn to scale not less than one-eighth (1/8) inch equals one (1) foot, and shall be approved by the director before construction begins.

17.1.f.1. This requirement applies to new construction, additions, renovations, or alterations to existing nursing homes.

17.1.g. The submitted drawings and specifications shall be prepared, signed and sealed by a person registered to practice architecture in the state of West Virginia.

17.1.g.1. The project shall be inspected during the construction phase by a registered professional architect or his or her representative.

17.1.h. The requirement for a registered architect may be waived by the director depending on the scope of the project.

17.1.i. The governing body shall be responsible for submitting complete architectural drawings and specifications for any alterations, renovations, and equipment modifications or additions which may necessitate changes to the nursing home floor plan, impact on safety, or require the services of a design professional, and shall be approved by the director prior to beginning any construction.

17.1.j. Minor renovations, which do not alter floor plans, impact on safety, or require the services of a design professional, may not require approval of the director.

17.1.k. A performance statement shall be obtained by the owner from the builder and design professional of a proposed nursing home stating that in constructing the nursing home the builder has followed the plans which are on file with and approved by the director.

17.1.l. All new facilities, additions, and alterations shall be inspected by the director and shall have the director's approval in writing prior to admitting residents.

17.1.l.1. The governing body shall be responsible for requesting in writing a pre-opening inspection no less than thirty (30) days prior to the proposed opening date.

17.1.m. All fees specified in the division of health rule, fees for services, 64CSR51, for site inspections of new construction or major renovations, architectural review of drawings and specifications, and inspections of new projects prior to opening are the responsibility of the nursing home or design professional.

17.1.n. Unless substantial construction is started within one (1) year of the date of approval of final drawings, the owner or architect shall secure written notification from the director that the plan approval for construction is still valid and in compliance with this rule.

## 17.2. Site Characteristics and Accessibility.

17.2.a. Sites for all new nursing homes and sites for additions to existing nursing homes shall be inspected by the director prior to site development and the completion of final drawings and specifications.

17.2.b. The site shall be located in an environment that is free from excessive noise sources, such as railroads, freight yards, traffic arteries and airports, and in an area designated by the United States army corps of engineers as being outside of a 100-year flood plain.

17.2.b.1. The site shall not be exposed to excessive smoke, foul odors or dust.

17.2.c. The site shall have good drainage, approved sewage disposal, an approved potable water supply, electricity, telephone and other necessary utilities available on or near the site.

17.2.d. The site shall be accessible to physicians, emergency services and other necessary services.

17.2.e. Accessibility and transportation to the site and the nursing home shall be facilitated by paved, hard surfaced, all weather roads which are kept passable at all times.

17.2.e.1. The road shall connect directly to a paved hard surface highway.

17.2.e.2. Grades to all sites shall permit access for emergency vehicles and fire fighting equipment in all weather conditions.

17.2.f. Parking areas shall be sufficient according to the guidelines set by the American institute of architects.

17.2.g. Hard surface walks, a minimum of forty-eight (48) inches wide with a slip resistant surface, shall be provided at all entries and exits and connect into the main walk or parking area.

17.2.h. Soil conditions shall be reviewed by a qualified soils engineer and if conditions require, earth core boring shall be conducted.

17.2.h.1. The design professional shall supply the director with copies of soil test reports if engineered fill is installed or if other soil tests are conducted.

17.2.i. Local building codes and zoning restrictions shall be followed.

17.2.i.1. The owner, or his or her designee, shall maintain documentation certifying compliance signed by local fire, building and zoning officials, and this documentation shall be available for review.

### 17.3. Increase in Bed Capacity.

17.3.a. Bed capacity may be increased after the director has determined that the nursing home physical facilities will support the increase and there is compliance with other requirements including certificate of need requirements.

17.4. Equipment and Furnishings in Resident Rooms.

17.4.a. Each resident shall have individual towel bars or an equivalent. In semi-private rooms, towel bars shall be located to encourage individual use.

17.4.b. The administrator or designee shall provide cubicle curtains that assure visual privacy for each resident.

17.4.c. The administrator or designee shall provide window treatments that are homelike, afford for privacy, and are maintained in good condition.

17.4.d. The administrator or designee shall provide each resident with furniture as specified in subdivision 7.6.c. of this rule.

17.5. Laundry and Linens.

17.5.a. The resident care committee shall develop and implement written procedures for handling, storing, processing, and transporting linens and other laundered goods in a manner to prevent the spread of infection.

17.5.b. Sufficient supplies of linens shall be available to nursing personnel to assure the cleanliness and comfort of each resident.

17.5.c. The administrator or designee shall provide each resident with individual towels, wash cloths, pillows, and blankets.

17.5.d. When electric blankets are used, they shall be UL approved and checked periodically by the nursing home's staff for safety.

17.6. Nursing Equipment and Sterile Supplies.

17.6.a. The administrator or designee shall provide, in sufficient quantity and type, nursing equipment to meet the individual care needs for each resident.

17.6.b. All electrical resident care equipment shall be maintained, inspected and tested in accordance with the manufacturer's recommendations, and the applicable sections of the NFPA 99 standard for health care facilities.

17.6.c. All non-electrical equipment used for inhalation therapy (oxygen) shall be stored and maintained in accordance with the applicable sections of the NFPA 99 standard for health care facilities.

17.6.d. If a nursing home provides electrical life support services, all electrical equipment used to sustain life shall be connected to an emergency generator, through a critical branch electrical system.

17.6.d.1. The generator and all critical branch electrical circuits shall comply with the standards as identified in the NFPA 99 standard for health care facilities.

17.6.e. Clean nursing equipment and sterile supplies shall be stored in a clean work room or store room that does not permit resident contact.

17.6.f. Sterile supplies shall not be stored under sink drains, in soiled utility rooms or in areas where contamination may occur.

17.6.g. Sterile supplies shall not be stored nor used beyond their dated shelf life.

17.6.h. Damaged supplies and utensils shall not be used.

17.7. General Maintenance and Housekeeping.

17.7.a. The governing body shall be responsible for ensuring the nursing home is constructed, maintained and equipped to protect the health and safety of residents, personnel, and the public.

17.7.b. The governing bodies of all new nursing homes shall establish and maintain the nursing home and equipment in accordance with the guidelines in the 2006 edition of the guidelines for design and construction of hospitals and health care facilities as recognized by the American institute of architects for health.

17.7.c. The governing bodies of all existing nursing homes shall establish and maintain the nursing home and equipment in accordance with the guidelines referenced in the minimum requirements of construction and equipment for hospitals and medical facilities - U.S. department of health, education and welfare [DHEW NO. (HRA) 81-14500].

17.7.d. The administrator or designee shall establish and implement a maintenance program that assures that:

17.7.d.1. All equipment is operable;

17.7.d.2. The interior and exterior of the building is safe; and

17.7.d.3. The grounds are maintained in a presentable condition free from rubbish and other health hazards of a similar nature.

17.7.e. The administrator or designee shall establish and implement a housekeeping program and services that assures a clean, sanitary environment.

17.7.f. The administrator or designee shall provide a comfortable, home-like environment for residents.

17.7.g. The administrator or designee shall ensure the nursing home is kept free of insects, rodents and vermin by an effective pest control program. Insecticidal strips are prohibited.

17.7.h. Pesticides shall be applied only by an applicator certified by the West Virginia department of agriculture.

17.7.i. The administrator or designee shall ensure the nursing home has sufficient supplies for housekeeping and maintenance properly stored and conveniently located to permit frequent cleaning of floors, walls, woodwork, windows, and screens, and to facilitate building and grounds maintenance.

17.8. Solid Waste and Bio-Hazard Waste Disposal.

17.8.a. The administrator or designee shall have procedures and contracts for disposing of bio-hazardous waste.

17.8.a.1. Chain of custody receipts and forms shall be maintained by the nursing home for one (1) year.

17.8.b. The resident care committee shall develop and implement policies and procedures for disposing of non-hazardous medical waste and similar waste that is not considered hazardous in a safe sanitary manner.

17.8.c. Solid waste, including garbage and refuse, shall be removed from the building daily or more often as necessary.

17.8.d. All garbage and refuse shall be stored in durable, covered, leak-proof and vermin-proof containers or dumpsters.

17.8.d.1. The containers and dumpsters shall be kept clean of all residue accumulation.

17.8.e. All garbage and refuse shall be disposed of in accordance with the applicable provisions of state and local law and rules governing the management of garbage and refuse.

17.9. Water Supply.

17.9.a. The administrator or designee shall ensure the nursing home has as its source a water supply that is safe and of sufficient capacity to meet the residents needs and the requirements of the sprinkler system.

17.9.b. The administrator or designee shall ensure the nursing home have as its source of water a public water system that complies with West Virginia division of health rules, public water systems, 64CSR3, or a water well that complies with West Virginia division of health rules, water well regulations, 64CSR19 and water well design standards, 64CSR46.

17.9.c. The administrator or designee shall ensure the nursing home shall have hot and cold running water in sufficient supply to meet the needs of the residents.

17.9.d. Hot water distribution systems serving resident care areas shall be recirculating to provide continuous hot water at each hot water outlet.

17.9.d.1. The temperatures shall be appropriate for comfortable use but shall not exceed 110 degrees Fahrenheit.

17.9.e. The administrator or designee shall ensure the nursing home has written agreements with water suppliers to deliver water when there is a loss of the normal supply.

17.10. Sewage Disposal.

17.10.a. The administrator or designee shall ensure that sewage is disposed of in accordance with West Virginia division of health rules, sewage system rules, and West Virginia division of health rules, sewage treatment and collection system design standards, 64CSR47.

17.10.b. The administrator or designee shall ensure the sewage system is adequate to meet the nursing home's needs.

17.10.c. The administrator or designee shall ensure the sewage system is maintained in good working order.

§64-13-18. Disaster Preparedness.

18.1. The administrator or designee shall ensure the nursing home has evidence of compliance with applicable rules of the state fire commission.

18.1.a. Any variation to compliance with the fire code shall be coordinated with the department and approved in writing by the state fire marshal.

18.2. The resident care committee shall develop and implement a written internal and external emergency management plan approved by the director that sets forth detailed procedures to be followed in the event of an internal or external disaster or emergency that could severely affect the operation of the nursing home.

18.2.a. The emergency management plan shall conform with the requirements set forth in the 2005 edition national fire protection association (NFPA) 1600, national incident management system (NIMS) and in chapter 12 of the 2005 edition (NFPA) 99 standards for health care facilities, relating to health care emergency management, with the following exception:

18.2.a.1. The administrator or designee shall implement one (1) or more specific responses of the emergency management plan at least semi-annually. At least one (1) semiannual drill shall rehearse the nursing home's response to a missing resident.

18.2.b. The emergency management plan shall contain detailed procedures for:

18.2.b.1. Sheltering in place, when a full evacuation of the nursing home and its premises is not indicated;

18.2.b.2. Evacuating all persons in the nursing home (including residents and staff), pertinent records, and emergency supplies to an alternate emergency shelter (or shelters), when an evacuation order is issued; and

18.2.b.3. Serving as an emergency shelter to receive evacuees from the community, in the event that the nursing home is ordered to serve in this capacity.

18.2.c. The emergency management plan shall have procedures to be followed in the event of the following:

18.2.c.1. Fire,

18.2.c.2. Missing resident,

18.2.c.3. Outbreak within the nursing home of a communicable disease,

18.2.c.4. High winds,

18.2.c.5. Tornadoes,

18.2.c.6. Bomb threats,

18.2.c.7. Utility failure, flood

18.2.c.8. Internal and external flooding, and

18.2.c.9. Severe winter weather.

18.2.d. The emergency management plan shall include at least:

18.2.d.1. A written agreement with one (1) or more entities capable of providing emergency shelter to the residents and staff of a nursing home that has been ordered to evacuate;

18.2.d.1.A. Living space in an alternate shelter shall be calculated at approximately 60 to 80 square feet (ft) per person to accommodate a 6 ft by 3 ft cot or mattress with a 2 ft to 3 ft perimeter.

18.2.d.1.B. If the designated alternate shelter(s) with sufficient living space to accommodate all residents and staff is (are) not immediately available to the nursing home, the nursing home shall obtain a written agreement with an entity that shall provide a staging area to receive residents and staff on a short-term, temporary basis until the residents and staff can be relocated to the designated alternate shelter(s).

18.2.d.2. An emergency transportation plan that shall, once activated, facilitate the complete evacuation of all residents and staff within two (2) hours of receipt of an order to evacuate the premises;

18.2.d.3. A written agreement with a water supplier for obtaining both potable (drinking) and non-potable emergency water within no greater than four (4) hours of a loss of normal water supply;

18.2.d.3.A. If a water supplier is unable to guarantee delivery of water within four (4) hours of the nursing home's request, the nursing home shall store on its premises water, that is bottled and sealed, in an amount sufficient to provide at least one (1) gallon of potable water per person (resident and staff) for twenty-four (24) hours or until the water supplier is able to guarantee delivery of the water, which ever is greater.

18.2.d.4. An emergency food supply list and menu that will provide nutrition for all persons in the nursing home (including residents and staff) for a minimum of seventy-two (72) hours;

18.2.d.4.A. The dietary manager, in consultation with the dietitian, shall have a planned three (3) day disaster menu that correlates with the emergency food supply.

18.2.d.4.A.1. The dietary manager shall ensure that the planned three (3) day disaster menu is conspicuously posted in the kitchen and where the emergency supplies are stored, as non-dietary staff may be called upon to assist in meal preparation during an emergency.

18.2.d.4.A.2. The dietary manager shall ensure the emergency food supply is maintained on the premises with non-perishable foods and disposable supplies in sufficient amounts to meet the needs of all residents (based on the nursing home's highest occupancy level in the past three (3) months) and staff (based on the nursing home's highest average staffing level on a weekday day-shift) for three (3) days.

18.2.d.4.A.2.(a). The dietary manager, in consultation with the dietitian, shall ensure that the needs of residents who require mechanically altered foods are able to be met upon activation of the disaster menu during an emergency.

18.2.d.4.A.2.(b). Canned pureed foods need not be maintained in inventory provided the nursing home has the capability to modify the food to a texture that meets the residents' needs. For example, many foods can be made appropriate for pureed diets by

manually mashing, or soaking in nutritious liquids. This may also be accomplished by staff taking a food processor or blender to an emergency outlet.

18.2.d.4.A.2.(c). If nursing home staff is unable to puree foods during an emergency, the dietary manager shall maintain canned pureed items as part of the emergency food supply.

18.2.d.4.A.3. The emergency food supply may be incorporated with the regular stock of food supplies and must be rotated no less than every six (6) months.

18.2.d.4.A.3.(a). If the emergency food supply is incorporated with the regular stock of food supplies, the dietary manager shall still be responsible for having all items on the disaster menu available and in the quantities necessary to meet the needs of residents and staff. These quantities shall be available at any given time, as emergencies may arise between food and supply delivery dates.

18.2.d.5. A plan to obtain, or safely store on the premises, sufficient fuel to power the nursing home's emergency generator for at least seventy-two (72) consecutive hours; and

18.2.d.6. A plan to ensure minimum stockpiling of, immediate access to, or at least uninterrupted access to critical materials including:

18.2.d.6.A. Medications, including oxygen;

18.2.d.6.B. Medical supplies; and

18.2.d.6.C. Linen supplies.

18.2.e. The emergency management plan shall be developed and maintained with the assistance of qualified fire safety and other emergency response teams.

18.2.f. There shall be copies of the emergency management plan at all staff stations or emergency control stations.

18.2.f.1. The emergency management plan shall be located in an area that allows visual contact at all times. The nursing home staff shall know the location of the plan at all times.

18.2.g. The administrator or designee shall provide to the local fire department an up-to-date copy of the nursing home's floor plan, and emergency management plan, and the administrator or designee shall give the fire department opportunities to become familiar with the building and grounds.

18.2.g.1. When the governing body makes a change in the nursing home's physical plant, through either alterations in the nursing home's structure or re-designation of the use of existing space, the administrator or designee shall provide a copy to the local fire department of

the revised floor plan and emergency plan, if applicable, within ten (10) calendar days of the effective date of the change.

18.2.h. The resident care committee shall develop and implement written policies and procedures for transferring casualties and uninjured residents.

18.2.h.1. These policies and procedures shall include the transfer of pertinent resident records including identification information, diagnoses, allergies, advance directives, medications and treatments, and other records needed to ensure continuity of care.

18.2.h.1.A. If electronic records are in use, the resident care committee shall address, in its policies and procedures, how pertinent electronic resident records shall be transferred as required to ensure continuity of care.

18.2.i. The administrator or designee shall have written instructions regarding the location and use of alarm systems, signals and fire fighting equipment.

18.2.j. The administrator or designee shall have information regarding methods of fire containment.

18.2.k. The administrator or designee shall have written instructions regarding accessibility for evacuation routes.

18.2.l. The resident care committee shall review the emergency management plan on an annual basis, the administrator or his or her designee shall sign and date the plan to verify that the plan was reviewed.

18.2.m. The administrator or designee shall ensure that emergency call information is conspicuously posted near each telephone in the nursing home, exclusive of telephones in resident rooms. This information shall include at least the following:

18.2.m.1. The telephone numbers of the fire department, the police, and ambulance service and other appropriate emergency services; and

18.2.m.2. Key personnel telephone or pager numbers, including at least the following:

18.2.m.2.A. The administrator;

18.2.m.2.B. The director of nursing or nurse on call;

18.2.m.2.C. The maintenance director or safety director;

18.2.m.2.D. The physician on call; and

18.2.m.2.E. Other appropriate personnel.

18.2.n. The administrator or designee shall ensure the nursing home has at least one (1) non-coin operated telephone or one (1) extension on each resident occupied unit and additional telephones and extensions if needed to summon help in case of an emergency.

18.2.o. The governing body shall be responsible for ensuring the nursing home has an area of sufficient space to hold the congregate population of the nursing home with a heat source that is supplied with emergency electrical power from the emergency power source.

### 18.3. Disaster Training.

18.3.a. The administrator or designee shall operate an internal emergency management program that includes orientation and ongoing training and drills in procedures and specific assignments.

18.3.a.1. For an exercise to be considered a drill or a rehearsal, the following aspects must be incorporated and documented:

18.3.a.1.A. A general overview of the scenario;

18.3.a.1.B. Activation of the nursing home's disaster plan,

18.3.a.1.C. Evaluation of all involved participants / departments;

18.3.a.1.D. A critique session following the drill or rehearsal; and

18.3.a.1.E. Any identified follow-up training to correct or improve any deficiencies noted during the drill or rehearsal.

18.3.b. The internal disaster plan shall be rehearsed at least semiannually.

18.3.b.1. At least one (1) semiannual rehearsal shall rehearse the nursing home's response to a missing resident.

18.3.c. Fire drills shall be held at least quarterly for each shift.

18.3.c.1. Fire drills conducted at shift change shall only satisfy the requirement for holding a fire drill on one (1) of the two (2) shifts.

18.3.d. Disaster Rehearsal and Fire Drill Reports. The administrator or designee shall keep on file for at least two (2) years, a dated written report and an evaluation of each disaster rehearsal and fire drill conducted on the premises, containing all of the components of a drill or rehearsal as specified in paragraph 18.3.a.1. of this rule.

§64-13-19. Governing Body.

19.1. Licensure.

19.1.a. The governing body shall be responsible for ensuring that the nursing home is licensed pursuant to section 3. of this rule.

19.1.b. The governing body shall be responsible for ensuring that the nursing home is operated and provides services in compliance with:

19.1.b.1. All applicable federal, state, and local laws, rules, regulations, and codes, including this rule;

19.1.b.2. Accepted professional standards and principles that apply to professionals providing services in a nursing home; and

19.1.b.3. Its own policies and procedures.

19.2. Governing Body.

19.2.a. A nursing home's governing body, or designated persons functioning as a governing body, is legally responsible for establishing and implementing policies regarding the management and operation of the nursing home.

19.2.a. The governing body shall be responsible for conspicuously posting in the nursing home contact information for the person(s) serving as the governing body, as defined in section 2. of this rule, including name(s), address(es), and telephone number(s).

19.2.b. The governing body shall be responsible for adopting and enforcing rules governing the health care and safety of residents, the protection of their personal and property rights, and the operation of the nursing home.

19.2.c. The governing body shall be responsible for developing a written nursing home plan that will be reviewed annually. In addition to the other requirements described in law and in this rule, the nursing home plan shall include:

19.2.c.1. A detailed annual operating budget, including all anticipated income and expenses; and

19.2.c.2. A detailed capital expenditure plan for at least a three (3) year period.

19.3. Administrator.

19.3.a. The governing body of a nursing home shall appoint a full-time administrator, who holds a currently valid license or emergency permit issued by the West Virginia nursing home administrators licensing board, to serve as its on-site agent, with the necessary authority and responsibility to manage the day-to-day operations of the nursing home.

19.3.a.1. The governing body shall be responsible for ensuring that the nursing home's administrator maintains detailed time records of hours worked at the nursing home.

19.3.a.2. In the event that the administrator is temporarily absent from the nursing home, for a period of seven (7) or more consecutive days, due to illness, vacation, training, or an emergency situation, the governing body shall be responsible for designating an experienced, trained, competent employee to act for the administrator in his or her absence.

19.3.a.2.A. In the event that the director of nursing serves as relief for the administrator, he or she shall designate an experienced, qualified registered professional nurse to direct the nursing service, and

19.3.a.2.A.1. The registered professional nurse serving as relief director of nursing shall be free from other responsibilities.

19.3.a.3. The governing body shall be responsible for ensuring that the nursing home's administrator conspicuously displays his or her currently valid license certificate in location visible to the general public.

19.3.a.4. The governing body shall be responsible for notifying the director, in writing, within five (5) working days of a vacancy in the administrator position. The written notice shall give the name and West Virginia license number of the individual appointed to serve as the new administrator, and whether the appointment is permanent or temporary.

19.3.b. The governing body shall be responsible for ensuring that the nursing home's administrator is empowered to employ sufficient qualified staff and utilize the nursing home's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

19.3.c. Administrator Functions. The administrator's responsibilities shall include the following:

19.3.c.1. Assuring the nursing home's compliance with all applicable federal, state and local laws, rules, and regulations;

19.3.c.2. Chairing the resident care committee, as defined in section 2. of this rule.

19.3.c.3. Assuring that the public information describing the nursing home's services is accurate and fully descriptive;

19.3.c.4. Serving as liaison to the governing body, medical staff and other professional and supervisory staff;

19.3.c.5. Maintaining sufficient staff to provide, in a timely manner, adequate care and services to meet the needs of the residents in the nursing home and to properly operate all departments, and

19.3.c.5.A. Assuring that appropriate and adequate relief personnel are utilized for those necessary positions vacated either on a temporary or permanent basis;

19.3.c.6. Evaluating and implementing recommendations from the nursing home's quality assessment and assurance committee;

19.3.c.7. Apprising each member of the governing body of all:

19.3.c.7.A. Official inspection reports and complaint investigation reports issued by the secretary;

19.3.c.7.B. Plans of correction submitted by the nursing home to the secretary;

19.3.c.7.C. The nursing home's licensure classification; and

19.3.c.7.D. Requests, orders, complaints or policy statements filed with the administrator by the secretary.

19.3.c.8. Assuring the completion, maintenance, and submission of reports and records required by the secretary; and

19.3.c.9. Setting an example for all employees, staff, independent health contractors, and others affiliated with the nursing home, which recognizes that the institution exists to serve the interests and needs of the residents, emphasizes the importance of a resident's right to independence regarding all aspects of institutional life, and encourages residents to participate together with staff in resolving conflicts.

19.3.d. Where this rule requires statements of policies or procedures or other documentation, the administrator shall be responsible for ensuring that all such statements are in writing. Unless this rule states otherwise, these statements shall be reviewed annually, and signed and dated by the administrator at the most recent review.

19.3.e. The administrator shall be responsible for ensuring:

19.3.e.1. The reporting of certain deaths, in accordance with paragraph 8.5.g.4. of this rule and W.V.C. §61-12-8, the postmortem examinations act;

19.3.e.2. The monthly reporting of all deaths occurring in the nursing home to the office of vital statistics, in accordance with state law;

19.3.e.3. The reporting of all reportable diseases to the local health department within the required time frames, in accordance with W.V. 64CSR7, the reportable diseases, events and conditions rules;

19.3.e.4. The submission of any other reports required by state and federal law or rules; and

19.3.e.5. Promptly notifying the director upon receipt of a strike notice and keeping the director apprised of the strike status and the measures being taken to provide resident care during the strike, which shall be communicated in the form of a written detailed strike plan.

19.4. Policies and Procedures.

19.4.a. The administrator shall be responsible for ensuring the resident care committee develops and implements written policies and procedures approved by the governing body.

19.4.b. The administrator shall be responsible for maintaining a written record of the annual policy review by the resident care committee, including at least the review dates, participants, recommendations and action dates of the governing body.

19.4.c. Administrative and operational policies and procedures shall include, but not be limited to:

19.4.c.1. Administrative records;

19.4.c.2. Admission, transfer and discharge;

19.4.c.3. Resident care policies and procedures;

19.4.c.4. Medical direction and physician services;

19.4.c.5. Nursing direction and nursing services;

19.4.c.6. Pharmaceutical services;

19.4.c.7. Dietary services;

19.4.c.8. Social services;

19.4.c.9. Activities services;

19.4.c.10. Restorative and rehabilitative services;

19.4.c.11. Contractual services;

19.4.c.12. Clinical records;

19.4.c.13. Resident rights and grievances;

19.4.c.14. Quality assessment and assurance;

19.4.c.15. Infection control;

19.4.c.16. Resident safety;

19.4.c.17. Fire safety and emergency preparedness; and

19.4.c.18. Professional and clinical ethics, including:

19.4.c.18.A. Confidentiality of resident information;

19.4.c.18.B. Truthful communication with residents;

19.4.c.18.C. Observance of appropriate standards of informed consent and refusal of treatment;

19.4.c.18.D. Preservation of resident dignity, with special attention to the needs of the aged, the cognitively impaired, and the dying.

19.4.d. Personnel policies and procedures shall include, but not be limited to:

19.4.d.1. Written job descriptions that specify authority, responsibility, and qualifications for each job description, including that of the administrator;

19.4.d.2. An ongoing plan for employee orientation, staff development, inservice training and continuing education;

19.4.d.3. An accurate and complete personnel record for each employee, including the administrator, which shall include:

19.4.d.3.A. Verification of current professional license, registration or certificate or completion of required approved training course;

19.4.d.3.B. Evidence of a criminal conviction investigation as required at subdivision 6.3.e. of this rule;

19.4.d.3.C. Evidence of orientation to the nursing home, its policies and to the position and duties assigned;

19.4.d.3.D. Evidence of completion of inservice training for the individual as determined by the outcome of the annual performance evaluation;

19.4.d.3.E. Records of any disciplinary actions taken

19.4.d.4. Employee health-related information retained in a separate file from the personnel files.

19.4.e. Financial policies and procedures shall include, but not be limited to:

19.4.e.1. Admission agreements;

19.4.e.2. Methods of billing:

19.4.e.2.A. Services not included in the basic daily or monthly rate;

19.4.e.2.B. Services delivered by contractors of the nursing home; and

19.4.e.3.C. Third party payers;

19.4.e.3. Evidence of notifications of changes in fees and charges provided to the resident or financial legal representative;

19.4.e.4. Correction of billing errors and refund policy;

19.4.e.5. Collection of delinquent resident accounts; and

19.4.e.6. Handling of resident funds.

19.4.f. Policies shall be made available for review, upon request, to residents and their legal representatives, staff, and members of the general public.

19.5. Medical Director. The administrator shall designate, in writing, a physician accountable to the governing body to serve as medical director to ensure that medical care provided to residents is adequate and appropriate.

19.5.a. As a member of the resident care committee, the medical director is responsible for:

19.5.a.1. Participating in the development, implementation, evaluation, and revision of resident care policies and procedures, to ensure that resident care policies and procedures reflect current standards of practice for resident care and quality of life; and

19.5.a.2. Coordinating and evaluating medical care in the nursing home.

19.6. Laboratory Services.

19.6.a. The administrator shall ensure the nursing home provides or obtains laboratory services to meet the needs of its residents. The administrator is responsible for the timeliness of the services.

19.6.b. If a nursing home provides its own laboratory services, the administrator shall ensure services meet the requirements in the federal regulation, 42 CFR Part 493.

19.6.c. If a nursing home arranges for outside laboratory services, the administrator shall ensure that the laboratory services meet the requirements in the federal regulation, 42 CFR Part 493.

19.6.d. If a nursing home provides blood bank and transfusion services, the administrator shall ensure that the services meet the applicable requirements in the federal regulation, 42 CFR Part 493.

19.6.e. The administrator or designee shall ensure the nursing home:

19.6.e.1. Provides or obtains laboratory services only when ordered by a physician;

19.6.e.2. Promptly notifies the physician of the findings;

19.6.e.3. Assists the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

19.6.e.4. Files laboratory reports in the resident's clinical record that are dated and contain the name and address of the testing laboratory.

19.7. Radiology and Other Diagnostic Services.

19.7.a. The administrator or designee shall ensure the nursing home provides or obtains radiology and other diagnostic services to meet the needs of its residents. The administrator is responsible for the timeliness of the services.

19.7.b. If a nursing home provides its own diagnostic services, the administrator shall ensure services meet the applicable licensing and certification requirements established for those services.

19.7.c. If a nursing home does not provide its own diagnostic services, the administrator shall have an agreement to obtain these services from a provider or supplier that meets all applicable licensing and certification requirements established for those services.

19.7.d. The administrator or designee shall ensure the nursing home:

19.7.d.1. Provides or obtains radiology and other diagnostic services only when ordered by the attending physician;

19.7.d.2. Promptly notifies the physician of the findings,

19.7.d.3. Assists the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

19.7.d.4. Files in the resident's clinical record signed and dated reports of x-ray and other diagnostic services, with the name and address of the provider of the service.

19.8. Clinical Records.

19.8.a. Records Maintenance and Retention.

19.8.a.1. The administrator or designee shall ensure the nursing home maintains clinical records on each resident in accordance with accepted professional standards and practices that are:

19.8.a.1.A. Complete;

19.8.a.1.B. Accurately documented;

19.8.a.1.C. Readily accessible; and

19.8.a.1.D. Systematically organized.

19.8.a.2. All of a resident's clinical records shall be retained for the longer of the following time periods:

19.8.a.2.A. Five (5) years from the date of discharge or death; or

19.8.a.2.B. For a minor, three (3) years after a resident reaches eighteen (18) years of age.

19.8.a.3. The administrator or designee shall ensure the nursing home safeguards clinical record information against loss, destruction, or unauthorized use.

19.8.a.4. The administrator or designee shall ensure that each clinical record contains a photograph of the resident, unless the resident objects.

19.8.b. Confidentiality. The administrator shall ensure the nursing home shall keep all information contained in the resident's clinical record confidential, unless the resident, or applicable legal representative, authorizes disclosure or when release is required by:

19.8.b.1. Transfer to another health care institution;

19.8.b.2. Law; or

19.8.b.3. Third party payment contract.

19.8.c. Contents. The clinical record shall contain:

19.8.c.1. Sufficient information to identify the resident;

- 19.8.c.2. All the resident's assessments;
- 19.8.c.3. The resident's plan of care and services provided;
- 19.8.c.4. The results of any pre-admission screening conducted by the state;
- 19.8.c.5. Progress notes; and
- 19.8.c.6. Physician orders.

19.9. Quality Assessment and Assurance.

19.9.a. Quality Assessment and Assurance Committee. The administrator shall ensure the nursing home maintains a quality assessment and assurance committee consisting of:

- 19.9.a.1. The director of nursing services;
- 19.9.a.2. A physician designated by the nursing home;
- 19.9.a.3. A nurse aide;
- 19.9.a.4. At least two (2) other members of the nursing home's staff.

19.9.b. The quality assessment and assurance committee shall:

19.9.b.1. Meet at least quarterly to identify issues of quality assessment and assurance activities, to include but not be limited to:

19.9.b.1.A. Evaluating the effectiveness of the nursing home's resident safety program as set forth in paragraph 9.9.e.1. of this rule; and

19.9.b.1.B. Evaluating the medication error and adverse drug reaction reports as set forth in subdivision 15.2.g. of this rule;

19.9.b.1.C. Evaluating the effectiveness of the nursing home's overall infection control program as set forth in subdivision 16.3.a. of this rule.

19.9.b.2. Develop and implement appropriate plans of action to correct identified quality deficiencies;

19.9.b.3. Continuously measure, assess, and improve all important resident care and nursing home functions;

19.9.b.4. Collect and review outcome data and use it to systematically benchmark the level of quality with that of other extended care providers; and

19.9.b.5. Collect and review resident satisfaction.

19.9.b.6. Review all policies and procedures at least annually and submit recommended changes to the governing body for approval.

19.9.c. Disclosure of Records. The director may not require disclosure of the quality assessment and assurance committee records except insofar as the disclosure is related to the compliance with the requirements of this section.

19.9.d. Sanctions. The director shall not use good faith attempts, as documented by a nursing home's quality assessment and assurance committee, to identify and correct areas of concern or deficiencies as a basis for citing a new deficiency or as a basis for sanctions.

19.11. Transfer Agreements.

19.11.a. The administrator shall have in effect a transfer agreement with one (1) or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures:

19.11.a.1. Timely admission of a resident to the hospital when transfer is medically appropriate as determined by a physician; and

19.11.a.2. Medical and other information needed for care and treatment of residents is exchanged between the institutions.

§64-13-20. Human Resources.

20.1. Professional Staff.

20.1.a. The administrator shall employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of this rule.

20.2. Professional Qualifications.

20.2.a. Professional staff shall be licensed, certified, or registered in accordance with applicable laws.

20.3. Use of Outside Resources.

20.3.a. If the administrator does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the administrator shall have that service furnished to residents by a person or agency outside the nursing home under an arrangement or written agreement as described in 42 U.S.C. §1395x(w). Services shall meet the ongoing identified needs of residents to ensure implementation of the plan of care and to avoid unnecessary duplication of services.

20.3.b. The arrangements or written agreements pertaining to services furnished by outside resources, must specify in writing that the administrator is responsible for the following:

20.3.b.1. Obtaining services that meet professional standards and principles that apply to professionals providing services in a nursing home; and

20.3.b.2. The timeliness of the services.

20.4. Staff Development.

20.4.a. All staff shall attend and participate in regularly scheduled inservice training programs developed by either nursing home staff or outside resources. The purpose of the inservice program shall be to:

20.4.a.1. Plan and organize a system of training that begins with an orientation program and continues throughout employment with scheduled inservice training programs;

20.4.a.2. Develop in each staff an awareness of his or her abilities and limitations in providing care for residents; and

20.4.a.3. Develop the abilities of each employee by an in-depth review of operational policies and procedures, instruction of methods and procedures to follow in implementing assigned duties as it relates to a specific job description, and to provide current information that will assist in providing quality care.

20.4.b. The administrator or designee shall maintain records of attendance, and if absences occur shall schedule a make-up class to be completed.

20.4.c. Orientation Program. The resident care committee shall develop and implement policies and procedures to ensure that all employees, professional staff, temporary agency personnel, and volunteers used by the nursing home receive orientation and training to the extent necessary to perform their job responsibilities prior to commencing such job responsibilities independently.

20.4.c.1. The administrator or designee shall provide training to all new employees, staff, and independent health contractors used by the nursing home, within thirty (30) days of employment or the next regularly scheduled orientation program, whichever occurs first, on alzheimer's disease and other dementias. The training shall be a minimum of two (2) hours in duration and shall include all of the following: a basic explanation of how the disease process affects persons with alzheimer's disease and other dementias; communication approaches and techniques for use when interacting with persons with alzheimer's disease or other dementias; prevention and management of problem behaviors; and activities and programming appropriate for these individuals.

20.4.c.2. The orientation program shall also provide appropriate orientation and training to include, but not be limited to:

20.4.c.2.A. The protection of a resident's rights, including personal rights, property rights, and the protection of privacy (including confidentiality of resident information), and the nursing home's procedures for handling complaints;

20.4.c.2.B. The nursing home's physical layout, including introductions to key supervisory personnel with whom the individual will be interacting, an overview of the nursing home's fire safety and evacuation plan, and orientation to any special safety features unique to the nursing home (such as access codes to door locks with keypads and any alarming devices intended to alert staff to potential resident safety concerns);

20.4.c.2.C. A review of the nursing home's policies and procedures applicable to assuring safe and appropriate resident care, including a review of infection control practices relevant to the individual's job responsibilities; and

20.4.c.2.D. The individual's specific job duties and responsibilities.

20.4.d. Inservice training.

20.4.d.1. The administrator or designee shall provide training on alzheimer's disease and other dementias to all employees, staff, and independent health contractors used by the nursing home each calendar year. The training shall be a minimum of two (2) hours in duration and shall include all of the following: a basic explanation of how the disease process affects persons with alzheimer's disease and other dementias; communication approaches and techniques for use when interacting with persons with alzheimer's disease or other dementias; prevention and management of problem behaviors; and activities and programming appropriate for these individuals.

20.4.d.2. The administrator or designee shall also complete a performance review of all staff at least once every twelve (12) months and provide regular inservice education based on the outcome of these reviews. The inservice training shall:

20.4.d.2.A. Address areas of weakness as determined in each evaluation and may address the special needs of residents as determined by the nursing home staff; and

20.4.d.2.B. Be sufficient to ensure the continuing competence of all nurse aides, but shall be no less than twelve (12) hours per year, based on the anniversary of the nurse aide's employment date;

20.4.d.2.C. Include inservice instruction to all staff, including the administrator, on the following:

20.4.d.2.C.1. The prevention and control of infections;

20.4.d.2.C.2. Emergency preparedness and the nursing home's fire and safety rules;

20.4.d.2.C.3. Resident safety, staff safety and accident prevention;

20.4.d.2.C.4. Protection of a resident's rights, including personal rights, property rights, and the protection of privacy (including confidentiality of resident information), and the nursing home's procedures for handling complaints; and

20.4.d.2.C.5. Abuse prohibition practices, to include appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; how staff should report their knowledge related to allegations of abuse, neglect or misappropriation of resident property without fear of reprisal; how to recognize signs of burnout, frustration and stress that may lead to abuse or neglect; and what constitutes abuse, neglect and misappropriation of resident property.

20.4.d.2.D. Include inservice instruction to all nursing staff on the following:

20.4.d.2.D.1 Prevention and treatment of pressure sores;

20.4.d.2.D.2. Restraint use, including alternatives to physical and chemical restraints; and

20.4.d.2.D.3. Recognition and assessment of pain in both residents who are cognitively intact and residents who have cognitive impairments and/or communication deficits.

20.4.d.2.E.. Provide for a demonstration of staff's mastery of the material and/or skills acquired through each inservice training, as evidenced by successful completion of a post-test to assess knowledge and understanding and/or successful completion of a return demonstration to assess performance of a given skill.

20.4.d.2.E.1. Documentation of the results of each post-test and/or return demonstration shall be maintained for a period of not less than two (2) years and may be kept in a central location within the nursing home separate from the employee's personnel record.

20.5. Personnel Records. The administrator or designee shall maintain on the premises a confidential personnel record for all staff, including the administrator, containing the following information:

20.5.a. A dated application;

20.5.b. Reference verification;

20.5.c. Evidence of TB screening as specified in subsection 16.4. of this rule;

20.5.d. Results of annual physical, if required by the nursing home's policy;

20.5.e. Evaluations of work performance;

20.5.f. Evidence of verification of current license, registration, or certification status if applicable to the job;

20.5.g. A summary of inservice training for the previous two (2) years;

20.5.h. Any nursing home specific required forms;

20.5.i. A signed detailed job description;

20.5.j. For each staff member, evidence that staff received notification of the central abuse registry, as required by W.V.C. §15-2C; and

20.5.k. For each nurse aide, evidence that the nurse aide received a copy of the nurse aide abuse registry rule, as required by W.V. §69-6-8.1.

#### §64-13-21. Inspections and Investigations.

##### 21.1. Regular Inspections.

21.1.a. The director shall make, or cause to be made, inspections by his or her authorized representatives as necessary to carry out the intent of W.V.C. §16-5C-1 and this rule.

21.1.b. The director shall inspect annually, or in accordance with section 23. of this rule, all licensed nursing homes to determine each nursing home's compliance with applicable statutes and rules.

21.1.b.1. The director shall inspect with greater frequency, as determined by the director, nursing homes with the greatest number of deficiencies.

##### 21.2. Deficiency Categorization

21.2.a. After an inspection team determines that a deficiency (ies) exists, the inspection team shall assess the effect on resident outcome (severity level) and determine the number of residents potentially or actually affected (scope level). The results of this assessment shall determine whether or not the nursing home is in substantial compliance or is non-compliant with this rule.

21.2.a.1. Guidance on Severity Levels. There are four (4) severity levels. These four (4) levels are defined as follows:

21.2.a.1.A. Level 1 is non-compliance that has the potential for causing no more than a minor negative impact on a resident. Deficiencies cited at a severity of Level 1 constitute substantial compliance as defined in this rule.

21.2.a.1.B. Level 2 is non-compliance that results in no more than minimal physical, mental and/or psychosocial discomfort to a resident and/or has the potential (not yet realized) to compromise a resident's ability to maintain and/or reach his / her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

21.2.a.1.C. Level 3 is non-compliance that results in a negative outcome that has compromised a resident's ability to maintain and/or reach his / her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to a resident.

21.2.a.1.D. Level 4 is non-compliance at immediate jeopardy, a situation in which immediate corrective action is necessary because the nursing home's non-compliance with one (1) or more requirements of this rule has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a nursing home.

21.2.a.2. Guidance on Scope Levels. There are three (3) scope levels. These three (3) scope levels are defined as follows:

21.2.a.2.A. Isolated. Scope is isolated when one (1) or a very limited number of residents are affected and/or one (1) or a very limited number of staff is involved, and/or the situation has occurred only occasionally or in a very limited number of locations.

21.2.a.2.B. Pattern. Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff is involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the nursing home.

21.2.a.2.C. Widespread. Scope is widespread when the problem causing the deficiency is pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion of all of the nursing home's residents. Widespread scope refers to the entire nursing home population, not a subset of residents or one (1) unit of the nursing home. In addition, widespread scope may be identified if a systemic failure in the nursing home (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the nursing home.

21.2.a.3. General Procedures.

21.2.a.3.A. After a inspection team determines that a deficiency exists, the inspection team shall evaluate the deficient practice's severity level. The inspection team may base evidence of the impact or prevalence for residents of the deficient practice on record reviews, interviews, and/or observations; whatever the source, the evidence must be credible.

21.2.a.3.B. After determining the severity level, the inspection team shall evaluate the deficient practice's scope.

21.2.a.3.a.C. If the evidence gathered during the inspection for a particular requirement of this rule includes examples of various severity or scope levels, the inspection team shall classify the deficiency at the highest severity level, even if most of the evidence corresponds to a lower severity level. For example, if there is a deficiency in which one (1) resident suffered a severity Level 3 while there were widespread findings of the same deficiency at severity Level 2, then the deficiency would be classified as severity Level 3 with an isolated scope.

### 21.3. Complaint Investigations.

21.3.a. Any person may register a complaint with the director alleging violation of applicable statutes and rules by a nursing home.

21.3.a.1. The director shall document all complaints and shall identify the nursing home involved.

21.3.b. The director shall not investigate a complaint determined to be willfully intended to harass a nursing home or without any reasonable basis and shall notify the complainant that no investigation will be conducted.

21.3.c. The director shall conduct an unannounced inspection of the nursing home to determine the validity of the complaint.

21.3.c.1. The director shall provide the nursing home with general notice of the substance of the complaint only at the time of the inspection.

21.3.d. The director shall conduct other investigations necessary to determine the validity of the complaint.

21.3.e. No later than twenty (20) working days after investigating and completing a complaint, the director shall notify the complainant and the nursing home in writing of the results of the investigation.

21.3.e.1. If a complaint has been found to be substantiated, the director shall advise any injured party of the possibility of a civil remedy under W.V.C. §16-5C-1 et. seq.

21.3.f. The director shall not disclose the names of a complainant or of any person named in a complaint without that person's written authorization.

21.3.f.1. If a complaint becomes the subject of a judicial proceeding, nothing in this section shall be construed to restrict disclosure of information that would otherwise be disclosed in a judicial proceeding.

21.3.g. Before disclosing any complaint to a nursing home or the public pursuant to subdivision 21.3.k. of this rule, the director shall redact any information in the complaint that could reasonably identify the complainant or a resident.

21.3.h. The administrator is prohibited from discharging or in any manner discriminating against a resident, legal representative or employee for the reason that the resident, legal representative, or employee has filed a complaint or participated in a proceeding authorized by W.V.C. §16-5C-1 et seq.

21.3.h.1. Violation of this prohibition by any administrator shall be grounds for the suspension or revocation of the license of the nursing home as provided in section 11. of W.V.C. §16-5C-1.

21.3.h.2. If a resident, legal representative or employee, by whom or on whose behalf a complaint has been submitted to the director or who is involved in any proceeding instituted under W.V.C. §16-5C-1 et seq., is subject to any type of discriminatory treatment by the nursing home within one hundred twenty (120) days of the filing of the complaint or institution of such action, a rebuttable presumption shall arise that the discriminatory action was taken against the individual by the nursing home in retaliation for such complaint or action.

21.3.i. Timeliness of Initiating Complaint Investigations.

21.3.i.1. The director shall make investigations of complaints involving immediate jeopardy to resident health or safety within forty-eight (48) hours of the date of receipt of the complaint.

21.3.i.2. The director shall make investigations of complaints involving harm that does not present immediate jeopardy, within ten (10) working days of the date of receipt of the complaint.

21.3.i.3. The director shall make investigations of complaints involving no harm, but with potential for greater than minimal harm, that are not immediate jeopardy, within forty-five (45) calendar days of the date of receipt of the complaint.

21.3.i.4. The director shall make investigations of complaints involving no harm with potential for minimal harm at the time of the next inspection.

21.3.j. Timeliness of Notification of Non-Compliance. If, within one hundred twenty (120) days of an inspection or a complaint investigation, a nursing home fails to comply with the requirements of this rule, the director shall inform all residents of the nursing home's non-compliance.

21.3.j.1. If the non-compliance results in an action against the license of the nursing home, the director shall notify residents of the time period during which residents may relocate if they wish prior to the deficient nursing home being reported to the regional office of CMS, if the nursing home is certified under the medicare or medicaid programs.

21.3.j.2. The director shall provide all residents with a list of nursing homes and agencies to assist them in moving if they wish to relocate.

21.3.k. Within two hundred ten (210) days of an inspection or complaint investigation after which deficiencies are not timely corrected, the director shall send the name and address of the deficient nursing home to the appropriate regional office of CMS and identify it as a deficient nursing home.

21.4. Plans of Correction.

21.4.a. The director shall enforce these provisions to protect residents of nursing homes.

21.4.b. The administrator or designee of a nursing home, found during an inspection to have deficiencies, shall develop a plan of correction and submit it to the director within ten (10) working days of receipt of a report of inspection. The director may allow three (3) additional days in the event of a documented extenuating circumstance.

21.4.c. A plan of correction shall specify the date by which the nursing home shall correct each violation cited in the report.

21.4.c.1. The date specified shall be the shortest possible time within which the nursing home can reasonably be expected to correct the violation.

21.4.c.2. The date stated is subject to approval or modification by the director.

21.4.d. In determining whether to approve the date submitted by the administrator or designee, the director shall consider the following factors:

21.4.d.1. The seriousness of the violation;

21.4.d.2. The number of residents affected;

21.4.d.3. The availability of required equipment or personnel;

21.4.d.4. The estimated time required for delivery and installation of required equipment; and

21.4.d.5. Any other relevant circumstances.

21.4.e. A plan of correction shall contain:

21.4.e.1. The corrective actions that the nursing home shall accomplish for those residents affected by the deficiency;

21.4.e.2. How the nursing home will identify other residents having the potential to be affected by the same deficiency and what corrective action will be taken;

21.4.e.3. What measures the nursing home will put into place or what systemic changes will be made to ensure that the deficiency does not recur; and

21.4.e.4. How the nursing home will monitor the corrective actions put in place to ensure the deficiency will not recur, i.e., what quality assurance program will be put into place.

21.4.f. The director shall review the plan of correction submitted by the administrator or designee and shall approve, modify, or reject the plan.

21.4.g. The director shall notify the administrator or designee, within ten (10) working days of receipt, as to whether a plan of correction was been approved, modified, or rejected.

21.4.h. If the director rejects or modifies the plan, the director shall state the reasons for the action in the notice.

21.4.i. When the director rejects a plan of correction, the administrator or designee shall submit a revised plan to the director within ten (10) working days of receipt of the rejection.

21.4.j. If the administrator or designee fails to submit a plan of correction that is acceptable to the director, or fails to correct any deficiency within the time specified in an accepted plan of correction, the director may assess civil money penalties as provided in this rule or may initiate any other legal or disciplinary action available to him or her in accordance with state law and this rule.

21.5. Availability of Reports. The director shall make copies and information concerning applications, inspections, investigations and other reports available for public inspection from the time of receipt of the plan of correction.

21.5.a. The director shall make copies of all inspection reports available to the state long-term ombudsman, the local office of adult protective services, and the regional office of CMS.

21.5.b. The director shall provide the state long-term care ombudsman with the following within ninety (90) days:

21.5.b.1. A statement of deficiencies reflecting a nursing home's non-compliance;

21.5.b.2. Reports of adverse actions imposed on a nursing home; and

21.5.b.3. The date and time of any inspection.

21.6. Informal Dispute Resolution. (Informal Hearing)

21.6.a. The director shall offer the administrator of a nursing home an opportunity for an informal dispute resolution.

21.6.a.1. The administrator or designee shall submit documentation for an informal dispute resolution with, but separate from, the plan of correction for existing deficiencies.

21.6.a.2. The administrator or designee shall submit the request for an informal dispute resolution at the same time the administrator or designee submits the plan of correction for existing deficiencies.

21.6.a.3. The director shall write policy and procedures addressing the manner in which an informal dispute resolution shall be conducted.

21.6.a.4. The director's policy and procedures for an informal dispute shall be available to the public upon written request.

21.6.b. If the director fails to complete an informal dispute resolution in a timely manner, this shall not delay the effective date of any enforcement action against the nursing home.

21.6.c. If during the informal dispute resolution process a nursing home is successful in demonstrating that deficiencies should not have been cited, the director shall remove the deficiencies from the statement of deficiencies and rescind any enforcement action imposed solely as a result of those cited deficiencies.

21.6.d. All communications during an informal dispute resolution are confidential and cannot be used by or against the licensee or the director in the event a formal hearing takes place.

#### §64-13-22. Enforcement and Due Process.

##### 22.1. Enforcement: Director's Powers, Duties and Rights.

22.1.a. The director may invoke penalties against the nursing home for violations of the provisions of this rule, in accordance with the provisions of this rule.

##### 22.2. Enforcement Generally.

22.2.a. The director may assess civil penalties, and/or may suspend, revoke, or deny renewal of the license of a nursing home for cause after notice as required by this rule and the provisions of W.V.C. §16-5C-1, et seq., or take any other action contemplated by this rule. Cause may include one (1) or more of the following:

22.2.a.1. Failure to provide standard quality of care for residents;

22.2.a.2. Willfully and knowingly falsifying the material content of resident assessments;

22.2.a.3. Failure to submit a plan of correction required by W.V.C. §16-5C-1 et seq.;

22.2.a.4. Failure to submit a plan of correction that is approved by the director;

22.2.a.5. Failure to correct deficiencies within the time frame specified in an approved plan of correction;

22.2.a.6. Repeat non-compliance within the same regulatory grouping as defined in this rule;

22.2.a.7. Failure to cooperate with or interference with the director or an authorized representative of the director in the inspection of the nursing home;

22.2.a.8. Failure to comply with this rule;

22.2.a.9. Violation of any provision of this rule that produces immediate jeopardy to the health or safety of residents;

22.2.a.10. Violation of the provisions of this rule relative to the discharge of residents or employees because of complaints against the nursing home;

22.2.a.11. Use of subterfuge or other dishonest action in applying for an original or renewal license;

22.2.a.12. Use of subterfuge or other dishonest action in obtaining the time, date and location of any inspection;

22.2.a.13. Abuse of residents;

22.2.a.14. Neglect of residents;

22.2.a.15. Misappropriation of residents' property; or

22.2.a.16. Attempted bribery of any employee or contracted person of the department.

22.2.b. Enforcement Actions to Ensure Compliance.

22.2.b.1. The director shall begin an enforcement action to ensure compliance with W.V.C. §16-5C-1 et seq., or any rule or order issued thereunder, whenever the director determines that any person:

22.2.b.1.A. Has engaged in, or is engaging in, an act or practice in violation of W.V.C. §16-5C-1 et seq., or any rule or order; or

22.2.b.1.B. When it appears to the director that any person has aided, abetted, or caused, or is aiding, abetting or causing such an act or practice; or

22.2.b.1.C. That no action is being taken under federal regulation or that the action does not adequately protect the residents' health or safety.

22.2.b.2. The director shall impose one (1) or more of the following remedies:

22.2.b.2.A. Civil money penalties;

22.2.b.2.B. Ban on new admissions;

22.2.b.2.C. Reduction of bed capacity;

22.2.b.2.D. Temporary management;

22.2.b.2.E. Closure of the nursing home in emergency situations or transfer of residents, or both.

22.2.b.2.F. License termination;

22.2.c. A nursing home may not avoid cited deficiencies or enforcement actions because it has undergone a change of ownership.

22.3. Immediate Jeopardy or Repeat Deficiency. The director may enforce this rule, administratively or in court, without first affording an opportunity to correct a deficiency when the director finds either of the following:

22.3.a. Violation of this rule places the health or safety of a resident in immediate jeopardy; or

22.3.b. The violation is a repeat deficiency which has caused harm to a resident.

22.4. ~~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 this rule to take any of the following actions:

22.4.a. Institute or continue a disciplinary proceeding;

22.4.b. Institute or continue a proceeding for the denial of license application;

22.4.c. Enter an order denying a license application; or

22.4.d. Take any other disciplinary action as provided by state law or rules.

22.5. 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 this rule.

22.3. Procedure for Civil Penalties.

22.3.a. Assessment and application of civil penalties.

22.3.a.1. The director shall assess and apply penalties against the nursing home for violations of this rule in accordance with the provisions W.V.C. §16-5C-1 et seq., and this rule.

22.3.a.2. Upon completion of a report of inspection, the director shall determine what civil money penalties he or she shall assess.

22.4. Notice of Civil Money Penalty. The director shall send to the administrator of the nursing home a certified written notice of intent to impose a civil money penalty including the basis for imposing the civil money penalty. The notice shall include:

22.4.a. The nature of the non-compliance;

22.4.b. The statutory basis for the civil money penalty;

22.4.c. The amount of the civil money penalty;

22.4.d. Any other factors considered when determining the amount of the civil money penalty;

22.4.e. When the civil money penalty is due; and

22.4.f. Instructions for responding to the notice, including a statement of the nursing home's right to a hearing, and the implications of waiving a hearing.

22.5. Amount of Civil Money Penalty.

22.5.a. Civil money penalties assessed against licensed nursing homes may not be less than fifty dollars (\$50) nor more than eight thousand dollars (\$8,000) per deficiency, based on the severity level of each deficiency cited, except as noted in subdivision 22.5.b. et al of this rule with respect to cumulative remedies.

22.5.a.1. The director may not assess a civil money penalty against a nursing home that corrects the violation of the rule within twenty (20) days of receipt of written notice of the violation, unless it is a repeat deficiency or the nursing home is a poor performer when a civil money penalty can be assessed immediately.

22.5.b. Cumulative Remedies. The civil money penalties and remedies provided by W.V.C. §16-5C-15 are cumulative and are in addition to all other penalties and remedies provided by law.

22.5.b.1. For a violation that presents immediate jeopardy to the health, safety or welfare of one (1) or more residents, the director may impose a civil money penalty of not less than three thousand (\$3,000) dollars nor more than eight thousand dollars (\$8,000) per deficiency.

22.5.b.2. For a violation that actually harms one (1) or more residents, the director may impose a civil money penalty of not less than one thousand dollars (\$1,000) nor more than three thousand dollars (\$3,000) per deficiency.

22.5.b.3. For a violation that has the potential to harm one (1) or more residents, the director may impose a civil money penalty of not less than fifty dollars (\$50) nor more than one thousand dollars (\$1,000) per deficiency.

22.5.b.4. Civil Money Penalties for Repeat Deficiencies. For a repeat deficiency, the director may impose a civil money penalty of up to one hundred fifty percent (150%) of the penalties provided in paragraphs 22.5.b.1., 22.5.b.2. and 22.5.b.3. of this rule.

22.5.b.4.A. Any deficiency, for which an acceptable plan of correction has been provided to the director, that is not corrected upon revisit to the nursing home, shall be regarded as a repeat deficiency.

22.5.c. Civil Money Penalty for Not Submitting an Acceptable Plan of Correction. If no plan of correction is submitted as established in this section, the director may assess the nursing home a civil money penalty in the amount of one hundred dollars (\$100) a day unless the nursing home has provided a reasonable explanation for the violation that has been accepted by the director.

22.5.d. Residents, their families or legal representatives, and ombudsmen may also independently pursue violations of this rule in court. Any waiver by a resident or his or her legal representative of the right to commence an action under W.V.C. §16-5C-15, whether oral or in writing, is void as contrary to public policy.

#### 22.6. Civil Money Penalty Procedures after Termination of a License.

22.6.a. In the case of termination of a nursing home license, the director shall send the civil money penalty information after the:

22.6.a.1. Final administrative decision is made;

22.6.a.2. Nursing home has waived its right to a hearing: or

22.6.a.3. Time for requesting a hearing has expired and the director has not received a hearing request from the nursing home.

22.6.b. A civil money penalty payment is due fifteen (15) days after:

22.6.b.1. A final administrative decision;

22.6.b.2. The time period for requesting a hearing has expired;

22.6.b.3. Receipt of the written request to waive a hearing; or

22.6.b.4. The effective date of termination of a license.

22.7. Civil Money Penalty for Notification of Inspection.

22.7.a. The director shall assess a civil money penalty not to exceed two thousand dollars (\$2,000) against any person who notifies, or causes to be notified, a nursing home of the time or date on which an inspection is scheduled to be conducted.

22.8 Interest on Civil Penalties.

22.8.a. The assessments for penalties and for costs of actions taken under W.V.C. §16-5C-1 et seq., shall accrue interest at the rate of five percent (5%) per annum beginning thirty (30) days after receipt of notice of the assessment or after receipt of the director's final order following a hearing, which ever is later.

22.8.b. All assessments against a nursing home that are unpaid shall be added to the nursing home's licensure fee and may be filed as a lien against the property of the licensees or operators of the nursing home.

22.9. Action for Recovery of Civil Penalties.

22.9.a. The director shall, in a civil judicial proceeding, recover any unpaid civil money penalty that has not been contested under W.V.C. §16-5C-12 within thirty (30) days of receipt of the director's final order, or that has been affirmed on judicial review, as provided in W.V.C §16-5C-13.

22.9.a.1. All money collected by assessments of civil penalties or interest shall be paid into a special resident benefit account and shall be applied by the director for:

22.9.a.1.A. The protection of the health or property of the nursing home's residents;

22.9.a.1.B. Long-term care educational activities;

22.9.a.1.C. The costs arising from the relocation of residents to other facilities when no other funds are available;

22.9.a.1.D. In an emergency situation when no other funds available, the operation of the nursing home pending correction of deficiencies or closure; and

22.9.a.1.E. The reimbursement of residents for personal funds lost.

22.9.b. Hearing and Due Process for a Civil Money Penalty.

22.9.b.1. A nursing home shall, within sixty (60) days from receipt of the notice of an initial, reconsidered, or revised determination of the director, submit any request for a hearing on the determination of the non-compliance that is the basis for imposition of the civil money penalty. For good cause shown, a hearing examiner may extend the time for filing the request for hearing.

22.9.b.2. If a nursing home requests a hearing within the time specified in this rule, the director shall collect the civil money penalty within fifteen (15) days of a final adjudication that upholds the director's determination of non-compliance.

22.9.b.3. If a nursing home waives its right to a hearing in accordance with this rule, the director shall collect the civil money penalty within seventy-five (75) days of the notice of determination of the director.

22.9.b.4. If the nursing home waives its right to a hearing, the director shall reduce the civil money penalty by thirty-five percent (35%).

22.9.c. If CMS or the state medicaid agency assesses a civil money penalty for the same deficiency, the director shall reduce any state civil money penalty by the amount of the federal civil money penalty in calculating the amount owed.

22.10. Immediate Jeopardy. If there is immediate jeopardy to the residents' health, safety, welfare or rights the director may petition the circuit court, and the circuit court may issue an order to:

22.10.a. Appoint temporary management to oversee the operation of the nursing home and to assure the health, safety, welfare and rights of the nursing home's residents;

22.10.b. Transfer the residents in the nursing home to other nursing homes; or

22.10.c. Close the nursing home.

22.11. Ban on New Admissions and Reduction in Licensed Bed Capacity.

22.11.a. The director may by order place a ban on new admissions, reduce the licensed bed capacity of a nursing home, or both, when on the basis of inspection he or she makes the following findings:

22.11.a.1. The licensee is not providing adequate care under the nursing home's existing bed capacity; and

22.11.a.2. A reduction in licensed bed capacity or a ban on new admissions, or both, would place the nursing home in a position to render adequate care.

22.11.b. A reduction in licensed bed capacity or a ban on new admissions, or both, will remain in effect until the director determines the nursing home is in substantial compliance with this rule.

22.11.c. If the residents of the nursing home are in immediate jeopardy regarding their health, safety, welfare or rights, the director may seek an order to transfer residents out of the nursing home as provided for in subsection 22.10. of this rule.

22.11.d. Any notice to a licensee of reduction in licensed bed capacity or a ban on new admissions shall include the terms of the order, the reasons for the order and a date set for compliance.

22.12. Temporary Management.

22.12.a. Upon petition of the director, a circuit court may divest the licensee or operator of a nursing home of possession and control of a nursing home and appoint temporary management.

22.12.a.1. The temporary management is responsible to the court and has any powers and duties granted by the court to direct all acts necessary or appropriate to conserve the property and promote the health, safety, welfare and rights of the residents of the nursing home.

22.12.a.2. These powers include, but are not limited to, the replacement of management and staff, the hiring of consultants, the making of any necessary expenditures to close the nursing home or to repair or improve the nursing home to return it to compliance with applicable requirements and the power to receive, conserve, and expend funds, including payments on behalf of the licensee or operator of the nursing home.

22.12.a.3. The temporary management shall give priority to expenditures for current direct resident care or the transfer of residents.

22.12.b. The person charged with temporary management shall be an officer of the court, is not liable for conditions at the nursing home that existed or originated prior to his or her appointment, and is not personally liable, except for his or her own gross negligence and intentional acts for situations that result in injuries to persons or damage to property at the nursing home during the temporary management.

22.12.c. No person shall impede the operation of the temporary management.

22.12.c.1 There shall be an automatic stay for a ninety (90) day period subsequent to the establishment of a temporary management of any action that would interfere with the functioning of the nursing home, including, but not limited to, cancellation of insurance policies, termination of utility services, attachments to working capital costs, foreclosures, evictions and repossessions of equipment used in the nursing home.

22.12.d. The temporary management established for the purpose of making improvements to bring a nursing home into compliance with applicable requirements shall not be terminated until the court has determined that the nursing home has the management capability to ensure continued compliance with all applicable requirements.

22.12.d.1 If the court has not made the determination within six (6) months of the establishment of the temporary management, the temporary management terminates by operation of law at that time, and the nursing home shall be closed.

22.12.d.2. After the termination of the temporary management, the person who was responsible for the temporary management shall make an accounting to the court.

22.12.d.2.A. This accounting will be based on receipts and shall consist of the deduction of the cost of temporary management, expenditures and civil penalties and interest no longer subject to appeal in that order; and

22.12.d.2.B. The nursing home shall pay any excess to the licensee or operator of the nursing home.

22.12.e. The temporary manager shall bill the nursing home on a bi-weekly basis and the nursing home shall pay any amounts due within fifteen (15) days.

22.12.e.1. The amount paid to the temporary manager for a thirty (30) day period may not exceed the seventy-fifth percentile (75%) of the allowable administrators' salary reported on the most recent cost report for the nursing home's peer group as determined by the director.

22.13. Revocation or Suspension of License.

22.13.a. If the director suspends a nursing home's license, he or she shall also specify the conditions giving rise to the suspension that are to be corrected by the licensee during the period of suspension to entitle the licensee to apply for reinstatement of his or her license.

22.13.a.1. If the director revokes a license, he or she may stay the effective date of the revocation by not more than ninety (90) days upon a showing that the stay is necessary to assure appropriate placement of residents.

22.13.b. The director's order is final unless vacated or modified by court order.

22.14. Formal Hearings and Due Process for Actions of Enforcement.

22.14.a. A nursing home may request a formal hearing and seek judicial review pursuant to W.V.C. §§16-5C-12 and 13 to contest the deficiencies issued by the director, irrespective of whether the deficiency results in the imposition of civil money penalty.

22.14.b. All formal hearings shall be conducted in accordance with W.V.C. §§29A-4-1 et seq. and 29A-5-1 et seq. and West Virginia department of health and human resources legislative rules, rules of procedure for contested cases, 64CSR1.

22.14.c. An applicant for a license or a licensee or any other person aggrieved by an order or other action by the director pursuant to this rule or to W.V.C. §16-5C-1 et seq., shall have the opportunity for a formal hearing by the director, upon written request to the director in a manner prescribed in West Virginia department of health and human resources administrative rules, rules of procedure for contested case hearings and declaratory ruling, 64CSR1.

§64-13-23. Deemed Status.

23.1. Approval Process.

23.1.a. Upon approval of deemed status for a nursing home certified for participation in medicare and/or medicaid by the CMS, the director shall accept accreditation by the joint commission on the accreditation of healthcare organizations (JCAHO) or any other CMS approved accrediting organization with standards and inspection process comparable to W.V.C. §16-5C-1, et seq., and the regulations and rules duly promulgated thereunder, as evidence that the nursing home demonstrates compliance with or meets all licensing requirements. The director shall not perform a licensing inspection if the following criteria are met:

23.1.a.1. A nursing home's administrator sends the director a copy of the organization's official accreditation report within thirty (30) days of the nursing home's notification of accreditation; and

23.1.a.2. Quality of care measures are identified and assured as required by W.V.C. §16-5C-9a(c).

23.2. Responsibilities of the Director.

23.2.a. The director may use this report in lieu of one (1) regular nursing home licensure inspection.

23.2.b. The director shall make any inspections and investigations as he or she considers necessary, investigate complaints, perform follow up activities on adverse accreditation findings, conduct periodic validation inspections, and perform any CMS mandated tasks.

23.2.c. Pursuant to W.V.C. §16-5C-9a(d), the director may revoke the nursing home's exemption from state licensing inspections upon substantiation of a complaint.

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
*3 to 10	48	6	24	3	136	379	47	204	26
*11 to 20	56	7	32	4	137	382	48	206	26
*21 to 30	72	9	48	6	138	385	48	207	26
*31 to 40	96	12	56	7	139	388	48	209	26
*41 to 50	128	16	72	9	140	391	49	210	26
*51	142	18	77	10	141	393	49	212	26
*52	145	18	78	10	142	396	50	213	27
*53	148	18	80	10	143	399	50	215	27
*54	151	19	81	10	144	402	50	216	27
*55	153	19	83	10	145	405	51	218	27
*56	156	20	84	11	146	407	51	219	27
*57	159	20	86	11	147	410	51	221	28
*58	162	20	87	11	148	413	52	222	28
*59	165	21	89	11	149	416	52	224	28

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
*60	167	21	90	11	150	419	52	225	28
61	170	21	92	11	151	421	53	227	28
62	173	22	93	12	152	424	53	228	29
63	176	22	95	12	153	427	53	230	29
64	179	22	96	12	154	430	54	231	29
65	181	23	98	12	155	432	54	233	29
66	184	23	99	12	156	435	54	234	29
67	187	23	101	13	157	438	55	236	29
68	190	24	102	13	158	441	55	237	30
69	193	24	104	13	159	444	55	239	30
70	195	24	105	13	160	446	56	240	30
71	198	25	107	13	161	449	56	242	30
72	201	25	108	14	162	452	56	243	30
73	204	25	110	14	163	455	57	245	31

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
74	206	26	111	14	164	458	57	246	31
75	209	26	113	14	165	460	58	248	31
76	212	27	114	14	166	463	58	249	31
77	215	27	116	14	167	466	58	251	31
78	218	27	117	15	168	469	59	252	32
79	220	28	119	15	169	472	59	254	32
80	223	28	120	15	170	474	59	255	32
81	226	28	122	15	171	477	60	257	32
82	229	29	123	15	172	480	60	258	32
83	232	29	125	16	173	483	60	260	32
84	234	29	126	16	174	485	61	261	33
85	237	30	128	16	175	488	61	263	33
86	240	30	129	16	176	491	61	264	33
87	243	30	131	16	177	494	62	266	33

TABLE 64-13A

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
88	246	31	132	17	178	497	62	267	33
89	248	31	134	17	179	499	62	269	34
90	251	31	135	17	180	502	63	270	34
91	254	32	137	17	181	505	63	272	34
92	257	32	138	17	182	508	63	273	34
93	259	32	140	17	183	511	64	275	34
94	262	33	141	18	184	513	64	276	35
95	265	33	143	18	185	516	65	278	35
96	268	33	144	18	186	519	65	279	35
97	271	34	146	18	187	522	65	281	35
98	273	34	147	18	188	525	66	282	35
99	276	35	149	19	189	527	66	284	35
100	279	35	150	19	190	530	66	285	36
101	282	35	152	19	191	533	67	287	36

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
102	285	36	153	19	192	536	67	288	36
103	287	36	155	19	193	538	67	290	36
104	290	36	156	20	194	541	68	291	36
105	293	37	158	20	195	544	68	293	37
106	296	37	159	20	196	547	68	294	37
107	299	37	161	20	197	550	69	296	37
108	301	38	162	20	198	552	69	297	37
109	304	38	164	20	199	555	69	299	37
110	307	38	165	21	200	558	70	300	38
111	310	39	167	21	201	561	70	302	38
112	312	39	168	21	202	564	70	303	38
113	315	39	170	21	203	566	71	305	38
114	318	40	171	21	204	569	71	306	38
115	321	40	173	22	205	572	71	308	38

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day

(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
116	324	40	174	22	206	575	72	309	39
117	326	41	176	22	207	578	72	311	39
118	329	41	177	22	208	580	73	312	39
119	332	42	179	22	209	583	73	314	39
120	335	42	180	23	210	586	73	315	39
121	338	42	182	23	211	589	74	317	40
122	340	43	183	23	212	591	74	318	40
123	343	43	185	23	213	594	74	320	40
124	346	43	186	23	214	597	75	321	40
125	349	44	188	23	215	600	75	323	40
126	352	44	189	24	216	603	75	324	41
127	354	44	191	24	217	605	76	326	41
128	357	45	192	24	218	608	76	327	41
129	360	45	194	24	219	611	76	329	41

**TABLE 64-13A**

Minimum Ratios of Nursing Personnel to Residents Per Day  
(Note: Nurse Aide Hours are a Subset of the Total Hours of Nursing Personnel Per Day)

Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day	Resident Census	Total Hours of Nursing Personnel Per Day	Total Number of Nursing Personnel Per Day	Total Hours of Nurse Aides Per Day	Total Number of Nurse Aides Per Day
130	363	45	195	24	220	614	77	330	41
131	365	46	197	25	221	617	77	332	41
132	368	46	198	25	222	619	77	333	42
133	371	46	200	25	223	622	78	335	42
134	374	47	201	25	224	625	78	336	42
135	377	47	203	25	225	628	78	338	42

\*When the resident census is 60 and less, the total hours of nursing personnel may include the hours of the director of nurse.

The numbers of personnel per day are full-time personnel equivalents based on forty (40) hours per week.

**TABLE 64-13B**

## Surety Bond Schedule

Average Resident Funds Monthly Balance	Required Surety Bond Amount
\$1 to \$2,000	\$2,500
\$2,001 to \$2,100	\$2,625
\$2,101 to \$2,200	\$2,750
\$2,201 to \$2,300	\$2,875
\$2,301 to \$2,400	\$3,000
\$2,401 to \$2,500	\$3,125
\$2,501 to \$2,600	\$3,250
\$2,601 to \$2,700	\$3,375
\$2,701 to \$2,800	\$3,500
\$2,801 to \$2,900	\$3,625
\$2,901 to \$3,000	\$3,750
\$3,001 to \$3,100	\$3,875
\$3,101 to \$3,200	\$4,000
\$3,201 to \$3,300	\$4,125
\$3,301 to \$3,400	\$4,250
\$3,401 to \$3,500	\$4,375
\$3,501 to \$3,600	\$4,500

**TABLE 64-13B**

## Surety Bond Schedule

Average Resident Funds Monthly Balance	Required Surety Bond Amount
\$3,601 to \$3,700	\$4,625
\$3,701 to \$3,800	\$4,750
\$3,801 to \$3,900	\$4,875
\$3,901 to \$4,000	\$5,000
\$4,001 to \$4,100	\$5,125
\$4,101 to \$4,200	\$5,250
\$4,201 to \$4,300	\$5,375
\$4,301 to \$4,400	\$5,500
\$4,401 to \$4,500	\$5,625
\$4,501 to \$4,600	\$5,750
\$4,601 to \$4,700	\$5,875
\$4,701 to \$4,800	\$6,000
\$4,801 to \$4,900	\$6,125
\$4,901 to \$5,000	\$6,250
\$5,001 to \$5,100	\$6,375
\$5,101 to \$5,200	\$6,500
\$5,201 to \$5,300	\$6,625

**TABLE 64-13B**

## Surety Bond Schedule

Average Resident Funds Monthly Balance	Required Surety Bond Amount
\$5,301 to \$5,400	\$6,750
\$5,401 to \$5,500	\$6,875
\$5,501 to \$5,600	\$7,000
\$5,601 to \$5,700	\$7,125
\$5,701 to \$5,800	\$7,250
\$5,801 to \$5,900	\$7,375
\$5,901 to \$6,000	\$7,500
\$6,001 to \$6,100	\$7,625
\$6,101 to \$6,200	\$7,750
\$6,201 to \$6,300	\$7,875
\$6,301 to \$6,400	\$8,000
\$6,401 to \$6,500	\$8,125
\$6,501 to \$6,600	\$8,250
\$6,601 to \$6,700	\$8,375
\$6,701 to \$6,800	\$8,500
\$6,801 to \$6,900	\$8,625
\$6,901 to \$7,000	\$8,750

**TABLE 64-13B**

## Surety Bond Schedule

Average Resident Funds Monthly Balance	Required Surety Bond Amount
\$7,001 to \$7,100	\$8,875
\$7,101 to \$7,200	\$9,000
\$7,201 to \$7,300	\$9,125
\$7,301 to \$7,400	\$9,250
\$7,401 to \$7,500	\$9,375
\$7,501 to \$7,600	\$9,500
\$7,601 to \$7,700	\$9,625
\$7,701 to \$7,800	\$9,750
\$7,801 to \$7,900	\$9,875
\$7,901 to \$8,000	\$10,000
\$8,001 to \$8,100	\$10,125
\$8,101 to \$8,200	\$10,250
\$8,201 to \$8,300	\$10,375
\$8,301 to \$8,400	\$10,500
\$8,401 to \$8,500	\$10,625
\$8,501 to \$8,600	\$10,750
\$8,601 to \$8,700	\$10,875

**TABLE 64-13B**

## Surety Bond Schedule

Average Resident Funds Monthly Balance	Required Surety Bond Amount
\$8,701 to \$8,800	\$11,000
\$8,801 to \$8,900	\$11,125
\$8,901 to \$9,000	\$11,250
\$9,001 to \$9,100	\$11,375
\$9,101 to \$9,200	\$11,500
\$9,201 to \$9,300	\$11,625
\$9,301 to \$9,400	\$11,750
\$9,401 to \$9,500	\$11,875
\$9,501 to \$9,600	\$12,000
\$9,601 to \$9,700	\$12,125
\$9,701 to \$9,800	\$12,250
\$9,801 to \$9,900	\$12,375
\$9,901 to \$10,000	\$12,500
\$10,001 or more	Calculate <sup>1</sup>

<sup>1</sup> 1.25 times the prior year's average monthly balance of client's funds