Policy and Procedures
YOUR COMPANY NAME HERE

POLICY & PROCEDURES
Your Company Name Here

Policy Title: Infection Control/Respiratory Protection
Responsible Parties: All Staff

Definitions:
Respiratory symptoms – means coughing, shortness of breath, or with acute onset, not known to be caused by asthma, allergies, or another chronic disease.

Communicable Disease – means an illness caused by an agent or its toxic products that arises through the transmission of that agent or its products to a susceptible host, either directly or indirectly

Policy:

During times of heightened disease prevention controls mandated by the Governor, The Arizona Department of Health Services or other governing agency, Your Company Name Here will implement a disease prevention and control protocol to minimize the transmission of infectious diseases in our Facility. This protocol will include heightened monitoring of Residents and a response for Residents exhibiting symptoms of possible infectious disease. This Infection Control protocol will promote rapid detection, educate the Facility Staff on Airborne Precautions and Treatment(s) of Respiratory Symptoms.

Procedure
1. The Manager of Your Company Name Here. will direct Facility Staff to continuously monitor and assess Residents for signs and symptoms of possible Respiratory Symptoms or other Infectious/Communicable Disease.

1. Facility Staff will check the Resident's temperature on a daily basis and as needed.

1. Facility Staff will continuously monitor Residents for Respiratory symptoms.

1. If a Resident is identified as having a fever of 100 degrees or greater; or exhibiting Respiratory symptoms, The Manager will coordinate an evaluation by a Medical Practitioner to occur as soon as possible to determine what services need to be provided to the Resident and what precautions need to be taken by the Facility. The evaluation will be documented in the Resident's medical record.

1. When a Resident is exhibiting Respiratory symptoms or other potential Infectious/Communicable Disease, Facility Staff will implement the following protocols to minimize potential transmission;

The Administrative Staff will form a plan to keep the infected Resident (fever greater than 100 degrees or cough) in quarantine to the best of the Facility Staff's ability, minimizing the area(s) of exposure.
Facility Staff and support personnel will be educated on Airborne Precautions and then implement these precautions while providing services to the Resident. These services may include the use of gloves and a face mask and other Personal Protective Equipment deemed necessary depending on the severity of the Resident's illness.

.i. In some circumstances, Respiratory Protective Equipment may become necessary when providing services to the Resident to minimize the Facility Staff's exposure. Should the need arise the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health (NIOSH) has provided a list that can be used for protection against Respiratory Infections, such as M. tuberculosis, they are found below;
    - .i.1. Non-powered respirators with N95, N99, N100, R95, R100, R95, P95, P99, and P100 filters (including disposable respirators); and
    - .i.2. Powered air-purifying respirators (PAPRs) with high-efficiency filters.
    - .i.3. Facial sizing is the most important part of wearing a respirator.

.ii. The Facility Manager will train and fit test all Facility Staff and any support personnel or necessary Visitors on the proper use of a respirator prior to entering any of our Facilities.

Upon completion of providing services to a Resident, Facility Staff and support personnel will remove and, if applicable, dispose of the Personal Protective Equipment in the infectious waste container. Facility Staff and support personnel will then immediately wash their hands with soap and water for at least 20 seconds. If soap and water are not available hand sanitizer containing between 70% and 95% alcohol can be used. Hand washing or hand sanitizer MUST be used PRIOR to and AFTER providing services to any Resident. Hand washing MUST also be performed by anyone visiting the Facility.
Linens, dishes, utensils, and other items used by the Resident must be kept separate from similar items used by a Resident who does not have a fever or Respiratory symptoms indicative of an Infectious/Communicable disease. Linens, dishes, utensils, and other items used by the Resident must be disinfected or disposable dishes and utensils will be used and placed in the infectious waste collection container.

6. When a Resident is being admitted to the Facility, readmitted, begins to exhibit Respiratory Symptoms, Facility Staff will implement the following protocols to minimize potential transmission;

Residents that are not exhibiting signs of Respiratory illness must still have their temperature taken prior to entering the Facility.
If the Resident's temperature is normal and they have no Respiratory Symptoms they are free to move about the Facility.
If the Resident's temperature is 100 degrees or higher upon admission or readmission to the Facility and/or they are exhibiting Respiratory Symptoms they should immediately be quarantined. The Resident's Medical Practitioner will be notified and CDC, StateDHS and COUNTY Health regulations will be implemented and followed.

7. If Facility Staff are unable, sufficient staffing available, or if an insufficient amount of Personal Protective Equipment is available to meet the needs of all the Residents in the Facility:
The Assisted Living Manager will implement the Disaster Plan. The implementation of the Disaster Plan may include the relocation of a Resident to a different Your Company Name Here Facility.
If all other Your Company Name Here Facilities are full or unable to meet the scheduled and/or unscheduled needs of the Resident(s) they will be transferred to a higher level of care.
Attachments; TB Elimination CDC Tuberculosis CEU

POLICY & PROCEDURES
Your Company Name Here

Policy Title: Duty of Care (CPR, First Aid, Immunity, Falls)
Title 36, chapter 4, article 1.
Responsible Parties: All Staff

Policy: Regarding Affirmative Duty to render CPR and First Aid to Residents.

Procedure:
A. Your Company Name Here and its Staff, have an affirmative duty of care for our Residents as described in subsection B.

B. Your Company Name Here and it's Staff, in accordance with a Residents' Advance Directives (if known):

1. Shall initiate CPR, prior to the arrival of emergency personnel, to a Resident who is unresponsive or has a cessation of normal respiration. CPR Certified Staff shall be available at all times.
2. Shall provide appropriate First Aid before the arrival of emergency medical personnel, to a Resident who is in distress and to an uninjured Resident who has fallen, appears to be uninjured and is unable to reasonably recover independently.
3. Will not establish, nor implement policies that prevent employees from providing appropriate and immediate CPR and/or First Aid.

C. It is understood that Your Company Name Here and it's Staff, who in good faith render First Aid to a person who has fallen, will not be liable for any civil penalties (unless acting with gross negligence), if the Staff member rendering aid acted under any of the following circumstances:

1. Acted under the direction of an emergency dispatch operator.
2. Acted to prevent further imminent and serious injury to a fallen person.
3. The fallen person appeared to be uninjured, stated that they were not injured and requested assistance.

D. Your Company Name Here will develop and maintain a Training Program for all Staff regarding Fall Prevention and Fall Recovery.

1. Training Program shall include initial training and continued competency training in Fall Prevention and Fall Recovery per the training materials provided by the ADHS "Arizona Falls Prevention Coalition".

Policy Reference: R9-10-803

Definition(s):

<u>Vulnerable Adult</u>: Anyone eighteen (18) years of age or older who is unable to protect him or herself from abuse, neglect, or exploitation by others due to a mental or physical impairment. (A.R.S. §~ 13-3623; 46-451)

Abuse: Intentional infliction of physical harm, any injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault. It includes the impairment of physical condition as evidenced by skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition that imperils health or welfare. (A.R.S. §~ 13-3623; 46-451)

Neglect: A pattern of conduct, without the person's permission, resulting in deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating, or other services necessary to maintain a vulnerable adult's minimum physical or mental health. (A.R.S. §~ 13-3623; 46-451)

Exploitation: The illegal or improper use of a vulnerable adult or a vulnerable adult's resources for another's profit or advantage. (A.R.S. §~ 13-3623; 46-451)

Purpose:

All Your Company Name Here Residents will be afforded protection against abuse, neglect and exploitation. All Facility Staff, including Volunteers, will be the Residents' advocates in promoting the Residents' safety and well being.

Policy:

Your Company Name Here is committed to providing an environment free of abuse, neglect and exploitation. However, if an act is alleged or suspected, the Manager and/or Governing Authority will take immediate action to stop the alleged abuse, neglect or exploitation. An investigation and report will follow.

Procedure:

If abuse, neglect or exploitation of a Resident is alleged or suspected to have occurred before the Resident was accepted or while the Resident is not on the premises and not receiving services from the Facility Staff, the Manager or Governing Authority shall immediately report the alleged behavior(s) according to (ARS § 13-3623; 46-454).

If abuse, neglect or exploitation of a Resident is alleged or suspected to have occurred on the premises or while the Resident is receiving services from the Facility Staff, the Manager or Governing Authority shall:

- Take immediate action to stop the alleged or suspected abuse, neglect or exploitation (if applicable)

- Report the alleged or suspected abuse, neglect or exploitation of the Resident according to (ARS § 46-454)
- Document the action in subsection (1) and the report in subsection (2) and maintain the documentation for 12 months after the date of the report;
- Investigate the alleged or suspected abuse, neglect or exploitation and develop a written report of the investigation within five working days after the report required in subsection (2) that includes:

    - Dates, times, and description of the alleged or suspected abuse, neglect or exploitation;
    - A description of any injury to the Resident and any change to the Resident's physical, cognitive, functional or emotional condition;
    - The names of witnesses to the alleged or suspected abuse, neglect, or exploitation; and
    - The actions taken by the Manager/Governing Authority to prevent the alleged or suspected abuse, neglect or exploitation from occurring in the future.

- Submit a copy of the investigative report required in subsection (4) to StateDHS within 5 working days after submitting the report in subsection (2); and
- Maintain a copy of the investigative report required in subsection (4) for 12 months after the date of the investigative report.

Reporting:

Manager shall provide written notification to StateDHS:

- If a Resident's death is required to be reported according to (ARS §36-301; 11-593), within one working day after the Resident's death; and

- Within two working days after a Resident inflicts a self-injury that requires immediate intervention by an emergency services provider.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Activity Programming**
Responsible Persons: **Certified Caregivers/Manager**

Policy Reference: **R9-10-808**

Policy:

A daily program of social, recreational or rehabilitative activities will be provided for any Resident wishing to participate. The activities provided will be planned based on the needs, abilities, and preferences of each Resident.

All Residents are encouraged to attend activities and participate in the planning process if applicable.

The Activity Calendar will be posted at least one (1) week in advance and posted in a location that is easily seen by the Residents.

Changes are updated as necessary to reflect substitutions in the activities provided. The changes will be shown by a single line through the replaced activity and the actual activity performed/provided will be handwritten in its place.

Prior months' calendars, including any changes, will be retained on file for at least twelve (12) months after the last scheduled activity.

Sufficient equipment and supplies are maintained and accessible (unless it presents a potential safety concern) to accommodate a Resident who chooses to participate in a planned activity.

Multiple media sources, such as daily newspapers, current magStateines, internet sources and a variety of reading materials, are available and accessible to a Resident to maintain the Resident's continued awareness of current news, social events and other noteworthy information.

Your Company Name Here. will make available a broadcast of an evening news program to help maintain the Resident's continued awareness of the current news, this will be listed on our activities calendar daily. Also, a variety of current magStateines will be maintained for our Residents to maintain current news, social events and other noteworthy information.

Policy Statement: **All Your Company Name Here Facilities shall follow the CDC, StateDHS and Maricopa County Public Health Guidelines. For the most recent guidelines please visit;**

www.cdc.gov , www.Statedhs.gov , www.maricopa.gov

Procedure:

1. Upon admission/readmission if the Resident exhibits COVID-19 symptoms they will be quarantined to their room and evaluated by their medical practitioner within 24 hours to determine what precautions need to continue to be kept in place. Appropriate PPE and staffing will be provided to promote the health and safety of the Resident(s).

2. Quarantine is no longer recommended for Residents who are being admitted or readmitted if they are fully vaccinated and have not had an exposure to someone with COVID-19, including residing in a facility with a COVID-19 outbreak, in the previous 14 days.

3. Previously infected Residents (that are not fully vaccinated) with an exposure to someone with COVID-19 do not need to be quarantined if they meet ALL of the following criteria:

- **Exposure is within 3 months of symptom onset of their initial illness or since specimen collection (if asymptomatic) of the first positive COVID-19 PCR/antigen test; AND**
- **HAVE met criteria to end isolation; AND**
- **Remain asymptomatic**

4. However, if a previously infected Resident (that is not fully vaccinated) is identified as contact of a case 3 months or more after symptoms onset or since specimen collection (if asymptomatic) of the first positive COVID-19 PCR/antigen test, they should follow quarantine recommendation for healthcare settings.

5. Group Activities:

- **If all Residents participating in the activity are fully vaccinated, they may choose to have close contact and should be encouraged to wear a face mask (when safe).**
- **If unvaccinated Residents are participating then all parties in the group activity should be encouraged to wear a face mask (when safe) and unvaccinated Residents should physically distance themselves from others.**

6. Communal Dining:

- **Fully vaccinated Residents can participate in communal dining without the use of a face mask or physical descanting.**

- **If unvaccinated Residents are dining in a communal area (e.g. dining room) all Residents should be encouraged to wear a face mask (when safe) when not eating and unvaccinated Residents should continue to remain, at least, six feet from others.**

Policy Title: Adult Protective Service Registry

Responsible Parties: Administration

Policy: Your Company Name Here. will establish and maintain guidelines that are in compliance with the APS Public Registry. This Registry contains the names and dates of birth of the persons determined to have abused, neglected or exploited vulnerable adults and the description of the allegations made. All Caregivers will have their personal information inputted into the APS Registry to determine their employment status.

Procedure:

Your Company Name Here. outlines those guidelines as follows;

- Within one week of the Caregiver's hire date their personal information will be entered into the APS Registry.
- The results of the APS Registry will be printed, if possible, and maintained in their employee file.
- Should the results be unavailable to print, a notation will be made on the copy of their fingerprint card showing the outcome, date, and Administrative Staff's initials.
- The date the APS Registry was checked will be entered on the employee file coversheet.
- The APS Registry will be checked annually for each Caregiver and a new printout will be placed in their employee file. All old forms will be removed and archived.
- Should the APS Registry results determine that the Caregiver does have current allegations, they will be removed immediately from the schedule and placed on Administrative Leave pending investigation.
- Termination is probable if allegations are found.

Policy Title: Adult Protective Service Registry

Responsible Parties: Administration

Policy: Your Company Name Here. will establish and maintain guidelines that are in compliance with the APS Public Registry. This Registry contains the names and dates of birth of the persons determined to have abused, neglected or exploited vulnerable adults and the description of the allegations made. All Caregivers will have their personal information inputted into the APS Registry to determine their employment status.

Procedure:

Your Company Name Here. outlines those guidelines as follows;

Within one week of the Caregiver's hire date their personal information will be entered into the APS Registry.
The results of the APS Registry will be printed, if possible, and maintained in their employee file.
Should the results be unavailable to print, a notation will be made on the copy of their fingerprint card showing the outcome, date, and Administrative Staff's initials.
The date the APS Registry was checked will be entered on the employee file cover sheet.
The APS Registry will be checked annually for each Caregiver and a new printout will be placed in their employee file. All old forms will be removed and archived.
Should the APS Registry results determine that the Caregiver does have current allegations, they will be removed immediately from the schedule and placed on Administrative Leave pending investigation.
Termination is probable if allegations are found.

Your Company Name Here.
Caregiver Skills Assessment
R9-10-806 Personnel

Name: _____ House:_____

Date of Hire:_____ Position:_____

□ Qualified to provide services

□ Qualified to meet needs

□ Qualified to ensure health & safety

□ Orientation completed documenting skills performed

□ Copy of Approved & Valid Caregiver Certificate indicating education received

□ 2 Professional References verifying experience to apply to job duties

□ Policy & Procedure manual made available indicating
In-service education hours/dates

Signature of Manager:_____

Signature of Governing Authority_____

Policy Topic: **Contracted Services**
Responsible Persons: **Governing Authority/Manager/Maintenance Supervisor**

Procedures:

1. If a contracted service should be needed by the Facility, the Governing Authority/Manager/Maintenance Supervisor shall initiate a call to the service provider. At that time, current and correct information will be gathered.

2. Information to be gathered:
   a. Name of contracted service provider
   b. Place of business
   c. Telephone number
   d. Description of services

3. This list will be updated as necessary to ensure accuracy. However, it is very seldom that the Governing Authority contracts with outside services. Your Company Name Here. maintains all of it's own properties by providing landscaping and Facility maintenance.

Policy Topic: **Contracted Services List**
Responsible Persons: **Governing Authority**

1. Bill's Termite & Pest Control
   248020 North 16th Avenue
   Unit 130
   Phoenix, State 85085
   602-308-4510 (Office)

   * Company provides general pest control as well as specialty services such as termite and bed bug treatment, if necessary.

Fill with your billed services in above format, asterisks used for description of services

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Cardiopulmonary Resuscitation Training**
Responsible Persons: **All Personnel**

Policy reference: **R9-10-803**

Policy:
Your Company Name Here. accepts and recognizes Cardiopulmonary Resuscitation training issued by the following accredited organizations; American Red Cross, American Heart Association or National Safety Council. Your Company Name Here. may also accept Cardiopulmonary Resuscitation training issued by other comparable accredited organizations that offer equivalent training programs. The training must be specific to Adult Cardiopulmonary Resuscitation. All Facility Staff will be required to show proof of current and valid Cardiopulmonary Resuscitation. All accredited organizations are required to have every individual demonstrate knowledge and skills objectives prior to passing them and administering valid certification. The training that is received will include:

a. The method and content of CPR training, which includes a demonstration of the employee's or volunteer's ability to perform CPR.
b. The qualifications for an individual to provide CPR training.
c. The documentation that verifies that the employee or volunteer has received CPR training.

Procedure:

1. Prior to being scheduled for a shift or providing services to our Residents, a Facility Staff member must provide Your Company Name Here. with a valid copy of both front and back of their CPR certification. This certification will be maintained in the employee's file, which are stored at our Administrative Office.
2. A master log showing expiration dates for all required information will be maintained at our Administrative Office.

3. No Staff member will be allowed to provide services to our Residents with an expired or invalid CPR certification.

4. CPR certification will be renewed prior to the date of it's expiration.

Policy Title: Adult Protective Service Registry

Responsible Parties: Administration

Policy: Your Company Name Here. will establish and maintain guidelines that are in compliance with the APS public registry that contains the names and dates of birth of the persons determined to have abused, neglected or exploited a vulnerable adult and the description of the allegations made. All Caregivers will have their personal information inputted into the APS Registry to determine their employment status.

Procedure:

Your Company Name Here. outlines those guidelines as follows;

Within one week of the Caregiver's hire date their personal information will be entered into the APS Registry.
The results of the APS Registry will be printed, if possible, and maintained in the Employee file.
Should the results be unavailable to print, a notation will be made on the copy of the fingerprint card stating the outcome, date, and Administrative Staff signature.
The date the APS Registry was checked will be entered on the Employee File coversheet.
The APS Registry will be checked annually for each Caregiver and a new printout will be placed in their Employee file. All old forms will be removed and archived.
Should the APS Registry results determine that the Caregiver does have current allegations, they will be removed immediately from the schedule and placed on Administrative Leave pending investigation.
Termination is probable is allegations are found.

Policy Topic: **Disaster Plan**
Responsible Persons: **All Facility Staff**

Policy: If, for any reason, the Facility listed below is deemed uninhabitable, the Residents must be immediately protected from the environmental elements. The Residents, their records and medication will be relocated to one of the locations listed:

From:

Home name
Home Address
City, State Zip-code
Phone Number

To:
Primary Location: **Alternate Location:**

Home name
Home Address
City, State Zip-code
Phone Number

(Additional Alternate locations: Hospice Inpatient Units or Home with Family)

Procedure:

1. Once all the Residents have been evacuated from the immediate threat, the Certified Caregiver/Delegation of Authority on duty will contact the Manager and the Governing Authority notifying them of the disaster. The Manager and/or the Governing Authority will contact the location(s) that will be receiving the Residents and make arrangements for transfer.
   a. Transportation may be provided by the Resident's Representative, family member, hospice agencies, or by a transportation service.
   b. Facility Staff are not permitted to provide transport to any Resident at any time.

2. The Manager and/or the Governing Authority will then make every effort to contact the Resident's Representative, Primary Care Physician and Case Manager (if applicable) informing them of the disaster and the plan for relocation.

3. Once the Resident has been safely relocated, the Manager and/or the Governing Authority will make contact with the Resident's Representative to determine if continued placement in the alternate location is acceptable until all repairs have been made and the Facility is deemed safe. If not, the Manager and/or Governing Authority will make every effort to meet the desires of the Resident and/or Resident's Representative. Whenever

possible, Residents will be placed with their families and/or Resident's Representative until the Facility is deemed safe.

4. Resident records will be acquired immediately upon the Facility being deemed safe to enter. The Manager and/or Governing Authority will transport the records to the alternate location(s). If the physical records cannot be acquired, the Governing Authority will make copies of the backup records which are located at the Administrative Office - Your Main Office Here Road, City, Zip Code (second floor). The copies will be transported to the alternate location(s) and the originals will remain at the Administrative Office.

5. Medications will be acquired immediately upon the Facility being deemed safe to enter.

The Manager and/or Governing Authority will transport the medications, treatments and DME to the alternate location(s). If the medications cannot be retrieved from the Facility within a reasonable time-frame, the Manager and/or Governing Authority will contact the Resident's pharmacy, family or hospice agency to acquire additional medications. Your Company Name Here. has arranged company accounts with several local pharmacies should there be any issues with billing the Resident's insurance.

6. Food, water and shelter will be provided at the alternate location(s), which are fully operational Assisted Living Facilities that function with a minimum of a three day supply of perishable and non-perishable food items. If the alternate location is vacant, the three day supply or food items will be taken from one of the other locations and replenished within 24 hours.

7. Incontinent supplies will be provided at the alternate location(s), which are Assisted Living Facilities that maintain an emergency supply. Additionally, other personal care items are stored at our Administrative Office, should such an event occur. If the alternate location is vacant, the emergency supplies will be taken from one of the other locations and replenished within 24 hours.

8. This Disaster Plan will be reviewed and critiqued every 12 months in conjunction with the entirety of this Policy and Procedure Manual by the Governing Authority, Manager and

a Medical Practitioner. The date and time of the review will be documented in the front of the manual on the Policy & Procedure Manual Review/Policy Update Form.

9. Should any recommendations be made they will be listed below, reviewed and

potentially added to the policy after the Administrative Team discusses the recommendations.

Recommendation/Critique for improvement/changes (if applicable):

Critiqued by Company Owner, House Manager and Licensed Nurse Practitioner recommendations as followed:
The company has added an Emergency Hand Crank Solar Weather Radio to our Disaster Supplies. Otherwise, after critiquing this policy we deem no changes need to be made at this time.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Employee Continuing Education (In-services)**
Responsible Persons: **Facility Staff**

Policy reference: **R9-10-803**

Policy*:*

Your Company Name Here. will assist our Facility Staff in acquiring 14 Continuing Education Units in a 12 month period. We will make available many opportunities for our Facility Staff to earn CEUs, such as reading materials, self study and specialized classes held by our knowledgeable and trained Management and Administrative Team. We will also arrange for outside agencies to provide specialized training when needed. However, it is the responsibility of each Facility Staff member to track and earn their own CEUs each year. The number of CEUs earned will vary depending upon the type of training and or classes attended.

Classes taught by Your Company Name Here. will provide the skills and knowledge to enable the Facility Staff to meet the scheduled and unscheduled needs of our Residents per the Medical Practitioner's direction and our Policies and Procedures.

*In person/hands-on training is subject to change at the Governing Authorities discretion during times of heighten community outbreak.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Employee Orientation**
Responsible Persons: **All Personnel**

Policy reference: **R9-10-803**
Policy:
Your Company Name Here. will ensure that upon hire each Certified Caregiver or Manager will complete an Employee Orientation & Qualification Checklist. This checklist is subject to change as the Governing Authority deems necessary. The Orientation received will include:

1. Residents Needs and Characteristics
2. Philosophy and Goals
3. Residents Rights, Ethical and Legal Issues
4. Policy and Procedure (Manual 2013)
5. Service Plans
6. Infection Control/Standard Precautions
7. Lifting, Transfers and Assisted Ambulation
8. Incontinence, Changing and Peri-care
9. Bathing Frequency and Procedures
10. Calculation and Recording Vitals
11. Proper Charting
12. House Walk-through
13. Resident's Charts
14. Resident Emergencies
15. Internal Facility Requirements
16. Food Service and Serving Times
17. Overview of Dementia, Agitation and Sundowners
18. Abuse, Neglect and Exploitation
19. Resident Reports of Unusual Occurrence
20. Confidentiality
21. Evacuation/Disaster Plan and Fire Safety
22. Staffing Time Off, Scheduling and Time Cards
23. Medication Services Overview
24. Laundry and Linens
25. Grievance Procedure
26. TB Risk Assessment Screening Form
27. COVID - 19 Screening Form
28. Smoking Safety

Procedure:
1. Upon hire a Certified Caregiver/Manager will be given our Orientation Procedure Manual to review.
2. Each Certified Caregiver/Manager must complete the Orientation prior to providing direct care to any of our Residents. Each item reviewed requires the date of

review and both the Facility Staff's initials and the Facility Manager's initials.

3. Once the Checklist is complete it will be maintained in the Facility Staff's file which is located at our Administrative Office.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Equipment Inspection and Maintenance**
Responsible Persons: **Maintenance Supervisor**

Policy Reference: ***R9-10-818***

Policy: All required inspections shall be completed as required by law, and to ensure equipment is in good working order. Copies of the inspection reports will be maintained on the premises as required by law.

The required inspections are:

1. Fire Department — Conducted at least once every thirty-six (36) months by the local fire department or state Fire Marshall.

2. Fire system inspections will be done professionally by a contracted service provider and retained for 36 months:
   3. Fire system - will be professionally inspected annually.
   4. Fire sprinklers will be inspected and tested annually.
   c. Back flow will be inspected and tested annually.

3. Community provided inspections:
   4. Facility smoke detectors tested monthly (retain for 12 months);
   5. Call system in the bedroom and bathrooms, monthly (retain for 12 months);
   6. Emergency lights, monthly (retain for 12 months);
   7. Hot water temperatures tested monthly and maintained between 95º – 120º F (retain for 12 months)
   8. Resident electrical cords and extension cord compliance, monthly.

Policy Topic: **Evacuation Plan**
Responsible Person: **All Personal**

Policy Statements: **When the decision to evacuate the facility is made, do not panic. Exit in a controlled and calm manner through the exit closest to the area you are evacuating. The exiting plan is based upon the labeled floor plan of the facility.**

*** Note: In the event of a small fire, an immediate attempt should be made to put out the fire using the available fire extinguishers. If the fire is not extinguished, proceed with the evacuation plan.**

Procedure:
IN THE EVENT OF A FIRE, OR ANY INCIDENT INVOLVING THE FACILITY THAT PRESENTS A REAL THREAT TO THE HEALTH, SAFETY, OR WELFARE OF THE RESIDENTS:

1. **REMOVE THE RESIDENTS FROM DANGER. When the alarm sounds or a fire is discovered, all Caregivers will quickly identify the locations of each Resident and any visitors. Each Resident and visitor will be instructed on how and where to exit the facility. Residents will be evacuated in the following manner:**
   - **a. Residents who ambulate independently will exit and proceed to the designated meeting area (secured backyard, at least 30 feet from the facility).**
   - **b. Residents requiring assistance with ambulation will be exited with the assistance of the caregivers. They will be assisted to the designated meeting area.**
   - **c. Residents who are having a difficult time ambulating will be placed in a wheelchair or another wheeled chair if available and moved out to the designate meeting area.**
   - **d. Wheelchair Residents will be given full assistance with exiting to the designated meeting area.**
   - **e. If possible without causing yourself harm, remove the Resident records and medications promptly.**

2. **SOUND THE ALARM. As Residents are exiting attempt to call 911. If you are not able to do so send someone to the neighbor's house to call. Call the Governing Authority and Manager as soon as all the Residents their records, and medications are safe.**

3. **CONFINE THE FIRE. Close doors as you exit the rooms. If you are in a room and the door is closed, feel the door with the back of your hand before opening it. If it is hot,**
find another exit (i.e. windows) . A hot door indicates a fire burning on the other side. A door is your barrier for 7 - 10 minutes.

4. **EXTINGUISH THE FIRE. Know the location and operation of all fire extinguishers in the facility. If the fire is not burning out of control use a fire extinguisher. Use your common sense. Remember that a fire extinguisher is meant for a small confined fire. Do nothing to**
cause harm to yourself or your Residents while trying to extinguish the fire.
Grease Fire Cover with Metal Lid
Use a large amount of baking soda
Turn off burner

Electrical Fire NEVER USE WATER
Use CO2 Fire Extinguisher (which all of our facilities carry)
Call 911 immediately!!!

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Staff Complaint regarding Resident Care**
Responsible Persons: **Governing Authority/Manager**

Policy Reference: **R9-10-807**

Policy: It is the policy of Your Company Name Here to provide a method for the staff to report any complaints that they might have in the area of Resident care.

Procedure:

If a staff member has any type of complaint in regard to Resident care, they will proceed as follows:

1. A serious complaint will be reported immediately to the Governing Authority or Manager, after the staff member that made the report is sure that the Resident is in a safe position/condition. The Manager's cellular telephone number is posted in the designate Personnel area. The Manager is available at all times while not on the premises.

2. The reporter should follow up in writing, with details of the complaint, noting all factors or individuals involved.

3. The Governing Authority or Manager will investigate appropriately, taking necessary action to rectify, if the complaint is substantiated.

4. A less serious complaint should be documented in writing and turned into the Governing Authority or Manager.

5. The Governing Authority or Manager will investigate appropriately, taking necessary action to rectify, if the complaint is substantiated.

Policy Topic: **Fingerprinting - Staff Members**
Responsible Persons: **Governing Authority**

Policy Reference: **R9-10-803; ARS § 36-411**

Purpose:
To ensure that every Facility Staff member who meets the ADHS definition of a Certified Caregiver and Supportive Services Staff member has an acceptable fingerprint clearance through Arizona Department of Public Safety.

Policy:
All Facility Staff members providing Direct care and Supportive Services must provide proof that they have a valid Fingerprint Clearance Card conducted by the Arizona Department of Public Safety.

Facility Staff Members who are denied clearance may not continue to work in a Healthcare Setting. If they appeal and are granted clearance, they will be reconsidered.

Copies of all documents pertaining to background checks will be kept in the Facility Staff's personnel file at the Administrative Office, located at Your Main Office Here Road, City.

Procedure:

1. After the application has been processed, the references checked, and the applicant accepted for employment we request a current Fingerprint Clearance Card.

2. At this time, it is acceptable to verify valid and in good standing fingerprints by logging onto the D.P.S. website and printing out the verification form.

3. If the Facility Staff Member does not have proof of the credentials listed in # 1 above, they must complete a form for a D.P.S. fingerprint background check within 10 days of starting work. Processing of the fingerprint forms is handled by Arizona Livescan Fingerprinting. They can be reached at 602.246.3444 to schedule an appointment.
4. Cost of the D.P.S. fingerprint background check will be paid by the applicant via payroll deduction or the cost of the fingerprints can be paid directly to Arizona Livescan when you arrive for your fingerprints to be taken. There are times when Your Company Name Here will cover the cost of fingerprinting and this will be discussed at the time of hire.

5. When the written results of the D.P.S. fingerprint check are returned, a front and back copy of the card will be maintained in the Facility Staff Member's personnel

file.

6. The fingerprint clearance card itself is the personal property of the individual whose name appears on the card. The card will not be withheld from a current or former Facility Staff member.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **First Aid Training**
Responsible Persons: **All Personnel**

Policy reference: **R9-10-803**

Policy:
Your Company Name Here. accepts and recognizes First Aid training issued by an accredited organization; American Red Cross, American Heart Association or National Safety Council. Your Company Name Here. may also accept First Aid training issued by other comparable accredited organizations that offer equivalent training programs. All Facility Staff members will be required to show proof of current and valid First Aid. All accredited organizations are required to have every individual demonstrate knowledge and skills objectives prior to passing them and administering valid cards.

Procedure:

1. Prior to being schedule for a shift or providing services to our Residents, a Certified Caregiver must provide Your Company Name Here. with a valid copy of both front and back or their First Aid certification. This certification will be maintained in the employee's file at our Administrative Office

2. A master log showing expiration dates for all required information will be maintained at our Administrative Office.

3. No employee will be allowed to provide services to our Residents with an expired or invalid First Aid certification.

4. First Aid certification will be renewed prior to the date of it's expiration.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Food Service**
Responsible Persons: **Certified Caregiver/Manager**

Policy Reference: **R9-10-817**

Policy Statement: **Your Company Name Here. will ask each Resident upon admission for food items that they enjoy or dislike to help them adjust to their new environment. We shall continue to accommodate requests when applicable. Additionally, it shall be the policy of Your Company Name Here that:**

1. The Food Menu:

   Will be prepared at least one week in advance, and is maintained for at least 60 calendar days after the last day included in the food menu;
   Includes the foods to be served each day.
   Is conspicuously posted at least one day before the first meal on the food
   menu is served.
   Includes a food substitution no later than the morning of the day of meal service that includes the food substitution, and
   Meals will be planned using the applicable meal planning guides in http://www.health.gov/dietaryguidelines/2015

2. Meals and snacks provided are served according to posted menus;

3. The facility will be able to store, refrigerate, and reheat food to meet the dietary needs of each Resident.

4. A Resident is provided a diet that meets the Resident's nutritional needs as specified in the Resident's service plan;

5. Water is available and accessible to Residents at all times, unless otherwise stated in a Medical Practitioner's order;

6. A Resident requiring assistance to eat is provided with assistance that recognizes the Resident's nutritional, physical and social needs, including the provision of adaptive eating equipment or utensils, such as plate guard, rocking fork, or assistive hand device, if not provided by the Resident.

7. If therapeutic diets are offered:

   A current therapeutic diet manual is available and accessible for use by employees. A therapeutic diet will be provided according to a written order from the Resident's Medical Practitioner.

Policy Topic: **Food Service**
Responsible Persons: **Certified Caregiver/Manager**

8. Food that is obtained, prepared, served, and stored as follows:

   Will be free from filth, spoilage or other contamination and is safe for human consumption;
   Food is protected from potential contamination;
   Food is prepared:
      Using methods that conserve nutritional value, flavor, and appearance; and
      In a form to meet the needs of each Resident, such as cut, chopped, ground, pureed or thickened;
9. Potentially hazardous food is maintained as follows:
      Food requiring refrigeration will be maintained at 41ºF or below, and
      Foods requiring cooking are cooked to heat all parts of the food to at least a temperature of 145º F for 15 seconds, except the following:
      Ground beef and ground meats are cooked to heat all parts of the food to at least 155ºF;
      Poultry, poultry stuffing, stuffed meats and stuffing containing meat are cooked to heat all parts of the food to at least 165º F;
      Pork or foods containing pork are cooked to heat all parts of the food to at least 155º F;
      Raw shell eggs for immediate consumption are cooked to at least 145º F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155º F;
      Roast beef and beef steak are cooked to an internal temperature of at least 155º F; and
      Leftovers are to be reheated to 165º F.
10. All refrigerators used by the community to store food or medication contain a thermometer, accurate to + or – 3º F at the warmest part of the refrigerator.
11. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair. Frozen foods are stored at zero degrees or below

Note: Your Company Name Here. strives to meet the needs of all our Residents. It is important to us that we create a safe and comfortable environment while staying on task. An alternate menu IS provided to those that do not enjoy the daily posted menu items.

Policy Topic: GRIEVANCES
Responsible Person(s): MANAGER/GOVERNING AUTHORITY

Policy:

The Resident or Resident's Representative has the right to file a grievance against any management decision to terminate the Residency Agreement or any other issue affecting the care of the Resident.

Procedure:

Step 1. A Resident or Resident's representative shall explain in writing the grievance to the manager.

- **a. The written grievance will include the cause of the grievance and provide a suggested remedy. A grievance must be brought within 10 working days from the day the decision, service, or lack of service was observed.**
- **b. The manager, either alone or in collaboration with the licensee (owner), if the two positions are distinct and separate, shall reach a decision and communicate it in writing to the Resident or Resident's Representative within 10 working days of receipt of the written grievance.**
- **c. Every effort should be made to settle grievances at this stage.**

Step 2. If the Resident or Resident's Representative feels the decision of the manager and/or licensee is still unfair, the resident or resident's representative shall respond in writing within 10 working days, requesting reconsideration of the issue. The response should again offer suggestions on what would be considered a fair compromise.

- **a. The licensee shall then form a committee of three individuals, including the manager, the individual who developed the service plan (or a nurse) and another individual affiliated with the facility i.e. resident, caregiver, or volunteer, to meet together and review their grievance.**
- **b. The licensee will make a written reply of the committee's decision to the resident's or resident representative's second written response within 10 working days.**
- **c. Resident or Resident's representative may choose to be present during the committee meeting to represent the case of the Resident.**

Step 3. If the Resident or Resident's Representative still feels that the decision of management has not resolved the problems, he or she should seek outside counsel through the Arizona Department of Health Services office of Home and Community Based Licensure, the DES Long Term Care Ombudsman or any other persons or resident advocacy agencies.

Any reply which is not appealed by the Resident or Resident's Representative within the time allowed at each level shall be considered settled and binding on the part of the Resident or Resident's Representative and the Facility.

Guidance On Screening Of Visitors for
COVID-19

❑ Please mark this box for Compassionate Care Visitation

Name of Visitor: _____ Date of Visit: ____/____/____

Name of Resident You are Visiting: _____

Help us practice excellent infection prevention to keep our Residents, Visitors and Staff safe. During your visit you agree to:

❑ Stay in the designated visiting area for the duration of your visit.
❑ Practice good hand hygiene prior to entering and upon exiting any of our facilities.
❑ Limit your touching of surfaces to only what is necessary.
❑ Practice Social Distancing of at least six feet and wear a mask or cloth face covering.
❑ Reach out to a Staff member if you have any questions or concerns.
❑ Contact us at the house manager's phone number if you are diagnosed with COVID-19 within 14 days after your visit.

Thank you for your continued cooperation and support!

Access to any of our facilities is limited to Staff and Visitors who willingly comply with all Family Care Homes, Inc. Policies and Procedures. If any Staff or Visitor is experiencing signs or symptoms of possible COVID-19, access to our facilities will be denied.

Please check all that apply below:

- ❑ You do not have a cough (note: a cough is defined as new onset of cough within the past 14 days.
- ❑ You do not have a fever over 100 degrees Fahrenheit.
  Temperature upon entry: _____
- ❑ You are not experiencing any shortness of breath.
- ❑ You have not had contact with someone with suspected or confirmed COVID-19 within the past 14 days.
- ❑ You do not have a household member with fever or respiratory symptoms.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Health Care Directives**
Responsible Persons: **Governing Authority/Manager**

Policy Statement: Your Company Name Here. wants you to be informed about a specific right that each individual has regarding the ability to refuse (in advance, in writing) the administration of any potentially life sustaining measures. By filling out a form called an "Advance Directive," an individual can specify should the need arise, no emergency life sustaining measures will be used to keep them alive.

What are advanced directives or pre-hospital directives?
In 1991, a federal law was passed, giving the right to refuse lifesaving emergency care. The Advance Directive is simply a document that makes an individuals choices clear in this regard, since when the time comes, they are extremely unlikely to be able to make their choices known.

What does this mean?
The Advance Directive is also sometimes referred to as a "DNR" (Do Not Resuscitate) or
"Pre-Hospital Medical Directive." It means that the individual has the right to refuse heroic measures in advance of ever needing them. For example: during a heart attack, the heart and breathing may stop. Without an Advance Directive in place, medical personnel are required to attempt to resuscitate you by all available means. If, on the other hand, an Advance Directive is in place, medical personnel are equally required to abide by the individual's written instructions that they do NOT wish to be kept alive or resuscitated. The Advance Directive does not however, prevent medical personnel from providing medical interventions necessary to provide comfort care or alleviate pain.

Each of us has our own views regarding this extremely personal choice. We strongly recommend that individuals discuss their choices with family members and let their choices be known. If their choice is to refuse heroic measures, an Advance Directive is the accepted method.

What measures are refused?
Cardiac Compression, Endotracheal Intubation, Artificial Ventilation, Defibrillation, Advanced Cardiac Life Support Medications and Related Emergency Medical Procedures

How does someone establish an Advance Directive?
An Advance Directive form (on orange paper) needs to be filled out documenting the individuals refusal of life sustaining treatments. It must be signed by the individual and their Medical Practitioner. It will be maintained in their medical record and a copy of the form (also on orange paper) will be provided to Emergency Personnel or hospital staff

whenever necessary.

For Further Information:

Health care directive forms and further information about them are available from the Office of the Attorney General of Arizona located at 2005 North Central Avenue, Phoenix, 85004. They can be reached by telephone at 602-542-5025.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Infection Control/Clostridium Difficile (C-Diff)**
Responsible Persons: **All Personnel**

Policy Reference: ***R-9-10-803***

Policy:

In order to reduce the likelihood of the transmission of Clostridium Difficile within the facility, when caring for the Residents, will observe the following procedure. All Outbreak Reporting will be conducted, pertaining to communicable disease.

Procedure:

Contact Precautions for Residents with C-Diff:

1. Residents with diarrhea caused by C. Difficile should be accompanied to the restroom by a Your Company Name Here staff member at all times.
2. All staff members are to wear gloves when assisting the Resident who has diarrhea caused by C. Difficile and dispose of those gloves in the bathroom trash receptacle. The bag should be tied and immediately taken to the outdoor trash receptacle.
3. A gown is needed when assisting the Resident who has diarrhea caused by C. Difficile when there is anticipated contact with fecal excretions with the Resident or environmental surfaces.
3. Gowns and gloves are to be removed before leaving the Resident's room and/or bathroom. Hands must be washed immediately after providing Resident care. The hand washing policy & procedure must be followed. Alcohol-based hand rubs do not kill spore-forming organisms. Plain, non-medicated soap is recommended. Staff may use antimicrobial soap and water or non-antimicrobial soap and water for hand washing. Items such as a stethoscope, sphygmomanometer, thermometer, etc. should be dedicated to use on that Resident only or thoroughly sanitized in between use.
4. Implement Contact Precautions. Contact precautions may be discontinued at the end of antibiotic usage and once diarrhea has ceased for 48 hours.
5. Sanitize soiled areas with bleach using a 1:10 ratio. Solution is to be made fresh, applied to surface and remain wet for 5 min known as “kill time”
6. Trash and linens will be handled by the guidelines set forth in the Policy and Procedure Manual.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Infection Control/Proper Dilution of Disinfectants**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-803**

Purpose: To make proper dilution of bleach water to prevent the spread of infection and/or diseases as well as preventing cross contamination within the facility.

Procedure:

1. Be sure to use a spray bottle that is heavy duty and chemical resistant.

2. Mark the name of the contents of the bottle with permanent marker:
   BLEACH & WATER

3. Masks, eye protection, face shield:
   a. To be worn to protect eyes, nose and mouth from potential exposure when providing care in which splashes or sprays of blood, bodily fluids, secretions and excretions may occur.

4. Gowns: (when applicable)
   a. Wear a clean non-sterile gown to protect skin and prevent soiling of clothing during procedures and Resident care activities that may generate splashes or sprays of blood, body fluids, secretions and excretions or cause soiling of clothing.
   b. Remove gown promptly and wash hands to prevent contamination of other Residents and environment.

5. Care equipment:
   a. Equipment contaminated with blood, bodily fluids, secretions or excretions should be handled in a manner that prevents contamination of clothing, Residents, staff, visitors or environment.
   b. Reusable equipment shall be disinfected with a company approved disinfectant prior to use with another Resident.

6. hazardous equipment:
   a. Use caution when using needles and other sharp instruments to prevent injuries to self or others.
   b. All efforts should be made to use only safety syringes and lancets for diabetic Residents.
   c. NEVER re-cap, bend, break or manipulate used needles.

d. Place used needles and sharps in a puncture resistant container. Container must be designed to not allow for removal purposes of hand/fingers to gain access to used sharps.

Policy Topic: **Infection Control Soiled Laundry from Residents with Infectious Disease**

Responsible Persons: **All Personnel**

Policy Reference: **R-9-10-803**

Policy:

Staff shall take appropriate action to prevent the spread of infectious conditions through handling of soiled linen. Soiled laundry is defined as any clothing, linens or bedding that is visibly soiled with any secretion from a resident, e.g., sputum, saliva, urine, feces, vomit or blood.

Procedure:

1. At such time as the Assisted Living Director, or other staff member, becomes aware of an infectious condition, or has reasonable cause to believe an infectious condition exists, all staff will be alerted.
    a. A box of disposable gloves will be placed in the Resident's room.
    b. Staff will wear gloves when handling soiled laundry.
2. Soiled linen and laundry shall be immediately placed in a plastic bag and tied off for transport to the laundry room. If the outside of the bag is visibly contaminated, it will be double bagged.
3. Bagged linen may be temporarily placed on the floor of the Resident's room, but should not be placed on the bed or other furniture.
4. When carrying the soiled laundry bag from the room, remove one glove to open the door. Dispose of the contaminated glove in the wastebasket. The hand carrying the laundry bag should remain gloved until the laundry is placed in the washing machine.
5. When handling the soiled laundry to load it into the washer, gloves should be worn. If indicated by the specific condition, a gown and a mask should be worn as well.
6. All laundry and linen from an infectious area shall be washed and dried separately from the laundry of the general population.
7. After putting soiled laundry into the washing machine, the outside of the machine should be wiped down with a 1:10 ratio of Clorox Cleanup (or a generic bleach product).
8. Thorough hand hygiene will be done after handling soiled laundry.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: `Infection Control/Methicillin-Resistant Staphylococcus Aureus
Responsible Persons: All Personnel

Policy Reference: ***R-9-10-803***

Policy:

In order to reduce the likelihood of the transmission of MRSA, when caring for Residents with MRSA, staff in all facilities will observe the following procedure. All facilities will also follow and act in accordance with any specific state regulations pertaining to communicable disease.

Procedure:

1. **Standard Precautions**
   Standard Precautions are used in the care of all Residents including Residents with MRSA. Isolation of Residents with MRSA in a long-term care setting is generally not necessary.
2. **Hand Hygiene**
   Thorough handwashing, following guidelines, will be done after caring for the Resident.
3. **Masks**
   As with Standard Precautions for all Residents, masks may be needed for face-to-face contact with Residents who are coughing.
4. **Gowns**
   Gowns are indicated if it is likely that the clothing will be soiled with the infectious material (e.g. sputum, wound drainage, urine, etc.).
5. **Gloves**
   Gloves will be worn at all times when providing care to the Resident with MRSA.
6. **Trash/Linen**
   Trash and linen will be handled per the Policy guidelines.
7. **Environmental Cleaning**
   The Resident's environment should be cleaned daily and when visibly soiled.
8. **Equipment**
   Items such as a stethoscope, sphygmomanometer, etc. should be sanitized in between use on each Resident.
9. **Bleach Ratio**
   1:10 solution of household bleach must be made fresh, applied to surface and remain wet for 5 min known as the "kill time"

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Infection Control/Standard Precautions**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-803**

Purpose: To prevent the spread of infection and/or diseases, as well as, preventing cross contamination.

Policy:

Staff shall utilize Standard Precautions for the care of all Residents, regardless of their diagnosis or presumed infection status. Standard Precautions apply to blood, bodily fluids, secretions, and excretions regardless of whether or not they contain visible blood, and to non-intact skin and mucous membranes.

Procedure:

1. Hand washing shall be in accordance with the policy and procedure for Infection Control - Handwashing.

2. Gloves:
    a. Shall be worn when it can be reasonably anticipated that there may be contact with blood, bodily fluids, secretions, non-intact skin or contaminated items. If a gown is needed, then gloves should extend to cover the wrists.
    b. Apply clean gloves before touching mucus membranes or non-intact skin.
    c. Change gloves between tasks and procedures on the same Resident and after contact with materials that may be contaminated or have a high concentration of microorganisms.
    d. Remove gloves promptly after use and wash hands.
    e. Change gloves between Residents.
    f. Replace gloves immediately if they become contaminated, torn, punctured or when ability to function as a barrier is compromised.
    g. Gloves shall be disposable, single use only.
    h. Utility gloves (used other than for Resident care) may be decontaminated for re-use as long as the integrity is not compromised.

3. Masks, eye protection, face shield: (if applicable)

    a. The outside of the equipment is contaminated! Be sure to discard if

single use or disinfect if able to be reused. To be worn to protect eyes, nose and mouth from potential exposure when providing care in which splashes or sprays of blood, bodily fluids, secretions and excretions may occur.

4. Gowns: (if applicable)
    a. Wear a clean non-sterile gown to protect skin and prevent soiling of clothing during procedures and Resident care activities that may generate splashes or sprays of blood, bodily fluids, secretions and excretions or cause soiling of clothing. This type of PPE will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions.
    b. Remove gown promptly and wash hands to prevent contamination of other Residents and environment.
    (See Sequence for Putting On/Removing PPE)
5. Care equipment:
    a. Equipment contaminated with blood, bodily fluids, secretions or excretions should be handled in a manner that prevents contamination of clothing, Residents, Staff, Visitors or the environment.
    b. Reusable equipment shall be disinfected with a facility approved disinfectant prior to use on another Resident.

6. hazardous equipment:
    a. Use caution when using needles and other sharp instruments to prevent injuries to self or others.
    b. All efforts should be made to use only safety syringes and lancets for diabetic Residents.
    c. NEVER re-cap, bend, break or manipulate used needles.
    d. Place used needles and sharps in a puncture resistant container. Container must be designed to not allow for removal purposes of hand/fingers to gain access to used sharps.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Infection Control/Handwashing**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-803**

Policy: To ensure that Standard Precautions are followed at all times to prevent the spread of disease, germs and cross contamination.

Procedure:

1. Remove jewelry
2. If using a towel dispenser, prepare paper towel before washing. Turn on water,
3. Wet hands,
4. Apply soap or anti-microbial agent,
5. Make sure hands are lower than elbows,
6. Wash all surfaces of both hands – for a minimum of 20 seconds while building up a lather:
    a. between the fingers
    b. the top of the fingers
    c. the top of the fingernails
    d. the cuticles
    e. under the fingernails
    f. the bottom of fingers
    g. the backs of the hands
7. Rinse under running water, making sure that water drips down from fingers
8. Tear off paper towel
7. Dry hands with paper towel
7. Use paper towel to turn off faucet
8. Use paper towel to open door
9. Deposit paper towel in garbage
10. Use alcohol gel/hand sanitizer containing at least 60% alcohol, in the absence of a place to wash hands.
11. Apply hand lotion if necessary, but do not apply right after washing or before giving direct care. Hand lotion can interfere with the cleansing action or an antimicrobial agent.

Examples of Proper Handwashing Situations:

1. When you arrive or leave work,
2. Between contact with different Residents,
3. Before putting gloves on and after removing gloves
    a. gloves do not replace hand washing.
4. Before contact with people who may be susceptible to infections such as older people and babies,
5. After coughing, sneezing or blowing your nose,
6. After using the bathroom,
7. After smoking cigarettes,
8. Before and after food preparation, and
9. Before and after eating.

Studies have shown that the best way to get others to wash their hands is to be a role model. When your Residents and staff observe you washing your hands, they are more inclined to do the same!

Effective hand washing is one of the most important means of preventing infections that are spread through direct contact between people or between people and infected substances.

INFECTION PREVENTION & CONTROL PRACTICES ORIENTATION FOR VISITORS & STAFF (5 CEUS)

- ❑ Infection Prevention
- ❑ Standard Precautions
- ❑ Appropriate Personal Protective Equipment (PPE)
- ❑ Transmission-Based Precautions
- ❑ Vaccination and Miscellaneous Information

By signing below, I acknowledge that I have been given the opportunity to review all of the documents contained in the Your Company Name Here "Infection Prevention and Control Practice" Orientation Binder. I understand that copies of these documents may also be obtained on the Centers for Disease Control and Prevention website at: www.cdc.gov .

_____

_____

Visitor/Staff member's Printed Name **Date**

_____

Signature

Name of Resident I am visiting: _____ Facility Name: _____

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Tuberculosis Screening**
Responsible Persons: **Facility Staff & Volunteers**

Policy Reference: **R9 - 10 - 113**

Policy Statement: **All Your Company Name Here Facilities shall follow the CDC, StateDHS and Maricopa County Public Health Guidelines. For the most recent guidelines please visit;**

www.cdc.gov , www.Statedhs.gov , www.maricopa.gov

Procedure:

1. Prior to employment, the potential Facility Staff member will be informed of the need for documentation ruling out Infectious Tuberculosis.

a. The documentation must be in the form of one of the following:

I. Documentation of an IGRA (Blood test) with a negative result, Mantoux Skin Test with a negative result or other Tuberculosis screening test recommended by the CDC administered within 12 months before or upon the date the individual begins providing services at or on behalf of the Facility that includes the date and type of Tuberculosis Screening Test.

II. If the Facility Staff had a positive Mantoux Skin Test or other Tuberculosis Screening Test;

- & this is their 1st positive result - they will require a Chest X-Ray
- if the Chest X-Ray is negative - they obtain a written statement
- if the Chest X-Ray is positive - they seek medical advice/treatment

If the Facility Staff member has had a positive result in the past and has filled out the TB Risk Assessment, been educated on the signs and symptoms of TB, been screened and obtained a written statement from a Medical Practitioner that they are free from Infection Tuberculous that is signed they are cleared to continue their employment.

2. Every 12 months after the date of the Facility Staff's most recent IGRA, Tuberculosis Screening Test, or written statement, one of the following should be performed to rule out Infectious Tuberculosis:

a. The documentation must be in the form of one of the following:

I. Documentation of a IGRA (Blood test) with a negative result, Mantoux Skin Test with a negative result or other Tuberculosis Screening Test recommended by the U.S. Center for Disease Control

(CDC) within 30 calendar days before or after the anniversary date of the most recent Tuberculosis Screening Test and includes the date and the type of Tuberculosis Screening.

II. If the Facility Staff member had a positive Mantoux Skin Test or other Tuberculosis Screening Test, a written statement that the individual is free from Infectious Tuberculous signed by a Medical Practitioner dated within 30 calendar days before or after the anniversary date of the most recent Tuberculosis Screening will be required.

3. Policy and Procedures will be established, documented and implemented for a Tuberculosis Infection Control Program that complies with the Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Settings, 2005, published by U.S. Department of Health and Human Service, Atlanta GA 3033

a. The following will be implemented:

I. Conduct Tuberculosis Risk Assessments, screen for signs and symptoms and provide training and education related to recognizing the signs and symptoms of Tuberculosis; and

II Maintain documentation of any;
Tuberculosis Risk Assessment
Tuberculosis screening test or other screening tests recommended by the CDC for all Facility Staff and volunteers for the Facility.
Screen for signs and symptoms of Tuberculosis of Facility Staff and volunteers for the Facility.

Policy Topic: **Freedom from Infectious Tuberculosis**
Responsible Persons: **Governing Authority/Manager**

Policy Reference: **R9 - 10 - 808**
Policy Statement: Prior to admission and every 12 months thereafter each Resident must provide documentation of Freedom from Infectious Tuberculosis.
Procedure:

1. Prior to admission, the potential Resident will be informed of the need for documentation ruling out Infectious Tuberculosis.

a. The documentation must show/read negative results:
I. A Mantoux Skin Test, IGRA (Blood Test) or other Tuberculosis Screening Test recommended by the U.S. Center for Disease Control (CDC) within 12 months before the date or at the time the Resident begins receiving services at the Assisted Living Facility and includes the date and the type of Tuberculosis Screening Test

OR

ii.If the Resident had a positive Mantoux Skin Test, IGRA (Blood Test) or other Tuberculosis Screening Test, an additional Chest X-Ray is needed to further rule out Infectious Tuberculosis Disease which includes a written statement that the Resident is free from Infectious Tuberculous signed by a Medical Practitioner dated within 12 months before the date the Resident begins receiving services at the Assisted Living Facility.

b. A Tuberculosis Risk Assessment must be filled out, signed and accompany any
Tuberculosis Screening Tests upon admission.

2. Every 12 months after the date of the Resident's most recent Tuberculosis Screening Test, Chest X-Ray/written statement, one of the following should be performed to rule out Infectious Tuberculosis:

a. The documentation must show/read negative results:
I. A Mantoux Skin Test, IGRA (Blood Test) or other Tuberculosis Screening Test recommended by the U.S. Center for Disease Control (CDC) within 30 calendar days before or after the anniversary date of the most recent tuberculosis screening test and includes the date and the type of Tuberculosis Screening Test

OR

ii. If the Resident had a positive Mantoux skin Test, IGRA or

other Tuberculosis Screening Test, an additional Chest X-Ray is needed to further rule out Infectious Tuberculosis Disease which includes a written statement that the Resident is free from Infectious Tuberculous signed by a Medical Practitioner dated within 30 calendar days before or after the anniversary date of the most recent Tuberculosis Screening Test.

Policy Topic: **Tuberculosis Screening**
Responsible Persons: **Facility Staff & Volunteers**

Policy Reference: **R9 - 10 - 113**

Policy Statement: **All Your Company Name Here Facilities shall follow the StateDHS, CDC and Maricopa County Public Health Guidelines.**
Procedure:

A. Tuberculosis Screening Program

1. Each Facility Staff member or Volunteer who is subject to the requirements of this section shall, prior to beginning any work, complete a TB screening consisting of the following:

a. Complete a "Prior TB Exposure Risk Assessment" (per CDC, included by ref.) and

b. Be assessed by a Manager or Administrator as having no signs or symptoms of Infectious TB, and

c. Provide documentation of being free from Infectious TB per subsection (B)(1);

2. If the individual is suspected of having a Latent TB Infection, per A.A.C. R9-6-1201:

a. Refer the individual for assessment or treatment; and

b. Annually obtain documentation of the individual's freedom from symptoms of Infectious Tuberculosis, signed by a Medical Practitioner, Occupational Health provider, as defined in A.A.C. R9-6-801, or local health agency as defined in A.A.C.R9-6-101;

3. Provide Annual training and education related to recognizing the signs and symptoms of Tuberculosis to Facility Staff members and Volunteers.

4. Annually assess the Facility's risk of exposure to Infectious Tuberculosis.

5. Report, as specified in A.A.C. R9-6-202, an individual who is suspected of exposure to Infectious Tuberculosis; and

6. If a documented exposure to Infectious Tuberculosis occurs in the Facility, coordinate and share information with the local health agency, as defined in A.A.C. R9-6-101, for identifying, locating, and investigating contacts, as defined in A.A.C.R9-6-101.

B. The Healthcare Facility's Chief Administrative Officer shall:

1. For a Staff member or Volunteer for whom screening and documentation of freedom from Infectious TB is required by subsection (A)(2)(a), obtain one of the following as evidence of freedom from Infectious TB

a. Documentation of a negative IGRA (blood) test, Mantoux skin test or other Tuberculosis screening test that:

I. Is recommended by the U.S. CDC,

ii. Was administered within 12 months before the date the individual begins providing services at or on behalf of the Facility, and

iii. Includes the date and type of Screening Test;

b If the individual has a history of TB or documentation of Latent TB Infection, per A.A.C. R9-6-1201, compliance with subsection (A)(2)(b) or

c. If the individual has had a positive screening test per subsection (B)(1)(a) and does not have a history of TB or documentation of Latent TB, per A.A.C R9-6-1201, a written statement that;

I. The individual is free from Infectious TB, signed by a Medical Practitioner or LHA as defined in A.A.C. R9-6-101; and

ii. Is dated within 12 months before the date the individual begins providing services at or on behalf of the Facility.

2. As part of the annual assessment of the Facility's risk of exposure to Infectious Tuberculosis according to subsection (A)(2)(b), ensure that documentation is obtained for each Staff member or Volunteer required to be screened for Infectious Tuberculosis that:

a. Indicates the individuals freedom from symptoms of Infectious TB, and

b. Is signed by a Medical Practitioner, Occupational Health Provider, as defined in A.A.C. R9-6-801, or LHA, as defined in A.A.C. R9-6-101.

Definitions;

R9-6-1201
Latent Tuberculosis Infection - means the presence of Mycobacterium tuberculosis, as evidenced by a positive result from an approved test for Tuberculosis in an individuals who; a) Has no symptoms of active tuberculosis and b) Has no clinical signs of tuberculosis other than the positive result from the approved test for tuberculosis, and c) Is not infectious to others.

R9-6-101
Approved tests for Tuberculosis - means a Mantoux skin test or other test for Tuberculosis recommended by the CDC or Control Officer appointed under A.R.S. 36.714.

LHA: Local Health Agency - means a county health department, a public health service district, a tribal health unit, or a U.S. Public Health Service Indian Health Service Unit

Infectious Active Tuberculosis means pulmonary or laryngeal active Tuberculosis in an individual, which can be transmitted from the infected individual to another individual.

Screening Test means a laboratory analysis approved by the U.S. Food and Drug Administration as an initial test to indicate the possibility that an individual is infected with a communicable disease.

R9-6-202
A health care provider required to report shall, either personally or through a representative, submit a report, in a Department-provided format, to the local health agency within the time limitation specified. Specific information is required in the report

and can be found in the Arizona Administrative Code.

R9-6-801
Occupational health provider means a physician, physician assistant, registered nurse practitioner, or registered nurse as defined in A.R.S. 32-1601, who provides medical services for work-related health conditions for an agency or entity for which a named employee or volunteer works.

Policy Topic: **Job Descriptions, duties and qualifications**
Responsible Persons: **All Personnel**

Policy reference: **R9-10-803**

Policy:

All Staff member's and "permanent" volunteers will have position descriptions that are written, with up-to-date descriptions that reflect current job responsibilities, qualifications, supervisory responsibilities, and physical requirements.

All potential Staff members for employment will be asked to review the job description for the position they wish to be hired for. Applicants will sign a statement that affirms that they have reviewed the document prior to employment and are capable of performing the duties as outlined.

Procedure:

1. Job descriptions will be written and provided to Staff members applying for employment at Your Company Name Here.

2. Job descriptions will include the following requirements or qualifications, specific to the position:

    a. The skills needed to perform the job.
    b. The knowledge needed to perform the job.
    c. The education needed to perform the job.
    d. The experience needed to perform the job.

3. Job descriptions will be reviewed and updated in conjunction with the review of the entirety of this policy and procedure manual.

POLICY TOPIC: LAUNDRY SERVICE
RESPONSIBLE PERSON(S): MANAGER

Policy:

The Manager of a facility shall ensure that each Resident's laundry is cleaned and disinfected in a manner designed to prevent, minimize and control illness and/or infection. Monitoring and performing laundry services will be carried out by all Assistant Caregivers, Certified Caregivers, and/or the Manager scheduled on the shift.

Procedure:

The following steps should be used:

1. When removing a Resident's clothing, the clothing should be placed in a plastic bag and taken to the laundry room. The clothing should remain in the bag until they are ready to be placed into the washing machine and laundered.

2. The Washing Machine setting should be adjusted to wash the clothing in hot water, and the hot water temperatures should be maintained between 95 & 100 degrees.

3. All clothing should be removed from the washing machine, shaken out and placed directly in the dryer on the regular setting, which requires heat to dry the clothes. All of the above steps will help minimize illness and/or infection.

The following steps should be taken when the Resident's clothing is being laundered outside of the Facility:

1. When removing a Resident's clothing, the clothing should be placed in a closed and lined laundry hamper or container.

2. The laundry hamper/container should be stored away from food storage, kitchen or dining areas.

3. The laundry should be removed from the Facility at least twice weekly, ensuring the health and safety of the Facility and Residents is maintained.

If a family member/responsible party has any specific requests regarding a Resident's laundry they MUST make arrangements directly with the Facility Manager.

If at any time any Resident is diagnosed with a Communicable/Infectious Disease the Infection Control Policy for Laundry should be strictly followed.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Licensing Classification**
Responsible Persons: **Governing Authority**

Policy Reference: **R9-10-815**

Definition(s):

Assisted Living Facility: means a Residential Care Institution, including Adult Foster Care, that provides or contracts to provide Supervisory Care Services, Personal Care Services, or Directed Care Services on a continuing basis.

Assisted Living Homes: means 10 Residents or fewer, usually in a home in a residential neighborhood.

Directed care services: programs and services, including Supervisory and Personal Care Services, that are provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

Policy:

The Provider meets ADHS criteria as an Assisted Living Home by being an Assisted Living Facility providing services to 10 or fewer Residents. Provider holds licensure at the Directed Care Services level. To maintain that classification, Provider shall not accept or retain a Resident who requires:

1. The Resident requires continuous:
    a. Medical Services;
    b. Nursing Services, unless the facility complies with A.R.S. 36-401(C);
    c. Behavioral Health Services;
2. The primary condition for which the individual needs Assisted Living services is a Behavioral Health issue (does not include Behavioral Care).
3. Services that needed by the Resident are not within the facility's Scope of Service & a Home Health or Hospice Agency is not involved in the Resident's care;
4. Facility does not have the ability to provide the Assisted Living services needed by the Resident.
5. The Resident requires restraints, including the use of bed rails.

Procedure:

Governing Authority will comply with the licensing requirements as described in R9-10-802 to successfully obtain licensure at the Directed Care level.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Manager's Designee**
Responsible Persons: **Governing Authority/Manager**

Policy Reference: **R9-10-803**
R4-33-401(B) NCIA

Purpose:

To assign a Manager's Designee to be physically present at the facility and in charge as per the StateDHS Rules and NCIA Regulations when the Manager is not physically present.

Policy:

It shall be the policy of the Governing Authority that a Designee shall be assigned to act in the Manager's place when the Manager is not physically present.

The criteria for a Manager's Designee under StateDHS includes:

Must be at least 21 years old,
Must have documentation of freedom from tuberculosis,
Must have current CPR training,
Must have current adult First Aid training,
Must have a valid Fingerprint Clearance Card,
Must have completed Caregiver training through the Directed Care level.

Procedure:

The following personnel who meet the criteria may perform the functions of a Manager's Designee and will perform as such in the absence of the Manager in the facility:

Only a Caregiver given direct permission from the Governing Authority and the facility Manager will be considered as a Designee. Must conspicuously display the name of the designee at all times.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Caregiver Response & Managing Difficult Behaviors**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-803**

Policy:

The Health and Safety of our Residents is our primary concern. If at any time a Resident exhibits a sudden, intense, or out-of-control behavior all Facility Staff Members will follow the procedure outlined below to prevent harm to the Resident or another individual.

Procedure:

The following steps should be taken to prevent harm:

1. Separate or remove the Resident from the immediate stressor or danger.

2. Isolate the Resident (locate a safe, quiet, private area of the Facility).
   A. If the above actions calm the Resident, call your Manager and ask for guidance.
   B. The Manager will inform the Responsible Party, Medical Practitioner and
   Case Manager, if applicable.
   C. If the above actions do not assist in diffusing the situation, take action.

3. Summons Emergency Assistance by calling 911. Have the Resident removed from the Facility and taken to a higher level of care to be evaluated and treated.

Resident's name: _____
First Last

Name of medication(s)

The above-named medications have been released to:_____
on physician's orders. I understand that the Provider will not be held responsible for any or all medication errors, loss, or improper administration while the medication is in my possession. These medications are accepted in non-childproof containers. If there is a concern with the accuracy of the medications that were released I will call and notify a supervisor immediately.

Responsible Party's Signature: _____ Date: _____

Your Company Name Here Staff Signature: _____
Date: _____

Date of Resident's Pick up: _____

Date of Resident's Return: _____

Policy Topics: **Medication Services**
Responsible Person: **Manager, Certified Caregivers & Medical Practitioners**

Policy Reference: **R9-10-816**

Policy Statement: This Policy shall be reviewed and approved by a Medical Practitioner annually, along with the entirety of this manual. All Resident medications and treatments will be handled according to the procedures outlined below:
Procedures:

1. The Resident or Resident's Representative must arrange for timely delivery of medications to the facility within 24 hours. The Manager may assist the Resident's Representative in making those arrangements. No person shall bring medications into the facility for a Resident that is not prescribed by the Resident's Medical Practitioner, including prescription and non-prescription medications and/or treatments.
2. Medications must be obtained from reliable, legal sources such as a Pharmacy or Medical Practitioner, be in the original labeled container with legible instructions printed on the label and can be delivered to the facility by courier, family or the Resident's Representative, Your Company Name Here staff member (fee may apply), or mail order.
3. Whenever possible, written medication orders will be obtained prior to admission or by verbal order the day of admission.
    a. If orders are not obtained prior to admission, after contacting the Medical Practitioner and verifying the medications and treatments to be administered in the facility, the Manager will list the medications including strength, route and dosage on the Verbal Order Form or a Medication Sheet.
    b. The Verbal Order or Medication Sheet shall be dated and signed by the Manager receiving the order and must include the Medical Practitioner's name, date and medication/treatment as received.
    c. The Manager will obtain written orders to verify the verbal orders within 14 working days.
    d. The unsigned copy of the verbal order shall be disposed of once the signed copy is obtained.
4. All Resident medications will be secured in a locked storage area. Only the Manager or a trained and authorized Certified Caregiver/Delegation of Authority shall be in possession of the keys to the facility's medication storage area.
5. Your Company Name Here does not allow any medications to be kept in a Resident's bedroom. There are no exceptions!
6. Residents will have their medications reviewed and approved, at least, every 90 days by a Medical Practitioner.
7. A Resident's Medical Practitioner shall sign a statement acknowledging that all Certified Caregivers/Delegations of Authority have the skills and knowledge to administer medications and treatments as directed by the Medical Practitioner.

8. Pharmacies may prepare medications in labeled bottles, bubble packs, cassettes, etc.

a. Families may provide Resident medications from their pharmacy of choice, but must be in original container.

b. Changes in pharmacy packs will be made by the pharmacy representative.

Policy Topics: Medication Services
Responsible Person: Manager, Certified Caregivers, R.N.

9. Your Company Name Here Staff will provide medication administration of all medications and treatments to each Resident. We do not allow Residents to self administer medications and we do not provide assistance with self administration of medications.
    a. Medication administration is not documented until the Resident has taken the medication.
    b. Medications are administered to one Resident at a time.
    c. Medications must be administered per the 5 Rights (Resident, Med, Dosage, Route, & Time).
    d. Once the medications have been taken, the Your Company Name Here Staff initials must be placed in the MAR.
    e. If the medications that have been ordered are not able to be taken, a dose is missed or the Resident has refused them, the Your Company Name Here Staff must circle the appropriate box and write the reason the medication was not taken on the back of the MAR.
    f. Your Company Name Here Staff must be sure to close and lock the medication storage cabinet before walking away.
    g. At the end of each shift a narcotic count and a review of shift medication pass will be required before transferring keys. If the narcotic count is off and/or the MARs are missing initials, Management MUST be called.
10. The following procedures apply to administering all other medications.
    a. Liquid Internal Medications
        1. Measure accurately (1 teaspoon is 5 ml/cc) (1 tablespoon is 15 ml/cc)
        2. Suspensions need to be shaken well (30 seconds) before giving.
        3. Medications needing refrigeration will be stored in the lock box in the refrigerator and must be kept locked at all times.
    b. Oral (PO) Capsules and Tablets.
        1. If a Resident has trouble swallowing PO medications, large tablets may need to be cut in half. A Physician's Order MUST be obtained before crushing, cutting or mixing it with other substances (i.e. food or liquids).
    c. Sublingual Medications
        1. Place tablet/liquids under tongue/cheek pocket & have the Resident close their mouth.
        2. Instruct them to hold the saliva in their mouth as long as can be tolerated.
        3. Wait at least 5 more minutes before drinking any liquid.
        4. Do not smoke, eat or chew gum while medication is dissolving.
    d. Eye Drops
        1. Wash hands before and after administering these medications.
        2. Residents should be sitting or laying down with head tilted back.
        3. Using your thumb and forefinger gently and carefully pull the lids open.
        4. Instill the prescribed dosage.
        5. Instruct the Resident to keep head tilted for approximately 2 minutes.
    e. Ear Drops
        1. Have Resident lay on side opposite ear needing the drops or tilt their head to the side.

2. Grasp the earlobe and pull upward and back to straighten the ear canal.
3. Fill the dropper with medication and instill the prescribed number of drops.
4. Continue to lay on side or keep head tilted for 2-3 minutes

Policy Topics: Medication Services
Responsible Person: Manager, Certified Caregivers, R.N.

f. Rectal suppositories
   1. Store in refrigerator to keep firm.
   2. Wear gloves when inserting suppositories.
   3. Have Resident lay on left side with knees bent.
   4. Insert into the rectum pointed end first.
   5. Instruct Resident to fight the urge to defecate for at least 1 hour.

g. Topical Ointment and Creams
   1. Apply a thin layer of medication.
   2. Do not cover with a bandage unless ordered by the Medical Practitioner.

h. Transdermal Patches
   1. Remove old patch before applying new one.
   2. Residents may shower or bathe with patch on.
   3. Apply new patch to areas with little hair and joint movement.
   4. Do not apply to same site where the old patch was removed.

i. Fleet-type Enemas
   1. Wear gloves when inserting the enema.
   2. Have Resident lay on left side with knees bent.
   3. Remove cap and lubricate the tip of enema tube.
   4. Gently insert the enema tip into the rectum.
   5. Instill the fluid by gently rolling the tube up (like a roll of toothpaste).
   6. Instruct Resident to fight the urge to defecate for at least 10-25 minutes.

j. Puff Inhalers
   1. Have Resident exhale as deeply as possible.
   2. Puff inhaler as Resident begins to breath in. Instruct Resident to breathe deeply.
   3. As Resident breathes out, have them blow through mouth with pursed lips.
   4. Rinse Resident's mouth afterward.

k. Thick It
   1. To thin liquids consistency as written per MP's order.
   2. Example: soup, milk, beverages.

l. Altered Diets
   1. To be given as prescribed per MP's order.
   2. Example: Puree, Mechanical Soft, Diabetic Diet, Lactose Intolerant, etc.

m. Oxygen (O2)
   1. To be administered at a rate as written per MP's order.
   2. Via cannula or face mask.

n. Small Volume Nebulizer (SVN)
   1. Dosage to be administer as written per MP's order.
   2. Cleaning and tubing cleaned/replaced as manufacturer recommends.

o. Vitals and Weights
   1. To be taken and recorded as prescribed per MP order.
   2. May obtain an order that states weighing the Resident is contraindicated.

p. Medication Administration not described in this policy and procedure will be

taught to the Certified Caregiver by the Manager/Governing Authority and recorded in their personal files.

11. The Certified Caregiver/Delegation of Authority may inject subcutaneous medication only after adequate training and documentation by an RN or Medical Practitioner has occurred.
12. PRN (as needed) medications are administered only when the Resident shows signs and/or symptoms, and/or upon the request of the Resident. The Certified Caregiver/Delegation of Authority will remove the correct dosage and administer.
13. The Certified Caregiver/Delegation of Authority will sign off on the medication for the date and time the medication was given to the Resident in the Medication Administration Record (M.A.R.) and complete the PRN Flowsheet, if applicable.
14. Any Resident's medication which is discontinued or expired shall be properly disposed of by the Manager/Governing Authority using the guidelines from (ADEQ) regulations R18-13-1418. ALL NARCOTICS WILL BE DESTROYED AT THE ADMINISTRATIVE OFFICE, located at Main Office, City, Zip Code and written proof of destruction will be maintained.
15. All Medication Administration errors will be reported immediately to a Manager, Medical Practitioner and to the prescribing Physician, Resident's Representative and Case Manager (if applicable) and recorded on a Quality Management Assessment Form . This report will be reviewed by the Governing Authority.
16. Any suspected errors in the medication packaging MUST be reported to a Manager immediately. An investigation will be initiated and if an error is validated, a Quality Management Assessment will be completed. The error will be corrected and reported to the Resident, Pharmacy, Medical Practitioner, Resident's Representative and Case Manager (if applicable).
17. All medication incidents resulting in the spilling, mixing, loss of medication, adverse reaction or medication error will be reported to the Manager immediately for correction.
    a. If the adverse reaction is severe and requires immediate medical attention 911 will be summoned.
    b. Otherwise, the Manager will contact the Resident's Medical Practitioner and follow their instruction.
    c. A Quality Management Assessment will be completed.
18. Your Company Name Here does not allow Staff, Residents, Resident's Representatives or Family Members to fill medication organizers.
19. If a medication is recalled for any reason, a Quality Management Assessment will be initiated and the Manager/Governing Authority will pull all recalled medication and follow the Manufacturer's recall instructions.
20. Using the guidelines from R18-13-1418, all unused or surplus narcotics will be destroyed by the Governing Authority or Manager and written proof maintained.
21. When a Resident is off the premises and is expected to miss scheduled medications, the medications will be released to the Resident's Representative, family, etc.. The individual assuming responsibility for the Resident will be required to follow the guidelines on the Medication Release Form.
22. Opioids are addressed separately and have their own policy: see Opioid Policy

_____ January 9th, 2025

Signature of Medical Practitioner Date

Licensed Nurse Practitioner, NP

1265831835

Printed Name Medical Practitioner License Number

Policy Topics: Medication Services
Responsible Person: Manager, Certified Caregivers, R.N.

R18-13-1418. Discarded Drugs

A. A generator of discarded drugs not returned to the manufacturer shall destroy the drugs on site prior to placing the waste out for collection. A generator shall destroy the discarded drugs by any method that prevents the drug's use. If federal or state law prescribes a specific method for destruction of discarded drugs, the generator shall comply with that law.

B. A generator of discarded drugs may destroy the drugs on site by a method that prevents the drug's use. Prior to placing the destroyed and discarded drugs out for collection, they should be placed in
a red, leak resistant bag and labeled appropriately.

R18-13-1419. Medical Sharps

Medical sharps shall be handled as follows:

1. A generator who treats biohazardous medical waste on site shall place medical sharps in a sharps container after rendering them incapable of creating a stick hazard by using an encapsulation agent or any other process that prevents a stick hazard. Medical sharps encapsulated or processed in this manner are considered to be solid waste.

2. A generator who ships hazardous medical waste off site for treatment shall either:

a. Place medical sharps in a medical sharps container and follow the requirements of R18-13-1407

b. Package and send medical sharps to a treatment Facility via a mail-back system as prescribed by the instructions provided by the mail-back system operator. An Arizona treatment Facility shall render medical sharps incapable of creating a stick hazard by using an encapsulation agent or any other process that prevents a stick hazard.

3. A person operating a treatment Facility who accepts medical sharps for treatment shall either:

a. Encapsulate medical sharps to prevent stick hazard, or

b. Use any other process that prevents a stick hazard.

Policy Topic: **Operational Standards and Manager's Responsibilities**
Responsible Persons: **Manager/Governing Authority**

Policy Reference: **R9-10-803**

Definition(s):
Governing Authority: The entity (consisting of one or more individuals) responsible for the organization, operation, and administration of an Assisted Living Facility.

Manager: Is the onsite Manager of the Assisted Living Facility who is a minimum of 21 years of age, and possesses a current Assisted Living Facility Managers certificate issued under A.R.S. §36-446.

Purpose:
To document the operational standards for the organization and management of the Provider and the responsibilities of the Governing Authority and the Manager.

Policy:

A. A Governing Authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of an Assisted Living Facility;

2. Establish, in writing, an Assisted Living Facility's scope of service;

3. Designate, in writing, a Manager who:
   a. Is 21 years of age or older; and
   b. Except for the Manager of an Adult Foster Care Home, has either a:
      I. Certificate as an Assisted Living Facility Manager issued under ARS§36-446.04(C),or
      II. A temporary certificate as an Assisted Living Facility Manager issued under A.R.S.§36-446.06;

4. Adopt a Quality Management Program that complies with R9-10-804;

5. Review and evaluate the effectiveness of the Quality Management program at least once every 12 months;

6. Designate, in writing, an acting Manager who has the qualifications established in subsection (A)(3), if the Manager is:
   a. Expected not to be present on the Assisted Living Facility's premise for more than 30 calendar days, or
   b. Not present on the Assisted Living Facility's premises for more than 30 calendar days;

7. Except as provided in subsection (A)(6), notify the Department according to A.R.S.§36-425(I) when there is a change in the Manager and identify the name and qualifications of the new Manager;

8. Ensure that a Manager or Caregiver who is able to read, write, understand, and communicate in English is on an Assisted Living Facility's premises, is able to follow all Your Company Name Here written Policies and Procedures, as well as, any verbal instructions given by Management, and;

9. Ensure compliance with A.R.S.§36-411.

B. A Manager:

1. Is directly accountable to the Governing Authority of an Assisted Living Facility for the operation of the Assisted Living Facility and services provided by or at the Assisted Living Facility.
2. Has the sole authority and responsibility to manage an Assisted Living Facility; this shall include the direct communication (face to face, phone, text or email) with the Resident or Responsible Party, Medical Practitioner and any other Health Related Services regarding all health and safety concerns.
3. Except as provided in subsection (A)(6), designates, in writing, a Caregiver who is:
    a. at least 21 years of age, and
    b. Present on the Assisted Living Facility's premises and accountable for the Assisted Living Facility when the Manager is not present on the Assisted Living Facility premises.

C. A Manager shall ensure that policies and procedures are:

1. Established, documented and implemented to protect the health and safety of a Resident that cover:
    a. Job descriptions, duties, and qualifications, including required skills and knowledge, education, and experience for employees and volunteers;
    b. Orientation and in-service education for employees and volunteers;
    c. How an employee may submit a complaint related to Resident care;
    d. The requirements in A.R.S.§Title 36, Chapter 4, Article 11;
    e. Except as provided in subsection (M), cover Cardiopulmonary Resuscitation training for applicable employees and volunteers, including:
        i. The method and content of Cardiopulmonary Resuscitation training, which includes a demonstration of the employee's or volunteer's ability to perform Cardiopulmonary Resuscitation;
        ii. The qualifications for an individual to provide Cardiopulmonary Resuscitation training;
        iii. The time-frame for renewal of Cardiopulmonary Resuscitation training; and
        iv. The documentation that verifies that the employee or volunteer has

received Cardiopulmonary Resuscitation training;

f. First Aid training;

g. How a Caregiver will respond to a Resident's sudden, intense, or out of control behavior to prevent harm to the Resident or another individual;

h. Staffing and record keeping;

i. Resident acceptance and Resident Rights;

j. Termination of Residency, including:

i. Termination initiated by the Manager of an Assisted Living Facility, and

ii. Termination initiated by a Resident or Resident's Representative;

k. The provision of Assisted Living services, including:

i. Coordinating the provision of Assisted Living Services

ii. Making vaccinations for Influenza and Pneumonia available to Residents according to A.R.S. §36-406(1)(d), and

iii. Obtaining Resident preferences for food and the provision of Assisted Living services;

l. The provision of respite services or adult day health services, if applicable, however Your Company Name Here does not offer these services at this time;

m. Methods by which the Assisted Living Facility is aware of the general or specific whereabouts of a Resident, based on the level of Assisted Living services provided to the Resident and the Assisted Living services the Assisted Living Facility is authorized to provided; (Directed Care)

n. Resident medical records, including electronic medical records;

o. Personal funds accounts, if applicable;

p. Specific steps for:

i. A Resident to file a complaint; and

ii. The Assisted Living Facility to respond to a Resident's complaint;

q. Health care directives

r. Assistance in the self-administration of medication, and medication administration;

s. Food services;

t. Contracted services;

u. Equipment inspection and maintenance, if applicable;

v. Infection control; and

w. A Quality Management Program, including incident reports and supporting documentation;

2. Available to Residents, their Responsible Party, employees and volunteers of the Assisted Living Facility; and

3. Reviewed at least once every year and updated as needed.

D. A Manager shall ensure that the following are conspicuously posted:
1. A list of Resident Rights,
2. The Assisted Living Facility's license,
3. Current phone numbers of:
   a. The unit in the Department responsible for licensing and monitoring the Assisted Living Facility,
   b. Adult Protective Services in the Department of Economic Security,
   c. The State Long-Term Care Ombudsman, and
   d. The Arizona Center for Disability Law; and
4. The location at which a copy of the most recent Department inspection report and any plan of correction resulting from the Department inspection.

E. A Manager shall ensure, unless otherwise stated:
1. Documentation required by this Article is provided to the Department within two hours after a Department request; and
2. When documentation or information is required by this Chapter to be submitted on behalf of an Assisted Living Facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the Assisted Living Facility.

F. If a requirement in this Article states that a Manager shall ensure an action or condition or sign a document:
1. A Governing Authority or licensee may ensure the action, condition or sign the document and retain the responsibility to ensure compliance with the requirement in this Article
2. The Manager may delegate ensuring the action or condition or signing the document to another individual, but the Manager retains the responsibility to ensure compliance with the requirement in the Article; and
3. If the Manager delegates ensuring an action or condition or signing a document, the delegation is documented and the documentation includes the name of the individual to whom the action, condition or signing is delegated and the effective date of the delegation.

G. A Manager shall:
1. Not act as a representative and not allow an employee or a family member of an employee to act as a representative of a Resident who is not a family member of the employee;
2. Your Company Name Here does not administer personal funds accounts for any Resident.
3. Notify a Resident's Representative, family member, Public Fiduciary or a Trust Officer, if the Manager determines that the Resident is incapable of handling financial affairs; and
4. Except when a Resident's need for Assisted Living services changes, as documented in the service plan, ensure that a Resident receives at least 30 calendar days written notice before any increase in a fee or charge.

H. A Manager shall permit the Department to interview an employee, volunteer, or Resident as part of a compliance survey or a complaint investigation.

I. If abuse, neglect, or exploitation of a Resident is alleged or suspected to have occurred before the Resident was accepted or while the Resident is not on the premises and not receiving services from an Assisted Living Facility's Manager, Caregiver, or assistant Caregiver, the Manager shall report the alleged or suspected abuse, neglect, or exploitation of the Resident according to A.R.S.§46-454.

J. If a Manager has a reasonable basis, according to A.R.S §46-454, to believe abuse, neglect or exploitation has occurred on the premises or while a Resident is receiving services from an Assisted Living Facility's Manager, Caregiver, or assistant Caregiver, the Manager shall:

1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitations:
2. Report the suspected abuse, neglect, or exploitation of the Resident according to A.R.S.§46-454
3. Document:
    a. The suspected abuse, neglect, or exploitation;
    b. Any action taken according to subscription (J)(1): and
    c. The report in subsection (J)(2);

4. Maintain the documentation in subsection (J)(3) for at least 12 months after the date of the report in subsection(J)(2):

Records are maintained at our Administrative location:

Your Company Name Here.
Your Main Office Here Road
City, State Zip Code
480-827-1575

Administration requires a scheduled appointment with the Governing Authority or Facility Manager to view documentation (see written Policy and Procedure).

5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after required in subsection (J)(2):
    a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
    b. A description of any injury to the Resident related to the suspected abuse or neglect and any changes to the Resident's physical, cognitive, functional or, emotional condition;
    c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
    d. The actions taken by the Manager to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and

6. Maintain a copy of the documented information required in subsection (J)(5) for at least 12 months after the date the investigation was initiated.

K. A Manager shall provide written notification to the Department of a Resident's:

1. Death, if the Resident's death is required to be reported according to A.R.S §11-593, within one working day after the Resident's death; and
2. Self-injury, within two working days after the Resident inflicts a self-injury that requires immediate intervention by an emergency services provider.

L. If a Resident is receiving services from a home health agency or hospice service agency, Manager shall ensure that;

1. The Resident's medical record contains:
   a. The name, address, and contact individual including contact information, of the home health agency or hospice service agency;
   b. Any information provided by the home health agency or hospice service agency; and
   c. A copy of Resident follow-up instructions provided to the Resident by the home health agency or hospice service agency; and

2. Any care instructions for a Resident provided to the Assisted Living Facility by the home heath agency or hospice service agency are:
   a. within the Assisted Living Facility's scope of services,
   b. Communicated to a Caregiver, and
   c. Documented in the Resident's service plan.

M. A Manager of an Assisted Living Home may establish, in policies and procedures, requirements that a Caregiver obtains and provides documentation of Cardiopulmonary Resuscitation training specific to adults, which includes a demonstration of the Caregiver's ability to perform Cardiopulmonary Resuscitation, from one of the following organizations:

1. American Red Cross,
2. American Heart Association, or
3. National Safety Council

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: Opioid Policy
Responsible Persons: Governing Authority/Manager

Policy Reference: R9-10-120

Definition(s):

<u>Opioid</u>: means a controlled substance, as defined in A.R.S. 36-2501

Policy:
Your Company Name Here. ensures that any prescription medication that is considered a controlled substance (Opioid/Narcotic) is prescribed through a Medical Practitioner. Only the Delegation of Authority will be permitted to follow the outlined Procedure when providing Residents with assistance in Opioid, Benzodiazepine, Stateepine or any other sedative medication administration and will administer the prescribed medication per the Medical Practitioner's order (e.g. amount, time, route, etc.). Your Company Name Here. does not order or prescribe medications at any time for any reason.

Procedure:
If Opioids are prescribed to a Resident at Your Company Name Here. the following procedure will be followed:

1. Only Staff with proof of a valid Certified Caregiver Certificate and completion of the Your Company Name Here sixteen hour Medication Training Course may hold the title of "DOA" (Delegation of Authority). These Staff members and the Facility Manager have the skills and knowledge to administer Opioids in any of our Facilities.

2. The DOA will document the administration of the prescribed Opioid(s) or other sedative medication on the Medication Administration Record (MAR), the Narcotic Count Sheet and the PRN sheet, if applicable. Should an adverse reaction occur, it will be noted in the appropriate area on the MAR (see #9 for further instructions).

3. Prior to the process of administering any of the above types of medications, the DOA will use their skills and knowledge to be certain the;
   - Resident's pain is assessed/identified through verbalization, observation and/or pain scale assessment and logged on the MAR
   - Resident is monitored for their response to the Opioid(s) by the DOA through observation and communication directly with the Resident and care staff.
   - Reactions to the Opioid(s) are assessed and documented by the DOA and logged on the MAR.

4. Monitor the Resident to be sure they are not refusing or having difficulty taking their Opioid(s). If stopped suddenly, the Resident may have withdrawal symptoms which may include;

- Stomach Cramps
- Tears in eyes
- Chills
- Nausea/Vomiting
- Trouble sleeping
- Diarrhea
- Anxiety
- Sweats
- Increase in Blood Pressure
- Loss of appetite
- Feeling very tired
- Extra saliva
- Runny nose
- Increased heart rate.
- This is not meant to act as a complete list of withdrawal symptoms. Each Resident is different and can experience totally different symptoms. Notify your Manager with any concerns.

5. Opioids will be stored in a secured locked storage area. Only the Manager or the DOA shall be in possession of the keys to the Facility's medication storage area. Opioid(s) are maintained separately from all other medications.

6. Using guidelines from R18-13-1418, prescriptions will be destroyed by the Governing Authority or Manager at our Administrative Office, which is located at the Main Office, City Zip Code. Written proof of destruction will be maintained. This will prevent any non-medical use of these medications.

7. These guidelines are not intended to apply to hospice or palliative care Residents (as defined by the World Health Organization), Residents at end of life or with a Terminal condition, or cancer-related pain as defined in R9-10-120(A)(5).

8. Notify the Department of Health Services of the death of a Resident from a suspected Opioid overdose within one working day.

9. All Opioid related incidents resulting in spilling, mixing, loss of medication, adverse reactions, negative outcomes and/or death in the facility will be reported to the Manager immediately for correction;

- If an adverse reaction is severe and requires immediate medical attention, a call will be summoned.

  Otherwise, the Manager will contact the Resident's Medical Practitioner and follow their instructions.
- A Quality Management Assessment will be completed. The report will be maintained in our

  Unusual Occurrence Binder, it and any supporting documentation will remain part of the Resident's permanent record for one year from the date of the occurrence.

· If the outcome resulted in loss of life, the Governing Authority will notify The Department of Health Services within 24 hours.

10. In the rare instance where it may become necessary to administer an emergency dose of an Opioid, the Resident's Medical Practitioner must prescribe and order the Opioid. All other Medication Policy & Procedures will be followed by Your Company Name Here Staff, including Medication Administration and this Policy.

11. Certified Caregivers will receive Opioid training upon hire and annually during their employment.

_____ January 9th, 2025
Manager's Signature Date

_____ January 9th, 2025
Governing Authority's Signature Date

_____ January 9th, 2025
Medical Practitioner's Signature Date

Policy Topic: **Oxygen Safety**
Responsible Persons: **All Staff**

Policy Reference: R9-10-818

Purpose: To ensure that a Resident's oxygen is used and stored in a safe and appropriate manner within the Facility.

Policy: When it is determined that a Resident requires oxygen, the following Procedures will be followed .

Procedure:
The DME company will provide a technician to calibrate the equipment to the manufacturer's requirements to ensure that all parts are functioning properly.

All Residents require their oxygen to be set up by DME company.

Receive signed orders from the Medical Practitioner, including the metered dose.

Add oxygen orders to the MARs and send them to the pharmacy.

Update the service plan, by notifying the Assisted Living Manager.

Place an "Oxygen In Use" sign in a visible location near the front entry to make Visitors aware.

Ensure that all oxygen tanks (empty or full) are stored in a secure upright position (unable to fall over). Inform the Resident of this requirement.

Policy & Procedure Reviewed/Updated (New Policy Added)	Individual(s) Involved in Review/Update	Signature's of Individual(s)	Title of Individual(s)	Date Reviewed / Updated	Time Reviewed / Updated
Annual P&P Manual Review	Company Owner House Manager Licensed Nurse Practitioner		Governing Authority Manager Nurse Practitioner	01/08/25	12:00 PM
Annual Disaster Plan Review	Company Owner House Manager Licensed Nurse Practitioner		Governing Authority Manager Nurse Practitioner	01/08/25	1:00 PM
Annual Medication Policy Review	Company Owner House Manager Licensed Nurse Practitioner		Governing Authority Manager Nurse Practitioner	01/08/25	1:10 PM
Annual Opioid Policy Review	Company Owner House Manager Licensed Nurse Practitioner		Governing Authority Manager Nurse Practitioner	01/08/25	1:30 PM

Houseforms:P&PLog
Updated: 01/01/2025

Policy Topic: **Personnel (including Volunteers)**
Responsible Persons: **Manager/Governing Authority**

Policy Reference: **R9-10-806**

Policy:

It shall be the policy of Your Company Name Here to maintain personnel files for each staff member, which will contain the following:

1. The employee's name, date of birth, home address, and telephone number;
2. Documentation of:
   Freedom from pulmonary tuberculosis;
   Compliance with fingerprinting requirements;
   Current training in CPR and first aid;
   Employee qualifications as required for the position;
   Employee orientation; and
   Ongoing training, as applicable;
3. An employee's starting date of employment and ending date, if applicable; and
4. At least two personal and two professional or work-related references, if the employee has previous work experience, and documentation of our good faith effort to contact each reference.

The personnel files for each volunteer and support staff who has contact on a regular basis with Residents shall contain:

The individual's name, home address, date of birth, and telephone number; and
Documentation of freedom from pulmonary tuberculosis.
(Required if volunteer has 8 or more hours weekly in the facility)

All records shall be maintained throughout the individual's period of employment or service and for at least 24 months from the individual's last date of employment or service.

All personnel files will be located at our Administrative Office, which is located at Your Main Office Here Road, City, Arizona, Zip Code.

Policy Topic: **Personnel Records**
Responsible Persons: **Manager/Governing Authority**

Policy Reference: R9-10-806

Policy:
A Manager of Your Company Name Here. shall ensure that a personnel record for each Staff member or Volunteer:

1. Includes;
a. The Staff member's name, date of birth, and contact telephone number
b. The Staff member's starting date of employment or volunteer service, and, if applicable, the ending date; and
c. Documentation of;
i. The Staff member's qualifications, including skills and knowledge applicable to the Staff member's job duties;
ii. The Staff member's education and experience applicable to the Staff member's job duties;
iii. The Staff member's completed orientation and in-service education required by these Policies and Procedures;
iv. The Staff member's license or certification, if the Staff member is required to be licensed or certified.
v. Evidence of freedom from infectious tuberculosis, if required for the Staff member according to subsection (A)(8).
vi. Cardiopulmonary resuscitation training, if required for the Staff member according to this Article or these Policies and Procedures.
vii. First aid training, if required for the Staff member according to this Article or these Policies and Procedures.
viii. Documentation of compliance with the requirements in A.R.S. 36-411 (A) & (C)

Procedure:

1. Prior to being scheduled for a shift or providing services to our Residents, a personnel record will be created for each Staff member.

2. All Personnel records will be maintained at our Administrative Office, located at; Your Main Office Here Road, City, State Zip Code.

3. Once the Manager and/or Governing Authoring have reviewed the record and deemed it complete,
The Staff member will be placed on the schedule for training.

Policy Topic: **Personnel Records**
Responsible Persons: **Manager/Governing Authority**

Policy Reference: **R9-10-806**

Policy: All Your Company Name Here. Facility Staff Files will be maintained at our Administrative Office, located at:

Your Main Office Here Road
City, Arizona Zip Code
Each Facility Staff's File will contain:

1. The Facility Staff's name, date of birth, home address, current telephone number, starting and ending date of employment (if applicable).

2. Each Facility Staff member is required to have an Emergency Contact listed.

3. All Facility Staff must have documentation of:
   - Completion of a Caregiver Training Program approved by the Department or the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Managers.
   - Qualifications, including skills and knowledge applicable to the Facility Staff's job duties.
   - Education and experience applicable to the Facility Staff's job duties.
   - Completed Orientation and In-Service Education required by Policy and Procedure.
   - Evidence of freedom from infectious Tuberculosis.
   - Tuberculosis Risk Assessment
   - Cardiopulmonary Resuscitation Training (CPR), which includes a demonstration
   - First Aid Training
   - At least two personal references and two professional references, if the employee has previous work experience, and documentation of our good faith effort to contact each reference.
   - Complies with the fingerprint requirements in A.R.S. 36-411.

4. Is maintained :
   - Throughout the Facility Staff's or volunteer's period of providing services in or for the assisted living facility; and
   - For at least two years after the last date the employee or volunteer provided services in or for the assisted living facility.

Policy Topic: **Pets**
Responsible Persons: **All Personnel**

Policy Reference: **R9 - 10 - 803**

***Policy*:** Your Company Name Here. does not accept live-in pets. However, visiting pets for therapeutic reasons are welcome with approval from the Manager.

Procedure:

1. Pets should be controlled to prevent endangering the Residents, by keeping pets leashed at all times.

2. Pets should be licensed consistent with local ordinances.

3. Dogs and cats must be vaccinated against rabies.

4. The facility's sanitation should be maintained at all times. Pet owners must clean up after their pets immediately and thoroughly.

5. Any Your Company Name Here staff member has the authority to ask the pet and/or its owner to leave and/or be removed from the facility at any time.

6. Any willful violation of this Policy will be grounds for disciplinary action.

Policy Topic: **Proper Conduct Upgrade**
Responsible Persons: **Governing Authority/Manager**

The State of Arizona does not have laws that require employers to give personal breaks or meal breaks to their employees, thus the federal law applies. The federal law does not require breaks of any sort, under The Fair Labor Standards Act (FLSA). It is to the agreement of the employer and employee, and must be paid break if short (5-20 minutes) and long breaks (30 minutes or more) do not need to be paid.

Policy:
We at Your Company Name Here care about the personal health of our employees and strive for fairness and safety in the workplace. One, 10-minute break will be allowed per 4-hour shift, two per 8- hours. The two breaks will not be allowed to be taken in conjunction with each other, and never with another employee whether inside or outside of the building. Employees that choose to smoke will only be allotted the time on their breaks to do so. Sleeping is never acceptable on breaks or on-duty. Absolutely no cell phone use on-duty OR on breaks.

I have been informed that a new Policy & Procedure Manual is available for my review at the Administrative Office.

Employee Name (Printed)

Employee Signature _____ Date

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION ("PHI")

Your Company Name Here. is dedicated to protecting your "nonpublic personal health information." This notice is to tell you how and why we collect that information and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. Via the Resident Information Sheet we ask for a copy of your insurance card(s) to ensure that this information is correct.

If you came to our facility through another health care facility, we may obtain much of that information from them. However, upon admission, we will ask you to review/fill out our Resident Information Sheet to ensure that the information we received from the other facility is still correct.

We may also ask any health care provider who referred you to us or who has been involved in your care to give us health information that will enable us to better provide you with the appropriate level of care. This provides us with test results, past medical history, etc. which we can provide to any new health care providers.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can provide you with the appropriate level of care and obtain payment from your health insurance, if necessary. We also request that you update us whenever any of this information changes.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, we may ask you to fill out a new Resident Information Sheet at our discretion.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or persons designated in writing, people directly involved in your medical care, people creating and maintaining your medical record(s) and those entities that need your information to process health care claims, have access to your Protected Health Information (PHI).

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and our company has no jurisdiction over them.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need and are legally authorized to acquire your information. We maintain physical, electronic and procedural safeguards so that no one but persons involved in your healthcare have access to your PHI.

YOUR RIGHTS:
You have the right to review your PHI. However, arrangements must be made in advance with the Manager/Governing Authority as our records are often in use. You also have the right to amend any errors you may find in your record(s).

If you leave our Assisted Living Facility, your PHI will continue to receive the protection outlined in this notice for, at least, six years. Afterwhich, it will be destroyed.

COMPLAINTS/COMMENTS:
If you have any concerns regarding our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independent Avenue, S.W. Room 509F, HHH Building, Washington D.C. 20201.

Your Company Name Here. reserves the right to amend our privacy policy, as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be available for review in our Policy and Procedure Manual, which is located on site at each Assisted Living facility.

_____
Resident's Printed Name

_____

_____
Signature of Resident or Responsible Party **Date**

Policy Topic: **Quality Management**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-804**

Policy Statement: A plan has been established and will be documented and implemented, for an ongoing Quality Management Program.

Procedures:

1. Any Resident Care Issue or Concern and any Facility or Maintenance Concerns will be identified, documented and evaluated by a Manager, Governing Authority and/or Maintenance Supervisor, as applicable.

2. Our Report of Unusual Occurrence Form and any supporting documentation and/or information will be used to collect data to evaluate services provided to our Residents, identify any concerns about the delivery of services related to Resident Care, and to make changes or take action as a result.

3. Quality Management Assessment forms are internal documents and Your Company Name Here does not track these forms. Resident incidents will be recorded on an Report of Unusual Occurrence form and included in the Quality Management Program Binder.

4. The Quality Management Report will be submitted quarterly. The information will be entered into a spreadsheet and reviewed by the Governing Authority. The report will be maintained along with each assessment form in a binder at each Assisted Living Facility for at least 12 months after the date the report is submitted to the Governing Authority.

5. If any changes are deemed necessary once the review is complete, a follow up will be documented on the Quarterly Report.

Policy Topic: **Reports Made by Health Professionals**
Responsible Persons: **All Personnel**

Policy: Your Company Name Here. utilizes the following procedure with regard to the review of reports made in good faith, by health professionals, regarding any policy or practice that the person believes satisfies both of the following criteria:

1. Violates professional standards of practice or is against the law: and
2. Poses a substantial risk to the health, safety or welfare of our Residents.

Procedure:

Any such report may be made in person, by telephone, or in writing to the Facility's Manager, or to the Governing Authority.

During the initial report, the individual making the report should be identifiable by the person receiving the report, as being a credible health professional, who is making the report in good faith.

the identity of the reporting individual will be treated as confidential by the person receiving the report and by the reviewing committee. Provided that the Reporting individual has taken the necessary steps to ensure their own confidentiality (by not sharing the report with co-workers or others) their confidentiality will be ensured.

The report will be placed into written form by the person receiving the report and a meeting will be held by the reviewing committee which will include the Facility Manager, and the Governing Authority for the review of the report. If further clarification is required, the individual having made the report may be asked to participate in an interview about the report.

No retaliatory action will be taken against a health professional, for making such a report; provided that the report was made pursuant to the above procedure and that Your Company Name Here was provided a reasonable opportunity to address the report, prior to the information concerning the activity, policy, or practice that was the subject of the report being provided to any private health care accreditation organization or governmental entity.

Policy Topic: **Residency Criteria**
Responsible Persons: **Governing Authority/ Manager**

Policy Reference: **R9-10-807**

Policy: The criteria listed must be followed and/or provided for an individual to be accepted as a Resident at Your Company Name Here.

Procedure:
Each prospective Resident and his or her Representative, if applicable, shall be assessed by the Governing Authority or a Manager prior to acceptance. If there is no Resident Representative, it is preferable to meet with a member of the Resident's care team to obtain the most accurate Resident History Profile.

The following topics and items will be covered in the assessment, if applicable:

1. Acceptance of policies and the terms of occupancy
2. Resident services, deposits, fees, charges, and refunds
3. Resident agreements and termination of agreements
4. Resident service plans and the Resident's individual needs
5. Resident rights and procedure and healthcare directives
6. Responsibilities of the Resident and the facility
7. Facility location available

Residents will be accepted for openings based on their needs, level of service required, and Your Company Name Here ability to provide the needed services within the confines of the Directed Care licensure. No Resident will be refused acceptance based on race, national origin, religion, gender, sexual orientation, disability or marital status.

Procedure:

The assessment will be performed by the Governing Authority or Manager prior to the Resident's admission. The assessment will occur not more than thirty (30) days of the proposed admit date. The following admission criteria will be taken into consideration during the assessment process:

1. Each person being considered for Residency is required by The Arizona Department of Health Services to show proof of freedom of Infectious Tuberculosis. A TB Risk Assessment, Signs & Symptoms Screening and A negative Mantoux skin test (PPD) or Blood test is acceptable upon admission or within seven calendar days after the Resident's date of occupancy as long as it has been administered within the last 12 months of the Residents admission. It should include the date and type of TB Screening. Annually, the following documentation is acceptable: 30 days prior or 30

days after the Anniversary date, a Mantoux skin test (PPD) or Blood test. Annual education will be provided on the signs and symptoms of TB. Please see TB Education Program Binder for details.

2. Documentation before or at the time of acceptance dated within 90 days before the potential Resident is accepted by Your Company Name Here. and:

a. If the potential Resident is requesting or is expected to receive Personal or Directed Care Services;

i. Includes whether the potential Resident requires;

- Continuous medical services
- Continuous or intermittent nursing services, or
- Restraints, including bed rails; and

b. Is dated and signed by a;

- Physician,
- Registered nurse practitioner,
- Registered nurse, or
- Physician assistant

2. Your Company Name Here. shall not accept or retain a Resident if;

1. The Resident requires continuous:
   a. Medical Services;
   b. Nursing Services, unless the facility complies with A.R.S. 36-401(C);
   c. Behavioral Health Services;
2. The primary condition for which the Resident needs Assisted Living services is a Behavioral Health issue (does not include Behavioral Care, Dementia or TBI)
3. Services that are needed by the Resident are not within the facility's Scope of Service & a Home Health or Hospice Agency is not involved in the Resident's care;
4. Facility does not have the ability to provide the Assisted Living services needed by the Resident.
5. The Resident requires restraints, including the use of bedrails.

The Governing Authority will make the final determination concerning acceptance for Residency.

Policy Topic: **Resident Immunization**
Responsible Persons: **Governing Authority/Manager**
Policy Reference: **A.R.S. 36-406-1(d), R9-10-803**

Definition(s):
Immunization: a process that involves stimulating the immune system of an organism in order to improve its ability to resist or fight a specific future infection, specific to Influenza and pneumonia

Policy:
All Residents at Your Company Name Here will be offered the opportunity to receive the Influenza Vaccination on an annual basis when it becomes available to the public, typically between the months of September and December. All Residents or Responsible Parties must fill out an Immunization Form stating their acceptance or refusal of the Influenza Vaccination.

All Residents at Your Company Name Here will be offered the opportunity to receive the one time Pneumonia Vaccination, or orders designated by their Medical Practitioner. All Residents or Responsible Parties must fill out an Immunization Form on an annual basis stating their one time acceptance of the Pneumonia Vaccination or their annual refusal of the Pneumonia Vaccination.

Your Company Name Here. shall not be held accountable financially if a Resident's health plan does not cover the cost(s) of the vaccination(s). A good faith effort will be made to contact the Resident's Representative to see if the cost can be incurred privately. Documentation will be kept to support lack of coverage showing why the vaccination(s) were unable to be administered.

As stated in A.R.S.36-406(d)(1) The Department of Health Services shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of the vaccination in this state as determined by the Director. Your Company Name Here. will attach supporting documentation to our annual Influenza/Pneumonia Vaccination Forms should a shortage occur.

Procedure:
1. In the fall when the Influenza Vaccination becomes available, all Residents will be notified of the availability of the vaccines.
2. For those Residents with known cognitive impairments, the information will be sent to their Responsible Parties. *The Responsible Parties of all dementia Residents will be notified.*
3. All Residents/Responsible Parties must fill out an Annual Vaccination Form stating their acceptance or refusal of the vaccinations.
4. Residents receiving either/both of the Influenza Vaccination and the Pneumonia Vaccination are responsible for payment of the vaccinations if their medical insurance does not cover their cost. If they are unable to pay for the vaccination privately the Medical Practitioner, CM (if applicable) and any other necessary parties will be notified. Your Company Name Here is not financially responsible for any vaccinations.

Annual Vaccination Forms will remain in the Resident's Record until the next year.
Then they will be archived in the Administrative Office with all other health related records.

Policy Topic: **Resident Records**
Responsible Persons: **Governing Authority/Manager**
Policy Reference: **R9-10-811**

Policy:

The Resident's records are legal documents and shall be treated as such. A medical record will be established and maintained for each Resident according to ARS Title 12, Chapter 13, Article 7.1:

1. Each Resident shall have a separate record.
2. All entries shall be in black ink.
3. The records shall be maintained in:
    a. The Resident's Chart in the facility.
    b. The Administrative Office at Your Main Office Here Road, City, Zip Code:
    i. All back up documentation
    ii. All aged records for the past 6 years
4. The records shall be retained for six (6) years from the date of termination of the Residency Agreement.
5. Resident financial records shall be maintained in a separate file and will be accessible only by a time previously arranged with the Governing Authority.

All Resident records are considered confidential and will be treated as such by the staff. Any employee breach in confidentiality will result in disciplinary action up to and including termination.

The Resident or the Resident's Representative may review his or her file during normal business hours when prior arrangements have been made with the Governing Authority and/or Facility Manager. The contents of the records will only be released to others upon written permission from the Resident or Representative unless required to do so by a court order or when existing law mandates the release without permission.

The Resident records will only be recorded by Your Company Name Here. Certified Caregivers, Facility Manager and where applicable Administrative Staff. Each recording will be dated, legible, authenticated and not changed to make the initial entry illegible.

If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or signature.

All Resident records will contain the following components:

3. Full legal name, date of birth, previous address, and social security number of the Resident (kept in electronic database at Administrative Office and Resident Chart in facility),

4. Date of acceptance and referral source
5. Names, addresses, and telephone numbers of:
    a. Resident's Representative
    b. Medical Practitioner (may be a physician, physician's assistant, or nurse practitioner who directs the Resident's care)
    c. Case manager (if applicable)
    d. Medical practitioner(s) providing services to the Resident
    e. Person(s) to contact in the case of: an emergency, a significant change in the Resident's condition, or the termination of the Residency Agreement
6. Resident's preference, if any, for hospice, home health and mortuary if applicable, Residency Agreement and any amendments (written copy),
7. Written documentation of receipt of Resident Rights, and required telephone numbers (written copy),
8. Written documentation that the Resident was oriented to the facility's exits and evacuation plan (written copy),
9. The Resident's service plan including any amendments or updates (written copy),
10. Health care directives (written copies), if applicable,
11. Documentation of general consent and informed consent, if applicable,
12. Documentation of freedom from infectious tuberculosis (written copies),
13. Any orders from a medical practitioner including those required for the residency or continued residency of the individual (written and electronic database),
14. Medication administration records (written and electronic database),
15. Any Reports of Unusual Occurrences (written),
16. Documentation of any change in a Resident's behavior, physical, cognitive or functional condition, and any action taken by staff to address the Resident's changing needs (Your Company Name Here INTERNAL USE ONLY/written copy).
17. Documentation of services provided in the service plan by the Caregiver will be "documentation by exception". Only those items listed that do not occur, otherwise the assumption is made that the Resident received the services.
18. In the case of the termination of a Residency Agreement:
    a. A copy of the notice and any other required documents (written),
    b. Documentation of any relocation assistance given (written)
    c. Documentation of the disposition of the Resident's personal property and monies owed (written and electronic database),
17. If a Resident is receiving behavioral care, documentation as required in R9-10-812, If applicable, documentation that evacuation from the facility, during a drill may cause physical harm to the Resident,
18. Documentation of the notification required in R9-10-803(G) if the Resident is incapable of handling financial affairs;
19. Other documents as approved by the Governing Authority (written and electronic database).

All electronic records shall be password protected, with access given only to staff responsible for recording data, and will be used only by the authorized personnel.

Policy Topic: **Resident Refund, Charges, or Deposits**
Responsible Persons: **Governing Authority**
Policy Reference: **R9-10-807**

Refund Policy:

Approximately 30 days after the Resident has vacated the facility (including their personal belongings), the Resident, Resident's Representative or Resident's estate shall be provided with a written statement that includes:

1. An accounting of all fees, personal funds, or deposits owed to the Resident, and
2. An accounting of any deduction from fees or deposits.

Procedure:

If a refund is due, our Administrative Office will process the refund approximately 30 days from the Resident's move-out date or date of passing. The Refund will be mailed using The United States Postal Service.

Charges Policy:

Our Monthly Room and Board is determined by an assessment that is conducted prior to admission. The Room and Board rates vary depending upon the individual's level of care. All members of ALTCS will have their Room and Board set by their Program Contractor (e.g. Mercy Care or United).

A list of additional Charges and Services is given at the time of admission and is updated as needed. To obtain the most current copy of our Charges and Services please contact our Administrative Office at: 480-827-1575; Your Main Office Here Road, City, State Zip Code.

Deposit Policy:

Your Company Name Here. does not require a deposit. However, we do have a one time Administrative Fee of $1,000.00 due at the time of admission. Please note, Residents that are members of ALTCS are not charged an Administrative Fee.

Policy Topic: **Resident Rights**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-810**

Policy:

All Residents are entitled to the Rights summarized in the Arizona rules covering Assisted Living Facilities.

All Residents and Staff are made aware of these Rights as they govern how Residents are treated and assist in maintaining their health and safety. A copy of these Rights are provided to each new Resident or Resident's Representative upon acceptance and are also posted inside the main entrance of each Facility. The Resident or Resident's Representative will sign an acknowledgment, located on the last page of the Residency Agreement, that they have received and understand these Rights.

Residents who feel their Rights have been withheld or violated are encouraged to file a grievance without fear of reprisal or retribution.

Reasonable accommodations to ensure that the Resident understands his or her rights will be made. Including the need to insure that language barriers or physical disabilities do not prevent a Resident or Resident's Representative from becoming aware of facility rules and Resident Rights.

See Grievance Policy

Policy Topic: Resident Use of Medical Marijuana
Responsible persons: Governing Authority/ Manager/ Caregivers

A.R.S. 36-2805 allows, but does not require, assisted living facilities to adopt reasonable restrictions in the use of marijuana for their residents. The statute also states that an assisted living facility may not "unreasonably limit a registered qualifying patient's access to or use of marijuana...unless failing to do so would cause a facility" to be penalized under Federal law or regulations.

Policy:

Your Company Name Here. accepts Residents who are qualifying patients for medical marijuana. The Resident must have a registry identification card and a written order from a physician. Acceptable forms of marijuana medication at Your Company Name Here are :
a. edibles,
b. cream, lotions,
c. oils
d. suppositories,
e. tinctures,
f. other infused products like vaporizing pens

Smoking is not permitted inside any of the facilities. Each facility has an outdoor area where smoking is permitted for our guests. Your Company Name Here will consider accepting Residents that smoke on a case by case basis at the Governing Authorities discretion.

Medical marijuana will be treated as all other medications and treatments in regards to individual treatment plans. The marijuana will be stored in our designated medication cabinet, inside its own locked container, the keys will be in the possession of the Designated Caregiver at all times. Medication administration will be based on:

a. the form of the medication (lotion, edible, etc.) and
b. will be administered to the Resident only by the Designated Caregiver.

Designated Caregiver:

Each qualifying Resident must have a Designated Caregiver who has registered with the department and has been issued registry identification cards.
Designated Caregiver:
a. Must be 21 years or older
b. Must agree to assist a qualifying patient with his or her medical use of marijuana
c. May not have been convicted of an excludable felony

A Designated Caregiver must submit a set of fingerprints and signed certification that he/she agrees to be the qualifying Resident's Designated Caregiver and not to divert medical marijuana to anyone who is not permitted to possess medical marijuana.

A Designated Caregiver may be a Designated Caregiver for up to five Residents.

Procedure:
Because of the nature of the medicine, (i.e. oils, creams, edibles etc.,) we accept only dispensary delivered forms of the medications to be sure of its quality and source. No person shall bring any form of the medical marijuana medication into the facility for a Resident.
1. Medications must be obtained from a reliable and legal clinic or dispensary. There are many dispensaries and clinics licenced by the Arizona Department of Health Services.
2. Whenever possible, written medication orders will be obtained prior to admission or by verbal order the day of admission.
3. All Resident's marijuana medications will be secured in the designated medication cabinet, inside its own locked container. Only the Designated Caregiver shall be in possession of the keys to the marijuana medication container.
4. Your Company Name Here does not allow any medications including marijuana medications to be kept in a Resident's bedroom. There are no exceptions!
5. Residents will have their medications reviewed and approved every 90 days by their PCP, PA or NP. Unless there is a significant change in the Resident's condition, in which case they will be reviewed within 14 days of the change and be placed in the Resident's Chart for 12 months.
6. Prior to, or upon admission Your Company Name Here will provide a complete list of Certified Caregivers to the PCP to authorize the administration of medications and treatments as ordered. The list will be maintained under Medical Misc. in the Resident's Chart. This list will be changed to reflect the Designated Caregiver, if applicable.
7. Your Company Name Here Staff will provide medication administration of all medications and treatments to the Residents, we do not allow our Residents to self-administer medications.

Policy Topic: **Grievances (Complaints)**
Responsible Persons: **Manager/Governing Authority**

Policy: The Resident or Resident's Representative has the right to file a grievance to the Manager and/or Governing Authority without fear of retaliation.

Procedure:

Step 1: Written Grievance
The Resident or Resident's representative shall explain in writing the grievance to a manager. The written grievance will include a clear statement of the grievance, a suggested remedy and must be brought within 5 working days from the day the decision, service, or lack of service was observed.

Step 2: Written Response
The Facility, in collaboration with a manager, (if the two positions are distinct and separate), shall reach a decision and communicate it in writing to the Resident or Representative within 5 working days of receipt of the written grievance.

Step 3: Reconsideration Request
If the Resident or Representative is unsatisfied with the Written Response, they shall respond in writing within 5 working days offering alternative suggestion(s) and requesting reconsideration.

Step 4. Committee Response
The licensee shall then form a committee of three individuals, including a manager, the individual who developed the service plan (or a nurse) and another individual affiliated with the facility to meet and review the grievance. This committee will offer a written reply of their decision to the Resident or Representative within 5 working days.

Step 5. Outside Assistance
If the Resident or Representative still feels that the decision of management has not resolved the grievance, they should seek outside counsel through The State Long Term Care Ombudsman Program at (602) 277-7292.

Any reply which is not appealed by the Resident or their Representative within the time allowed at each level shall be considered settled and binding on the part of the Resident or Resident's Representative and the Facility.

Policy Topic: **Resident Report of Unusual Occurrence**
Responsible Persons: **All Personnel**
Policy Reference: **R9-10-804**

Policy:

Your Company Name Here will use Reports of Unusual Occurrences, document the necessary/required information and take appropriate action..

Procedure:

1. When there is an accident, emergency, injury or incident that affects the health and safety of a Resident, visitor or staff, the following actions will be taken:

   Remove the Resident, Visitor or Staff from any immediate danger, if present. Notify, if necessary, the emergency response team by calling 911
   Notify the Manager.
   Notify the Resident's Representative, Medical Practitioner, Resident's emergency contact and ALTCS Case Manager (if applicable).

2. The witnessing Staff member/initial responder to the unusual occurrence shall fill out a written Report of Unusual Occurrence. This includes documentation of:

   Date and time of the accident, emergency, injury, or incident;
   Description of the unusual occurrence, i.e., what happened;
   Names of witnesses, including Residents;
   Actions taken immediately following the unusual occurrence;
   Names of individuals notified and/or the times that they were contacted.

3. The Manager will complete the following sections:

   2. Actions taken to prevent a recurrence;
   3. Any follow-up made with Staff Members, Resident, Resident's Representative, family members, Medical Practitioner or Case Manager (if applicable).

4. The Governing Authority will conduct a final review of the Unusual Occurrence reports.
5. Service plans will be updated as necessary.
6. A log of all Reports of Unusual Occurrences that occurred in each calendar month will be tracked by the Administration and reviewed by the Governing Authority during the months of March, June, September and December of each calendar year. Quality Management Assessments will also be maintained for each calendar year.

An Unusual Occurrence report is to be completed if and when a Resident wanders off the property. Reports of Unusual Occurrences will remain on file for a period of one year. The reports will be kept in the binder and logged as stated above.

Policy Topic: **Respite Care Services/Adult Day Health Services**
Responsible Persons: **Governing Authority**

Policy Reference: **R9-10-803**

Policy: Your Company Name Here. does not offer Respite Care Services or Adult Day Health Care Services.

Procedure: If, at any point, the facility begins offering either or both of these services appropriate policies and procedures will be put in place.

Policy Topic: **Scope of Services**
Responsible Persons: **Governing Authority/Manager**

Definition:
Means a list of the Physical Health Services or Behavioral Health Services the Governing Authority of the Health Care Institution has designated as being available to a Resident at the Health Care Institution.

Policy:
The Governing Authority shall define the Scope of Services for Your Company Name Here. and delegate to it's Manager(s) the parameters in which the Assisted Living Facility will operate at the Directed Care Licensure.

Procedure:
Your Company Name Here. may accept Residents whose needs may include, but are not limited to, any of the conditions and treatments listed below. Upon acceptance, each Resident's Medical Practitioner shall authorize the 'Your Company Name Here' Delegation of Authority, to administer any orders for medications and treatments as may be issued by such practitioner.

☐ Alcohol Use	☐ Durable Medical Equipment	☐ Multiple Sclerosis
☐ Alzheimer's Disease	☐ APP/Low Air Loss Mattress	☐ Obesity
☐ Bed Bound	☐ Bed Cane	☐ Osteoporosis
☐ Behavioral Care	☐ Hoyer Lift	☐ Oxygen Use
☐ Bi-Polar	☐ Motorized Scooter	☐ Pacemaker
☐ Blindness	☐ Motorized Wheelchair	☐ Pain Management
☐ Bowel Management	☐ Walker	☐ Paralysis
☐ Cancer(s)	☐ Wheelchair	☐ Renal Disease/Dialysis
☐ Congestive Heart Failure	☐ Wheelchair Cushion/Pad	☐ Schizophrenia
☐ Central Vascular Accident	☐ _____	☐ Seizure Disorder
☐ Colostomy	☐ Incontinence (Bladder)	☐ Sleep Disorder
☐ Catheter	☐ Incontinence (Bowel)	☐ Smoking
☐ Deafness/Hearing Loss	☐ Gastric Tube	☐ Therapeutic Diets
☐ Depression	☐ Medication Administration	☐ Traumatic Brain Injuries
☐ Diabetes (sliding scale)	☐ _____	☐ Wandering
☐ _____	☐ _____	☐ Wound Care

The above list is not intended to be complete, but representative. The Governing Authority may, at any time, update the Scope of Services by either adding to or deleting any services it deems necessary.

Policy Topic: **Service Plans**
Responsible Persons: **Governing Authority, Manager, Designee, RN or NP, PA, PCP**

Policy Reference: **R9-10-808**

Definition(s):

Service plan: means a written description of a Resident's need for Supervisory Care Services, Personal Care Services, Directed Care Services, Ancillary Services or Behavioral Health Services and the specific Assisted Living services to be provided to the Resident.

Assessment: means an analysis of a Resident's need for Physical Health Services or Behavioral Health Services to determine which services a health care institution will provide to the Resident.

Significant change: means an observable deterioration or improvement in a Resident's physical, cognitive, behavioral, or functional condition that may require an alteration to the Physical Health Service or Behavioral Health Services provided to the Resident.

Purpose:

To ensure that all Your Company Name Here Residents receive appropriate services that meet their needs. To ensure that the needed services are within the scope of Your Company Name Here's license to operate.

Policy:

The service plan will be initiated when the Resident is accepted or no later than the day the Resident moves into the facility, and completed within fourteen (14) days of admission.

The service plan will be developed with assistance and review from the Resident or Resident's Representative and a Manager. The following individuals will be involved in developing and updating the Resident's service plans:

The Resident and/or his or her Representative,
The Manager or Designee,
Any individuals requested by the Resident or the Resident's Representative,

EFFECTIVE: OCTOBER 2013

Policy Reviewed/Updated	Date Reviewed/Updated	Individuals Involved in Review/Update	Individual's Signatures	Title of Individual

Policy Topic: Smoking Safety

Responsible Persons: All Staff

Definition(s):

Smoking: ***the inhaling or tasting of smoke produced by burning substances, most commonly tobacco. It is one of the most common forms of recreational drug use. Tobacco smoking is the most popular form of smoking and is commonly smoked through cigarettes.***

Policy:

Your Company Name Here. will follow all rules of The Smoke Free Arizona Act. This Act provides that people will not be subjected to secondhand smoke in most public places and places of employment.

In Public places means an enclosed area to which the public is invited or in which the public is permitted.

In Places of employment means an enclosed area under the control of a public or private employer that employees normally frequent during the course of employment.

The Law prohibits smoking inside and within 20 feet of entrances, open windows, or ventilation systems of an establishment.

However, a designated Smoking Area will be available in the backyard of each facility.

Procedure:

A Designated Outdoor Smoking Area will be provided at each facility and will include a Fire Marshall/CMS approved ash receptacle, located at least 20 feet from any entrances, open windows or ventilation systems.

Any Visitor choosing to smoke will be directed to the designated area and shown the ash receptacle for butt disposal. All Visitors must dispose of their smoking waste materials appropriately.

Your Company Name Here. The Governing Authority has the right to ask any Visitor to cease smoking if they are not following the Policy and Procedures.

Any Resident who wishes to smoke will require a Smoking Assessment. While this Assessment is not a guarantee of safety, it will assist in determining whether or not the Resident likely has a sufficient level of safety awareness to smoke safely.
This Assessment will be reviewed by the Manager, Governing Authority and Medical Practitioner.

If it is determined that it is safe for the Potential Resident to smoke, they will be informed of the determination and the Policy and Procedures will be reviewed.

All Residents that smoke will be assessed prior to admission and reassessed periodically, especially if there is a change in their condition, to ensure their continued safety to the best of our ability.

All smoking materials and lighters/matches will be stored in a locked area and only handled by employees of Your Company Name Here. Caregivers will supervise the smoking process.

Your Company Name Here will establish and post recommended smoking times to assist cognitively impaired Residents in maintaining a routine.
Recommended times: 7 am, 10 am, 1 pm, 4 pm, 7 pm and PRN.
These times are subject to change at the Governing Authority's discretion. Note that inclement weather, including excessive heat, may further restrict this activity.

Smoking will NEVER be permitted simultaneously with the use of Oxygen or any other hazardous material nearby.

Your Company Name Here. will have and strongly encourage the use of fire-retardant smoker's aprons.

Caregivers will be educated on Safe Smoking practices upon hire and as necessary.

Resident's Service Plan will be noted upon admission and updated as necessary.

Policy Title: TB Screening Requirements for Healthcare Institutions
R9-10-113

Responsible Parties: Administration & Manager

Policy:
Your Company Name Here. shall follow all Arizona Department of Health Services, CDC, and Maricopa County Public Health recommendations which will be detailed in our TB Education Program Binder.

Procedure:
Each of our Facilities shall maintain an updated TB Education Program Binder on its premises at all times.
This binder will include all information from R9-10-113 and all required forms/attachments. This binder reflects the most recents updates as of May 2022.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Staff Complaint regarding Resident Care**
Responsible Persons: **Governing Authority/Manager**

Policy Reference: **R9-10-807**

Policy: It is the policy of Your Company Name Here to provide a method for the staff to report any complaints that they might have in the area of Resident care.

Procedure:

If a staff member has any type of complaint in regard to Resident care, they will proceed as follows:

1. A serious complaint will be reported immediately to the Governing Authority or Manager, after the staff member that made the report is sure that the Resident is in a safe position/condition. The Manager's cellular telephone number is posted in the designated Personnel area. The Manager is available at all times while not on the premises.

2. The reporter should follow up in writing, with details of the complaint, noting all factors or individuals involved.

3. The Governing Authority or Manager will investigate appropriately, taking necessary action to rectify, if the complaint is substantiated.

4. A less serious complaint should be documented in writing and turned into the Governing Authority or Manager.

5. The Governing Authority or Manager will investigate appropriately, taking necessary action to rectify, if the complaint is substantiated.

Policy Topic: **Staffing/24 Hour Awake Staff**
Responsible Persons: **All Personnel**

Policy reference: **R9-10-803/R9-10-806**

Policy:
Your Company Name Here. staffs four, eight hour shifts in a twenty-four hour period. All Facility Staff are to remain awake on their shift. These shifts are as follows:

Morning, Afternoon, Evening and Night

* All shifts are subject to change at the Governing Authorities discretion and with the input of the Manager of the Facility.

Procedure:

1. Prior to being scheduled for a shift or providing direct care to our Residents, a Certified Caregiver must have a current and valid Caregiver Certificate, current CPR specific to Adults, current First Aid, documentation of evidence of freedom of infection Tuberculosis (within the last 12 months) a TB Risk Assessment and met the requirements for Fingerprint Clearance in A.R.S. 36-411.

2. Each Facility Staff member will have their name placed on the schedule indicating the Facility, days, and times of the current week's shifts. Each Facility Staff member will also be required to fill out a time card upon beginning and ending each shift.
   Time cards will remain in the Facility until the end of the pay period and then will be collected and turned in to the Administrative Office for review.

3. Only a Caregiver given direct permission from the Governing Authority and the Facility Manager will be considered as a Designee.

4. Each Facility will post a current schedule, in plain sight, for all Facility Staff to view. If a Facility Staff member or Manager is not able to perform their assigned duties or work their schedule shift, a Manager should be notified. However, if they cannot be reached, the Primary location on your Disaster Plan should be notified. If you are unable to obtain the necessary resources from the Primary location, move on to the Alternate location listed (see Disaster Plan in P & P)

5. At least, one year of past schedules will be maintained on site. After a 12 month period they will be turned into the Administrative Office at Your Main Office Here, City, State Zip Code.

6. Facility Staff wishing to have time off must fill out a Time-Off Request Form.

7. All schedule changes and time-off requests must be approved by the Facility Manager and Governing Authority. Please see Time-Off Request Forms for policy on appropriate procedure to assure your request will be granted.

8. All Facility Staff are to remain awake on their scheduled shifts. At no point in time are any of our Facility Staff members allowed to remain in the Facility when they are not scheduled.

Living in or sleeping in the Facility is not tolerated and may result in immediate termination.

9. During hours of sleep Residents will be monitored often by Facility Night Staff to promote their health and safety.

Policy Topic: **Staffing/24 Hour Awake Staff**
Responsible Persons: **Facility Staff**

Policy Reference: **R9-10-803/R9-10-806**

Policy:
Your Company Name Here. staffs four, eight hour shifts in a twenty-four hour period. All Facility Staff are to remain awake on their shift. These shifts are as follows:

MORNING, AFTERNOON, EVENING & NIGHT

*All shifts are subject to change at Governing Authorities discretion and with the input of the Facility Manager.

Procedure:
1. Prior to being scheduled for a shift or providing direct care to our Residents, a Certified Caregiver must have a current and valid Caregiver Certificate, current CPR specific to Adults, current First Aid, documentation of evidence of freedom of infectious Tuberculosis (within the last 12 months), complete our TB Education Program Binder and met the requirements for Fingerprint Clearance in A.R.S. 36-411
2. Each Facility Staff member will have their name placed on the schedule indicating the Facility days and times of the current week's shifts. Each Facility Staff member will also be required to fill out a time care upon beginning and ending each shift. Time cards will remain in the Facility until the end of the pay period and then will be collected. The Manager is responsible for collecting them and delivering them to the office for Administrative review.
3. Only a Certified Caregiver given direct permission from the Governing Authority and the Facility Manager will be considered as a Designee.
4. Each Facility will post a current schedule, in plain sight, for all Facility Staff to view. If a Facility Staff member or Manager is not able to perform their assigned duties or work their scheduled shift a Manager should be notified. However, if they cannot be reached, the Primary location on the Disaster Plan should be notified. If the Facility Staff member is unable to obtain the necessary resources from the Primary location, move on to the Alternate location listed (see Disaster Plan in P & P).
5. At least, one year of past schedules will be maintained on site. After a 12 month period the records will be brought to our Administrative Office at Your Main Office Here Road, City, State Zip Code and properly destroyed.
6. Facility Staff wishing to have time off must complete a Time-Off Request Form.
7. All schedule changes and Time-Off requests must be approved by the Facility Manager and Governing Authority. Please see Time-Off Request Forms for the policy on appropriate procedure to assure your request has the best chance of being granted.
8. All Facility Staff are to remain awake on their scheduled shifts. At no point in time are any of the Facility Staff allowed to remain in the Facility when they are not scheduled. Living in or sleeping in the Facility is not tolerated and may result in immediate termination.
9. During hours of sleep, Residents will be monitored frequently by Facility Night Staff to promote their health and safety.

Policy Title: TB Screening Requirements for Healthcare Institutions
R9-10-113

Responsible Parties: Administration & Manager

Policy:
Your Company Name Here. shall follow all Arizona Department of Health Services, regulations and recommendations which will be detailed in our TB Education Program Binder.

Procedure:
Each of our Facilities shall maintain an updated TB Education Program Binder on its premises at all times. This binder will include all information from R9-10-113, as well as all required forms/ attachments. This binder reflects the most recent updates to the State DHS Regulations, as of May 2022.

Policy Topic: **Termination of Residency**
Responsible Persons: **Governing Authority & Manager**

Policy Reference: R9-10-806/R9-10-807

Policy:
This Residency Agreement may be terminated by either party, with 30 days written notice.
Note: Any action by the Facility under this section, will be overseen and coordinated by a licensed Assisted Living Manager.

Procedure:
The Resident or the Representative may terminate this Agreement;
1. Without notice due to neglect, abuse, exploitation, or if conditions exist which place the Resident in imminent danger to life, health or safety, if substantiated by a governmental agency.

The Facility may terminate this Agreement;
1. Without notice if: The Resident exhibits behavior that is an immediate threat to the health and safety of themselves, or other individuals in the facility, or the Resident's medical or health needs require immediate transfer to another health care institution, or the Resident's care and service needs exceed the services the facility is licensed or able to provide.

2. After providing 14 days written notice if: There is any documented failure to pay fees, charges or deposits.

The Facility will include the following documents with any written notice of termination:
- The reason and effective date for the termination.
- The Resident's right to grieve the termination and grievance procedure.
- The facility's refund policy and deposition of all the Residents fees, charges and deposits.
- A copy of the Resident's Service Plan and most recent TB test documentation.
- Contact information for the D.E.S. Long Term Care Ombudsman.
- If the Resident requires services the Facility is unable to provide, a detailed explanation thereof.

Policy Topic: **Transport and Transfer**
Responsible Persons: **Manager, Designee & Certified Caregivers**

Policy Reference: **R9-10-809**

Policy:
Staff will make sure that Residents requiring a non-emergency transfer will remain safe before, during and after transfer, arriving safely at the receiving Health Care Institution, and according to policies and procedures. A 911 call where it is determined that the Resident must be sent to an Emergency Room is not subjected to this policy.

Procedure:

Our Staff will coordinate the non-emergency **transport** or **transfer** and the services provided to the Resident, performing the following:

1. An evaluation of the Resident before and after the transport;

2. Prepare necessary medical records, including orders and nature in effect at the time of the transfer, to be provided to a receiving Health Care Institution;

3. Explanation of the risks and benefits of the transport to the Resident or the Resident's Representative; and

4. Document in the Resident's medical record to include:

    5. Communication with an individual at a receiving Health Care Institution;
    6. The date and time of the transport;
    7. The mode of transportation; and
    8. If applicable, the name of the caregiver accompanying the Resident during a transport.

5. This does not apply to:

    a. Transportation to a location other than a Licensed Health Care Institution,
    b. Transportation provided for a Resident by the Resident or the Residents Representative,
    c. Transportation provided by an outside entity that was arranged for a Resident by the Resident or the Resident's Representative, or
    d. A transport to another Licensed Health Care Institution in an emergency.

Policy Title: Visitation Requirements (at a glance)
Responsible Parties: All Staff
Policy:
During times of heightened disease controls mandated by the Governor, Arizona Department of Health Services and other governing agencies. Your Company Name Here. will implement Visitation Requirements and Policies that follow Arizona Department of Health Services guidelines.
Procedure:
Visitation at any of our facilities will only be resumed if the conditions of the benchmarks, which means the percentage/level of positive Covid-19 cases are met. The benchmarks are updated weekly, on Thursday. The updated benchmark information can be found by viewing;

Statehealth.gov/businessCOVID19

These benchmarks are as follows:

Compassionate Care Visitation is allowed at all levels of community spread under specific guidelines.

1. Minimal Community Spread = 5% or fewer cases

   Limited indoor visitation, with no contact & negative Covid test
   Limited outdoor visitation
   Personal Protective Equipment (PPE) required
   Symptom screening & physical distancing

2. Moderate Community Spread = 5% to 10%

   Limited outdoor visitation, with no contact
   Limited indoor visitation, with no contact & a negative Covid test
   Symptom screening & physical distancing
   Personal Protective Equipment (PPE) required
   Communal spaces will remain closed

3. Substantial Community Spread = anything greater than 10%

No outdoor visitation
Limited indoor visitation, with no contact & negative Covid test
Symptom Screening & physical distancing
Personal Protective Equipment (PPE) required
Communal spaces will remain closed

Residents may receive one visit per day with a limit of 2 people per visit. The length of the visitation will be no longer than 15 minutes. Visits must be scheduled with the Manager and only one visitation may take place in the facility at a time. No offsite or community visitation during Substantial/Moderate levels of community spread, unless the trip is medically necessary. At Minimal Community Spread offsite trips will be decided by the care team.

POLICY & PROCEDURES
Your Company Name Here

Policy Topic: **Visitation during COVID-19**
Responsible Persons: **Facility Staff**

Policy Statement: **All Your Company Name Here Facilities shall follow the CDC, StateDHS and Maricopa County Public Health Guidelines. For the most recent guidelines please visit;**

www.cdc.gov , www.Statedhs.gov , www.maricopa.gov

Procedure:

1. Prior to entering any Your Company Name Here facilities all visitors must sign in on the

Enhanced Protocol Facility Access Tracking Log. Each visitor must answer "NO" to all three questions prior to entry and have their temperature taken and logged.

2. If any visitor answers "YES" to one or more of the questions on the Enhanced Protocol Facility Access Tracking Log or they have a fever greater than 100.4, they will be denied access to the facility until they have been cleared medically.

3. In addition to signing in, a Visitor Screening Guidance form must be completed for each visit to the facility.

4. All visitors must wash/sanitize their hands for, at least, 20 seconds prior to entering and exiting the facility.

5. All visitors must wear a face mask (bandanas and neck gaiters are not permitted) and maintain, at least, six feet distance from all other Residents and Facility Staff during their visit. If the Resident they are visiting is vaccinated and gives consent the visitor may have close contact with the Resident. However, if the Resident is unvaccinated a distance of, at least, six feet, should be maintained.

6. All visitors will be directed to our designated indoor visitation area and our Facility Staff will disinfect and sanitize the visitation area after the completion of each visit.

7. Visitors should limit their visit to three times a week for a maximum of 45 minutes per stay. Visits should be scheduled so that all of our Residents have the opportunity to receive outside socialization. Visitation during meal times should be avoided.

8. Outdoor visitation is available when the weather permits. During times of excessive heat warnings, rain, etc. the Facility Staff will restrict outdoor visitation for all Residents.

9. Your Company Name Here. will allow for compassionate care visits regardless of the level of community spread. Compassionate care visits include visits for end-of-life,

terminal disease, and visits deemed necessary for the Residents well being. All other policy and procedures must be followed during this type of visit.

10. **For clarification, questions or scheduling of visit please call House Manager at house manager phone number.**

VOLUNTEER INFORMATION FORM

Full Name:_____ Date of Birth:_____

Address:_____

Telephone #:_____ Secondary #:_____

Starting Date of Service:_____ Ending Date of Service:_____

(If applicable)

Name of Represented Organization:_____
(hospice, AIL, Alz. Association, etc)

Telephone # of Organization:_____ Supervisor's Name:_____

Name(s) of Resident(s) visiting:_____

_____

I understand that by completing and signing this form, I have agreed to provide volunteer services at Your Company Name Here. I have been made aware that a copy of their Policy & Procedure Manual is available for my review by contacting the facility Manager. I understand that I must complete a TB Risk Assessment Prior to starting & I have provided a current/valid TB test or other screening test prior to my initial visit. I have received Orientation Training and will contact the facility Manager or Governing Authority should any concerns arise while I am present in the facility.

_____
_____
Signature of Volunteer **Date**

This portion is to be used for PET VISITS

Pet's Name:_____
Type_____

(dog, cat, etc.)

2nd Pet's Name:_____
Type_____

3rd Pet's Name:_____
Type_____

I have provided the facility with a copy of my pet's:

❒ **Current Rabies Vaccination** ❒ **License Information**

_____
_____
Signature of Pet Owner **Date**

Policy Topic: **Wandering Residents/Resident Whereabouts**
Responsible Persons: **All Personnel**

Policy Reference: **R9-10-815**

Policy: To monitor the health & safety of all Residents it is essential to know their whereabouts in the Facility and have a plan in place to monitor their location.

Procedure:

1. Caregivers on duty will continuously monitor and account for the presence of each Resident as well as confused and ambulatory Residents in the Facility.
2. Caregivers will attempt to engage Residents, especially those who are determined to leave, in diversional activities within the Facility (e.g. folding laundry, setting table, etc.).
3. Caregivers will maintain security locks on all doors, gates and hazardous areas at all times.
4. Caregivers will check alarms being used on doors and/or windows. All front doors have magnetic locks which require a passcode, which only the Facility staff has access to. All back doors are equipped with alarms, which sound upon entering and exiting. This will be done on a daily basis to be sure that they remain fully operational. Also, Maintenance shall include these items on their monthly safety check of the Facility.
    a. Alarms that are triggered will be investigated immediately to ensure that all Residents are present and accounted for.
    b. If it is determined that a Resident has wandered off the property see #6
    c. If it is determined that there is difficulty with the alarm itself (e.g. it is broken) Call your Manager and fill out a Quality Management Form.
    d. If it is determined that a Resident/Visitor has learned the passcode for the front door please notify your Manager immediately so that the passcode can be reset.
5. Caregivers will turn on motion sensors in Residents rooms (if applicable) to assist in monitoring their health and safety.
6. Caregivers during hours of sleep will monitor each Resident on a routine basis and as needed to promote their whereabouts.
7. A photo of each Resident will be provided to the facility or taken upon admission and maintained in the Resident's chart to aid Your Company Name Here Staff Members and the appropriate authorities in locating missing Residents. If necessary, this photo can be copied and distributed.
8. If a Resident does wander from the Facility and is not immediately located by the Delegation of Authority then the following measures will be implemented:
    a. The Manager and Governing Authority will be notified immediately.
    b. Call 911, the local authorities will notify the appropriate departments to assist.
    c. The Resident's Representative will be contacted as soon as possible.
    d. The Governing Authority will provide photos of the Resident along with personnel for searching the neighborhood and going door to door.
    e. A Report of Unusual Occurrence will be completed describing the occurrence and outcome.
    f. The Department of Health Services will be notified of the occurrence.

g. Once the Resident has returned to the Facility it is important to implement new safety measures (e.g. a safe return bracelet, louder alarms, etc.)

9. If the Facility deems it has made every effort to safely monitor and house the Resident and they continue to wander/elope they may be referred to another Facility in an effort to provide for the Resident's personal health and safety.

AT RISK MONTHLY REPORT

House: Month:

List all Residents who have any of the conditions listed below. Each month, update in a different color font and include the date.

30 day move out notices: including reason for move out, anticipated move out date and where they're moving to.

Hospice: date admitted to hospice and diagnosis

Wounds: including onset, type, location, staging if any, who is treating and brief description, must include weekly measurements

Falls: frequent falls, include fall risk interventions

Behaviors: Those that are dangerous to self or others or may otherwise put the Resident at risk of move out

Dissatisfaction with care

Resident Name	Concerns/Interventions	Wound Measurements	Date of Resolution/Closure
