North Dakota
Long Term Care
ASSOCIATION

Basic Care Resource Manual

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Section 1
Basic Care Licensing Rules and Regulations

CHAPTER 23-09.3
BASIC CARE FACILITIES

23-09.3-01. Definitions.

As used in this chapter:

1. "Basic care facility" means a residence, not licensed under chapter 23-16 by the department, that provides room and board to five or more individuals who are not related by blood or marriage to the owner or manager of the residence and who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four-hour medical or nursing services and:
   a. Makes response staff available at all times to meet the twenty-four-hour per day scheduled and unscheduled needs of the individual;
   b. Is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility; or
   c. Is attached to a nursing home or assisted living facility and its staff are available to meet the needs of all residents and comply with state and federal regulations.
2. "Department" means the state department of health.
3. "Services" includes responsibility for resident health and safety, assistance with activities of daily living and instrumental activities of daily living, provision of leisure, recreational, and therapeutic activities, supervision of nutritional needs, and medication administration.

23-09.3-01.1. Moratorium on expansion of basic care bed capacity.

1. Basic care beds may not be added to the state's licensed bed capacity during the period between August 1, 2019, and July 31, 2021, except if:
   a. A nursing facility converts nursing facility beds to basic care;
   b. An entity licenses bed capacity transferred as basic care bed capacity under section 23-16-01.1;
   c. An entity demonstrates to the state department of health and the department of human services that basic care services are not readily available within a designated area of the state or that existing basic care beds within a fifty-mile [80.47-kilometer] radius have been occupied at ninety percent or more for the previous twelve months. In determining whether basic care services will be readily available if an additional license is issued, preference may be given to an entity that agrees to any participation program established by the department of human services for individuals eligible for services under the medical assistance program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.]; or
   d. The state department of health and the department of human services grant approval of new basic care beds to an entity. The approved entity shall license the beds within forty-eight months from the date of approval.
2. Transfers of basic care beds from one basic care facility to another entity is permitted. Transferred basic care beds must become licensed within seventy-two months of transfer. The entity receiving the transferred beds or any new facility may seek to participate in the basic care assistance program. If the entity can demonstrate that individuals can be cared for at a more independent level and that this service will delay entry into the nursing facility, the entity may be approved for basic care assistance funds.
3. If an Indian tribe acquires basic care beds, the tribal facility must meet state licensing requirements for those beds within seventy-two months of acquisition. A tribal facility may seek to participate in the basic care assistance program. Basic care assistance payments may only be made to a tribal facility that agrees to participate and adhere to all federal and state requirements of the basic care assistance program including participation, screening, ratesetting, and licensing requirements.

23-09.3-02. Residential areas - Nongeriatric persons.

A nursing home, intermediate care facility, basic care facility, or any combination of a nursing home, intermediate care facility, or basic care facility may establish residential areas specifically for inhabitation by nongeriatric persons subject to any reasonable rules adopted by the department.

23-09.3-03. Access to pharmacist.

Repealed by S.L. 2001, ch. 432, § 7.

23-09.3-04. Department to establish standards - Licensing - Inspection - Survey - Prosecute violations.

1. The department shall establish standards for basic care facilities. The department shall inspect all places and grant annual licenses to basic care facilities as conform to the standards established and comply with the rules prescribed, as provided in this chapter. The department may waive all or a portion of a license standard if the department determines the lack of compliance does not adversely affect the health or safety of residents.
2. The department shall implement a survey process for basic care facilities which for purposes of the life safety portions of the survey, all surveys must be announced; which for purposes of the health portions of the survey, half of the surveys must be announced; and which for purposes of complaints related to health and life safety, all surveys must be unannounced. As part of the survey process, the department shall develop, in consultation with basic care facilities, and shall implement a two-tiered system of identifying areas of noncompliance with the health portions of the survey.
3. The department shall prosecute all violations of this chapter.

23-09.3-05. License required - Term - Revocation.

No person, institution, organization, limited liability company, or public or private corporation may keep, operate, conduct, or manage a basic care facility without holding a valid license issued by the department. The license is not valid for more than one year. Any license may be revoked by the department for violation of this chapter or the rules adopted by the department.

23-09.3-05.1. Application for license - License fee.

Applicants for a license shall file applications under oath with the state department of health upon forms prescribed. An application for a license for facilities not owned by the state or its political subdivisions must be accompanied by a fee of ten dollars per bed. License fees collected pursuant to this section must be deposited in the state department of health services operating fund in the state treasury and any expenditure from the fund is subject to appropriation by the legislative assembly.

23-09.3-06. Injunction.

The department may apply to the district court of the county in which the basic care facility is located for, and the court has jurisdiction upon hearing and for cause shown to grant, a temporary or permanent injunction restraining any person from establishing, conducting, managing, or operating any basic care facility without obtaining a license under this chapter.

23-09.3-07. Contents of license.

The license must show the name of the owner or manager of the basic care facility, its location, and the maximum number of persons that may be received and kept in the basic care facility at any one time.

23-09.3-08. Records kept by basic care facility.

A record of every individual admitted to any basic care facility must be kept at the place licensed by the owner or manager in the manner and form prescribed by the department.

23-09.3-08.1. Admission of residents to basic care facility - Restrictions - Exception.

1. A basic care facility may not admit and retain an individual unless the:
   a. Facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning; and
   b. Condition and abilities of that individual are consistent with the national fire protection association 101 life safety code requirements.
2. Notwithstanding contrary provisions in subsection 1, a basic care facility may retain an individual in need of end-of-life services if the facility wraps around the individual's family, or the individual's designee, volunteers, or staff services to support the individual through end of life. The facility, individual, or the individual's designee may contract with a person or hospice agency to meet the needs of the individual. A basic care facility continues to be responsible for the care and services of every resident.

23-09.3-09. Authority to adopt rules.

The department may adopt rules necessary to carry out its responsibilities under this chapter. Rules adopted by agencies prior to January 1, 1990, which relate to functions or agencies covered by this chapter, remain in effect until they are specifically amended or repealed by the department.

23-09.3-10. Rules on services to nongeriatric persons.

The department shall adopt rules under chapter 23-16 for patient and resident care and quality care review which are not in conflict with any federal laws, and as are necessary to ensure the appropriate medical, social, and psychological services to nongeriatric persons residing in a nursing home, intermediate care facility, basic care facility, or any combination of a nursing home, intermediate care facility, or basic care facility.

23-09.3-11. Department to furnish information when requested.

If called upon by any person, organization, corporation, limited liability company, or community interested in establishing a basic care facility, the department shall furnish information concerning the laws and rules governing operation of a basic care facility.

23-09.3-12. Penalty.

Any person who violates any provision of this chapter is guilty of a class B misdemeanor.

CHAPTER 33-03-24.1
BASIC CARE FACILITIES

Section
33-03-24.1-01 Definitions
33-03-24.1-02 Certificate of Need [Repealed]
33-03-24.1-03 Issuance of License
33-03-24.1-04 Waiver Provision
33-03-24.1-05 Plans of Correction
33-03-24.1-06 Enforcement Actions
33-03-24.1-07 Reconsideration of Enforcement Actions
33-03-24.1-08 Appeals
33-03-24.1-09 Governing Body
33-03-24.1-10 Fire Safety
33-03-24.1-11 Education Programs
33-03-24.1-12 Resident Assessments and Care Plans
33-03-24.1-13 Resident Records
33-03-24.1-14 Personal Care Services
33-03-24.1-15 Pharmacy and Medication Administration Services
33-03-24.1-16 Social Services
33-03-24.1-17 Nursing Services
33-03-24.1-18 Dietary Services
33-03-24.1-19 Activity Services
33-03-24.1-20 Housekeeping and Laundry Services
33-03-24.1-21 Adult Day Care Services
33-03-24.1-22 General Building Requirements [Repealed]
33-03-24.1-23 Optimal End-of-Life Care Service
33-03-24.1-24 Optional Alzheimer's, Dementia, Special Memory Care, or Traumatic Brain Injury Facility or Unit Services

33-03-24.1-01. Definitions.

1. "Abuse" includes the willful infliction of mental, physical, sexual, and verbal abuse which could result in temporary or permanent mental, physical, emotional, or psychological injury or harm. Mental abuse includes humiliation, harassment, intimidation, threats of punishment, or deprivation. Physical abuse includes hitting, slapping, pinching, kicking, unreasonable confinement, and deprivation, by an individual, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It also includes controlling behavior through corporal punishment. Sexual abuse includes sexual harassment, sexual coercion, sexual contact, or sexual assault. Verbal abuse includes any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, used within their hearing distance to describe the residents, regardless of their age, ability to comprehend, or disability.

2. "Activities of daily living" means those personal, functional activities required by an individual for continued well-being, including eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.

   a. "Assistance" means the resident is able to help with most of an activity, but cannot do it entirely alone. The resident may need prompting, encouragement, or the minimal hands-on assistance of the personal care attendant.

   b. "Independent" means the resident can perform the activities of daily living without help.

3. "Activity staff" means an employee who is responsible for providing an activity program.

4. "Adult day care services" means the provision of basic care facility services to meet the needs of individuals who do not remain in the facility overnight.

5. "Basic care facility" means a facility licensed by the department under North Dakota Century Code chapter 23-09.3 whose focus is to provide room and board and health, social, and personal care to assist the residents to attain or maintain their highest level of functioning, consistent with the resident assessment and care plan, to five or more residents not related by blood or marriage to the owner or manager. These services shall be provided on a twenty-four-hour basis within the facility, either directly or through contract, and shall include assistance with activities of daily living and instrumental activities of daily living; provision of leisure, recreational, and therapeutic activities; and supervision of nutritional needs and medication administration.

6. "Capable of self-preservation" means a resident's ability, with or without assistance, to evacuate the facility or relocate from the point of occupancy to a point of safety in case of fire in compliance with the requirements of this chapter.

7. "Department" means the North Dakota state department of health.

8. "End-of-life care" means a program of palliative and supportive care for a resident with a physician or nurse practitioner's order identifying a terminal illness or condition with a limited prognosis of six or fewer months to live that has elected to receive hospice services through a licensed and Medicare-certified hospice agency.

9. "Facility" means a basic care facility.

10. "Governing body" means the entity legally responsible for the operation of a basic care facility.

11. "Instrumental activities of daily living" includes preparing meals, shopping, managing money, housework, laundry, transportation, use of telephone, and mobility outside the basic care facility.

12. "Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care to individuals in North Dakota.

13. "Medication administration" means an act in which a drug or biological is given to a resident by an individual who is authorized in accordance with state laws and regulations governing such acts, and may include a licensed health care practitioner, licensed nurse, or medication assistant.

14. "Misappropriation of resident property" means the deliberate misplacement, exploitation, or wrongful temporary or permanent taking or use of a resident's belongings or money, or both.

15. "Neglect" includes failure to carry out resident services as directed or ordered by the licensed health care practitioner or other authorized personnel, or failure to give proper attention to residents.

16. "Personal care" means assistance with activities of daily living and instrumental activities of daily living and general supervision of physical or mental well-being.

17. "Resident" means an individual admitted and retained in a facility in order to receive room and board and health, social, and personal care who is capable of self-preservation, and whose condition does not require continuous, twenty-four-hour a day onsite availability of nursing or medical care.

18. "Restricting device" means any device which limits a resident from freely exiting the facility or unit, including pressure devices which delay the time frame in which a door will open.

19. "Secured facility" means a facility that is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility that has restricting devices to restrict residents from freely exiting the building.

20. "Secured unit" means a specific area of the facility that is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care unit that has a restricting device separating the residents in the unit from the residents in the remainder of the facility.

21. "Significant medication error" means a medication error which causes the resident discomfort or jeopardizes his or her health and safety, or a pattern of more than three medication errors that has the potential for causing a negative impact or harm to residents.

22. "Unsecured facility" means a facility that is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility without restricting devices to restrict residents from freely exiting the building.

23. "Unsecured unit" means a specific area of the facility that is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care unit that is separate from the residents in the remainder of the facility without a restricting device.

History: Effective January 1, 1995; amended effective January 1, 2008; July 1, 2015; January 1, 2018.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3

33-03-24.1-02. Certificate of need.

Repealed effective October 1, 1998.

33-03-24.1-03. Issuance of license.

A facility meeting the definition of a basic care facility as outlined in North Dakota Century Code chapter 23-09.3, North Dakota Administrative Code chapter 33-03-24.2, and this chapter must obtain a license from the department in order to operate in North Dakota.

1. Application to operate a facility must be made to the department prior to opening a facility, prior to change in ownership, annually, and upon determination by the department that a facility meets the definition of a basic care facility.

2. Floor plans must be submitted to the department for review and approval prior to opening a facility and prior to making structural alterations, including those which increase or decrease resident bed capacity.

3. Upon receipt of an application for an initial license, the department may schedule an inspection. Upon completion of the inspection and consideration of the findings, the department may issue an initial or provisional license, or deny the application.

4. An initial license is valid for a period not to exceed one year and shall expire on December thirty-first of the year issued.

5. Licenses must be issued on a calendar year basis and expire on December thirty-first of each year. An application for licensure renewal must be received by the department with sufficient time prior to the beginning of the licensure period to process.

6. A provisional license may be issued to a facility that does not comply with this chapter if practices in the facility do not pose a danger to the health and safety of the residents, as determined by the department.

a. A provisional license must be accompanied by a written statement of the specific rules or statutes violated and the expiration date of the license, which is not to exceed three months from the date of issuance.

b. If compliance with the requirements has been determined by the department prior to the expiration of the provisional license, an annual license may be issued. If an acceptable plan of correction has been approved by the department but compliance has not yet been achieved, the provisional license may be renewed no more than one time for an additional period up to three months at the discretion of the department.

7. Once issued, the facility shall display the license in a conspicuous place. A license is not subject to sale, assignment, or other transfer, voluntary or involuntary. A license is not valid for any premises other than those for which originally issued.

8. The department may, at any time, inspect a facility that the department determines meets the definition of a basic care facility as described in North Dakota Century Code chapter 23-09.3 and this chapter.

9. The facility must provide the department access to any material and information necessary, as determined by the department, for determining compliance with these requirements.

10. Information regarding facilities is public information and is available upon request through the department.

History: Effective January 1, 1995; amended effective January 1, 2008; July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04, 23-09.3-05

33-03-24.1-04. Waiver provision.

The department may waive licensure requirements for specified periods of time in specific instances, provided compliance with the requirement would result in an unreasonable hardship upon the facility and lack of compliance does not adversely affect the health or safety of the residents.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-19
Law Implemented: NDCC 23-09.3-09

33-03-24.1-05. Plans of correction.

1. A basic care facility must submit a plan of correction within ten days of receipt of the notification of deficiencies pursuant to this chapter.

2. The plan of correction must address how each deficiency will be corrected, what the facility will put in place to assure continued compliance, and the date upon which the corrective action will be completed.

3. The department may accept, reject, negotiate modifications to, or direct the plan of correction. A directed plan of correction is a plan of correction which has been developed in coordination with the department.

4. Correction of deficiencies must be completed within sixty days of the survey completion date, unless an alternative schedule of correction has been approved by the department.

5. The department shall determine, based on the review of the facility's plan of correction, what followup is necessary to verify the correction of deficiencies has been completed. Followup may occur by telephone, mail, or onsite revisit.

6. The department shall make available to the public, on the department's website, the deficiency statement and accepted plan of correction, following verification of correction.

History: Effective January 1, 1995; amended effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-05

33-03-24.1-06. Enforcement actions.

1. Facilities are subject to one or more enforcement actions, which include a ban or limitation on admissions, suspension or revocation of a license, or a denial to license, for the following reasons:

   a. Noncompliance with the requirements of this chapter or chapter 33-03-24.2 have been identified which:

      (1) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department;

      (2) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or

      (3) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

   b. Recurrence of the same or substantially same deficient practice in a thirty-six-month period.

   c. Failure to provide an acceptable plan of correction or to correct any deficiency pursuant to an approved plan of correction.

   d. Refusal to allow a survey of the facility by representatives of the department.

   e. Gross incompetence, negligence, or misconduct in operating the facility as determined through department investigation or by a court of law.

   f. Fraud, deceit, misrepresentation, or bribery in obtaining or attempting to obtain a license.

   g. Knowingly aiding and abetting in any way the improper granting of a license.

2. The effective date of the enforcement action must be ninety days from the date the department notifies the facility in writing of the department's decision to initiate an enforcement action, unless the department determines there is imminent danger to the residents.

3. The notice to the facility must include the basis of the department's decision and the effective date of the enforcement action and must also advise the facility of their right to:

   a. Request a review by the department.

      (1) A request for a review by the department to verify correction of the deficient practices must be submitted by the facility to the department within forty-five days from the date the department notifies the facility in writing of its decision to initiate an enforcement action.

      (2) The facility must submit written documentation to the department with the request for a review to verify correction of the deficient practices that were cited. The department shall determine, based on review of the documentation submitted, if an

onsite revisit is warranted. The department review and onsite revisit, if conducted, must take place within sixty days of the date the department notified the facility in writing of its decision to initiate an enforcement action.

(3) If the department determines, based on the review of the facility documentation and the onsite revisit, if conducted, that the deficient practices have been corrected, the enforcement action may be halted. The department shall notify the facility in writing of the decision within ten days of this determination.

(4) If the department determines, based on the review of the facility documentation and the onsite revisit, if conducted, that the deficient practices were not corrected, the enforcement action will be imposed. If imposed, the enforcement action will, at a minimum, remain in effect until the department determines that the conditions leading to the enforcement action have been corrected.

b. Request a reconsideration of an enforcement action consistent with section 33-03-24.1-07.

4. If the department sustains the decision, the department shall publish a public notice in the local newspaper not less than fifteen days prior to the imposition of the enforcement action stating the name of the facility, the enforcement action to be imposed, the reason for the action, the date on which the enforcement action will be effective, and the length of time for which it will be imposed.

5. The department of human services and the county social service office in the county in which the facility is located will be notified in writing by the department regarding the enforcement action.

History: Effective January 1, 1995; amended effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3

33-03-24.1-07. Reconsideration of enforcement actions.

The facility has the right to request a reconsideration of decisions resulting in enforcement actions.

1. A written request for a reconsideration must be filed with the department within ten days of the date the department notified the facility in writing of the decision to initiate an enforcement action.

2. The facility requests for reconsideration must be accompanied by written documents, including:

   a. A copy of the notice received from the department.

   b. The reason or basis in fact for the dispute and request for reconsideration.

   c. The statutes or rules relied upon with respect to each disputed issue and the factual basis for the facility's contention that the violation was erroneously determined.

   d. The name, address, and telephone number of the person to whom all notices will be mailed or delivered regarding the request for reconsideration.

3. Within ten days after the receipt of the request for reconsideration, the department shall grant or deny the request.

4. A request for reconsideration will be denied unless it specifically identifies each disputed deficient practice and states the factual basis for the facility's contention that the deficient

practice was erroneously determined. The correction of the factors that led to the determination of a deficient practice may not be asserted as a basis for a request for reconsideration.

5. If the department denies the request for reconsideration, the department shall notify the facility in writing of that decision. If denial was for any reason other than a failure of the request to conform to the requirements of subsection 4, the notice must advise the facility of the right to appeal.

6. If the department determines to undertake reconsideration, the decision on reconsideration must be rendered within twenty days of receipt of the request for the reconsideration and the department must notify the facility in writing of the decision. The notice of the decision on the reconsideration must advise the facility of the right to appeal.

7. The reconsideration of an enforcement action does not delay the implementation of the enforcement action. The date of implementation of the enforcement action is effective unless otherwise determined.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-19
Law Implemented: NDCC 23-09.3-09

33-03-24.1-08. Appeals.

1. A facility dissatisfied with the decision on a request for reconsideration, which conforms to the requirements of subsection 4 of section 33-03-24.1-07, may appeal. An appeal may be initiated by mailing or delivering the information described in subdivisions a through d to the department, division on health facilities, state capitol, Bismarck, North Dakota, on or before 5:00 p.m. on the fortieth day from the date the department notified the facility in writing of the department's decision to initiate an enforcement action. Written documents including all of the following must accompany the appeal:

   a. A copy of the notice received from the department regarding the department's decision on the request for reconsideration.

   b. A statement of each disputed deficient practice and the reason or basis in fact for the dispute.

   c. The authority in statute or rule upon which the facility relies for each disputed item.

   d. The name, address, and telephone number of the person to whom all notices will be mailed or delivered regarding the appeal.

2. Except as otherwise provided in this section, the appeal must be considered as provided in article 98-02.

3. The appeal must be decided based on whether the deficient practice occurred, not whether the deficient practice has been corrected.

4. The hearing officer must make written findings of fact and conclusions of law and must recommend a decision to the department. The recommended decision must set forth the reasons for the decision and the evidence upon which the decision is based.

5. The department may accept, modify, or reject the recommended decision. If the department rejects the recommended decision, it may remand the matter to the office of administrative hearings with directions. The department may require, through its directions, the receipt of additional evidence and the submission of amended findings of fact and conclusions of law

and recommend a decision that reflects consideration of the additional evidence. The department may require, through its direction, that the matter be referred to the same or a different hearing officer, and the office of administrative hearings shall comply with that direction unless compliance is impossible.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-19
Law Implemented: NDCC 23-09.3-09

33-03-24.1-09. Governing body.

1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws.

2. The governing body is responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility. These policies and procedures must be in writing, signed, dated, reviewed annually, and revised as necessary, and shall address:

   a. All services provided by the facility to meet the needs of the residents, including admission, transfer, discharge, discharge planning, and referral services.

   b. Protocols developed by appropriately licensed professionals for use in the event of serious health-threatening conditions, emergencies, or temporary illnesses. These protocols must include provisions for:

      (1) Designation of a licensed health care practitioner for each resident and arrangements to secure the services of another licensed health care practitioner if the resident's designated licensed health care practitioner is not available.

      (2) Notification of an appropriately licensed professional in the event of an illness or injury of a resident.

   c. Provisions for pharmacy and medication services developed in consultation with a registered pharmacist, including:

      (1) Assisting residents in obtaining individually prescribed medications from a pharmacist of the resident's choice.

      (2) Disposing of medications that are no longer used or are outdated, consistent with applicable federal and state laws.

      (3) Allowing the resident to be totally responsible for the resident's own medication upon resident request and based on the assessment of the resident's capabilities with respect to this function by an appropriately licensed professional.

   d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members.

   e. Prohibition of resident abuse, neglect, and misappropriation of resident property, including investigation, reporting to the department, and followup action.

   f. Reporting a significant medication error to officials in accordance with state law. A significant medication error by a medication assistant I or II shall be reported to the department of health.

g. A process for handling complaints made by residents or on behalf of residents.

h. Resident rights which comply with North Dakota Century Code chapter 50-10.2.

i. Personnel policies to include checking state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination.

j. Personnel records to include job descriptions, verification of credentials where applicable, and records of training and education.

3. If the facility provides any clinical laboratory testing services to an individual, regardless of the frequency or the complexity of the testing the governing body is responsible to obtain and maintain compliance with the applicable parts of the clinical laboratory improvement amendments of 1988, 42 CFR part 493.

4. The governing body shall appoint an administrator to be in charge of the general administration of the facility. Provisions must be made for a staff member to be identified in writing to be responsible for the onsite operation of the facility in the absence of the administrator.

5. The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents twenty-four hours a day.

History: Effective January 1, 1995; amended effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-10. Fire safety.

The fire safety provisions located in section 33-03-24.2-08 apply to this chapter.

History: Effective January 1, 1995; amended effective July 1, 1996; October 1, 1998; July 1, 2015.
General Authority: NDCC 23-09.3-19
Law Implemented: NDCC 18-01-03.2, 23-09.3-09

33-03-24.1-11. Education programs.

1. The facility shall design, implement, and document educational programs to orient new employees and develop and improve employees' skills to carry out their job responsibilities.

2. On an annual basis, all employees shall receive inservice training in at least the following:

   a. Fire and accident prevention and safety.

   b. Mental and physical health needs of the residents, including behavior problems.

   c. Prevention and control of infections, including universal precautions.

   d. Resident rights.

3. The administrator shall attend at least twelve continuing education hours per year relating to care and services for residents.

4. The staff responsible for food preparation shall attend a minimum of two dietary educational programs per year.

5. The staff responsible for activities shall attend a minimum of two activity-related educational programs per year.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-12. Resident assessments and care plans.

1. An assessment is required for each resident within fourteen days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly.
2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include:
   a. A review of health, psychosocial, functional, nutritional, and activity status.
   b. Personal care and other needs.
   c. Health needs.
   d. The capability of self-preservation.
   e. Specific social and activity interests.
3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths.
4. The care plan must be updated as needed, but no less than quarterly.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-13. Resident records.

1. The facility shall provide for secure maintenance and storage of all resident records.
2. Resident records must include:
   a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person.
   b. The licensed health care practitioner's orders and report of an examination of the resident's current health status.
   c. An admission note.
   d. A copy of an initial and current assessment and care plan.
   e. Documentation of resident observations by authorized staff.
   f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility.

g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs.

h. Documentation of review of prescribed diets.

i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility.

j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts.

k. Documentation of an annual medication regimen review.

l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund.

m. Documentation of a fire drill walk-through within five days of admission.

n. All agreements or contracts entered into between the facility and the resident or legal representative.

o. A discharge note.

3. The facility shall maintain resident records for a period of not less than five years from the date of discharge or death.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-03, 23-09.3-04

33-03-24.1-14. Personal care services.

The facility shall provide personal care services to assist the resident to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. These services must include assistance with:

1. Activities of daily living and instrumental activities of daily living and observation and documentation of changes in physical, mental, and emotional functioning, as needed.

2. Arrangements to seek health care when the resident shows signs or describes symptoms of an illness or abnormality for which treatment may be indicated.

3. Arrangements for appropriate transfer and transport as needed.

4. Functional aids or equipment, such as glasses, hearing aids, canes, crutches, walkers, or wheelchairs.

5. Clothing and other personal effects as well as maintenance of personal living quarters.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-03, 23-09.3-04

33-03-24.1-15. Pharmacy and medication administration services.

1. The facility shall provide assistance to the resident in obtaining necessary medications and medical supplies.

2. The facility shall provide a secure area for medication storage consistent with chapter 61-03-02.

   a. A specific system must be identified for the accountability of keys issued for locked drug storage areas.

   b. Residents who are responsible for their own medication administration must be provided a secure storage place for their medications.

3. Medication administration services must be available for residents.

4. All medications used by residents which are administered or supervised by staff must be:

   a. Properly recorded by staff at the time of administration.

   b. Kept and stored in original containers labeled consistently with state laws.

   c. Properly administered.

5. The resident's licensed health care practitioner, another licensed health care professional consistent with applicable state practice acts, or a consulting pharmacist shall review the medication regimen of each resident as needed, but at least annually.

6. A medication record need not be kept for those residents for whom authorization has been given by the licensed health care professional to keep their medication in their rooms and to be fully responsible for taking the medication in the correct dosage and at the proper times.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-16. Social services.

Social services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate agency offering social services.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-17. Nursing services.

Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-18. Dietary services.

The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include:

1. A minimum of three meals each day. Meals must be nutritious and well-balanced in accordance with the recommended dietary allowances of the food and nutrition board of the national research council, national academy of sciences.

2. No more than a fourteen-hour span may exist between an evening meal and breakfast.

3. Snacks between meals and in the evening. These snacks must be listed on the daily menu. Vending machines may not be the only source of snacks.

4. Provisions for prescribed diets, if the facility accepts or retains individuals in need of such diets.

   a. The facility shall provide for preparation and serving of prescribed diets.

   b. Menus for prescribed diets must be planned and reviewed as needed by a professional consistent with North Dakota Century Code chapter 43-44.

5. Menus of food served, which must be kept for at least three months.

6. Preparation of food by methods that will conserve nutritive value and enhance flavor and appearance, and be served at the proper temperatures and in a form to meet individual needs.

7. Meals must be served to all residents in a dining room, except for residents with a temporary illness.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-19. Activity services.

There must be a planned and meaningful activity program to meet the needs and interests of the residents and encourage self-care and continuity of normal activities. This program must:

1. Be developed based on the activity needs and interests of each resident identified through the initial and ongoing assessments.

2. Develop and post a monthly group activity calendar, based on the individual interests identified, which lists social, recreational, and other events available to residents.

3. Activities must be available and provided to meet the needs of all residents during the day, in the evening, and on the weekend.

4. Assist residents with arrangements to participate in social, recreational, religious, or other activities within the facility and the community in accordance with individual interests and capabilities.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-20. Housekeeping and laundry services.

The facility shall maintain the interior and exterior of the facility in a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-21. Adult day care services.

1. A facility must obtain approval from the department to provide adult day care services.
2. Use of existing space and equipment to deliver adult day care services is acceptable if this does not diminish the services provided to the residents of the facility and their needs being met.
3. Medications and treatments must be administered only by order of a licensed health care practitioner.
4. Records must be maintained of services provided to individuals participating in adult day care services.
5. An area allowing privacy for adult day care individuals must be developed to allow for rest periods.

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-22. General building requirements.

Repealed effective July 1, 2015.

33-03-24.1-23. Optional end-of-life care service.

A facility that intends to retain residents who require end-of-life care must comply with the requirements of this section, apply on an application as specified by the department, and receive written approval from the department prior to providing the services. The facility must meet the following requirements:

1. A facility may not retain residents who require more than intermittent nursing care unless the resident requires and elects to receive end-of-life care from a licensed and Medicare-certified hospice agency and the facility is licensed to provide end-of-life care.
2. A facility providing end-of-life care must employ or contract with a registered nurse to supervise resident care to meet the needs of the residents at all times, either directly or indirectly. The facility must employ a licensed nurse who is on the premises at least forty hours per week to identify and respond to resident needs, care plan accordingly, provide oversight related to care, and review and document the resident's individual needs and care provided.
3. Individuals in need of end-of-life care who require skilled nursing care or are not capable of self-preservation may not be admitted.
4. The facility and the licensed and Medicare-certified hospice agency shall enter into an agreement that delineates responsibilities, with the licensed and Medicare-certified hospice agency retaining the professional management responsibility for the hospice service.
5. The facility and licensed and Medicare-certified hospice agency in consultation with the resident shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes the following:
    a. What services are to be provided;
    b. Who will provide the services, the facility or hospice agency;

c. How the services will be provided;

d. Delineation of the roles of facility staff and the hospice agency in the care plan process;

e. Documentation of the care and services that are provided with the signature of the person who provided the care and services; and

f. A list of the current medications or biologicals the resident receives and who is authorized to administer the medications.

6. The facility shall notify the department within forty-eight hours of election that the resident has elected hospice, the date the hospice was elected, and the name of the hospice agency serving the resident.

7. The facility shall notify the department within forty-eight hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable of self-preservation.

8. A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.

9. Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of-life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.

10. A facility approved to provide end-of-life care shall ensure training and competency evaluation is completed for all nursing and personal care staff members specific to the care and services necessary to meet the needs of the terminally ill resident, and the hospice philosophy and services. The training and competency evaluation may be completed, and documented, by the facility registered nurse, a registered nurse consultant, or a hospice agency nurse. Nursing and personal care staff members shall complete the above training and competency evaluation:

    a. Prior to facility approval from the department to provide end-of-life care;

    b. Within thirty days of employment; and

    c. Annually.

11. A facility that intends to retain residents who require end-of-life care shall comply with the additional requirements in this section and request and receive approval on a printed new license from the department, prior to providing end-of-life care to residents.

12. The facility approved and licensed to retain residents in need of end-of-life care remains responsible for the appropriate delivery of end-of-life care in coordination with the licensed and Medicare-certified hospice agency. If the facility is unable, or becomes unable, to meet the needs of the resident requiring end-of-life care, the resident rescinds election of the hospice benefit, or the facility is unable to comply with these requirements, the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02

Law Implemented: NDCC 23-09.3-04, 23-09.3-09

33-03-24.1-24. Optional Alzheimer's, dementia, special memory care, or traumatic brain injury facility or unit services.

A basic care facility or unit that admits or retains only residents with Alzheimer's, dementia, or special memory care needs in a secured or unsecured facility or unit, or a facility that admits and retains only residents with traumatic brain injury must comply with the additional requirements of this section, apply on an application as specified by the department, and receive written approval from the department before providing the services. A basic care facility may not advertise or hold itself out to the public to provide specialized care to residents with Alzheimer's, dementia, memory loss, or care for residents with traumatic brain injury unless licensed consistent with this section. The facility must meet the following requirements:

1. A basic care facility licensed to provide specialized services to residents in this section may admit and retain residents who require twenty-four-hour per day dedicated personal care staff; however, do not need more than intermittent nursing or medical care.

2. Residents with Alzheimer's, dementia or special memory care needs, or traumatic brain injury admitted and retained must meet the basic care functional level of care and be capable of self-preservation.

3. The facility or unit licensed to provide specialized care and services to residents under this section shall provide:

   a. Care of residents with chronic moderate to severe memory loss or an individual who has significant emotional, behavioral, or cognitive impairments and needs services that may include independent living skills, support and training to promote and develop relationships, participate in the social life of the community, and develop behavioral skills as determined necessary based on assessment and care plan;

   b. Protective oversight and supervision in a structured environment that is staffed with sufficient personal care and intermittent licensed nursing staff to monitor, evaluate, and accommodate an individual's changing needs;

   c. Service in which assistance with activities of daily living and independent activities of daily living, therapeutic, social, and recreational programming is provided; and

   d. Care furnished in a way that fosters the maintenance or improvement, as appropriate, to promote independence of the resident.

4. The facility shall develop a written policy related to resident rights and provide the policy to the resident or designee, verbally and in writing. The facility shall ensure each resident's right to privacy, dignity and respect, and freedom from coercion and restraint by promoting individual initiative, autonomy, and independence in making life choices related to daily activities, physical environment, and with whom to interact. The facility or unit must comply with residents' rights in North Dakota Century Code chapter 50-10.2, and:

   a. Residents must be provided privacy in their sleeping or living area, including entrance doors lockable by the individual, with only appropriate staff having keys to the doors;

   b. Residents sharing a room with another resident must have a choice of roommate in that setting;

   c. Residents must be granted the freedom to furnish and decorate their sleeping unit or living area to the extent allowable based on facility policy and fire code requirements;

d. Residents must have the freedom and support to control their schedules and activities and have access to food any time and eat where they choose;

e. Residents are allowed to have visitors of their choosing at any time;

f. Must have access to the community; and

g. Residents must have access to outdoor space. Residents in a secured facility or unit must have access to a secured outdoor space.

5. The facility shall develop a person-centered care plan for each resident. The care plan must be completed following the functional assessment and be based on input from the resident or designee.

6. The person-centered care plans must be reviewed quarterly and anytime there is a change in need by the resident based on the assessment, and modified as needed.

7. A basic care facility licensed to provide specialized services to residents in this section shall ensure training and competency evaluation is completed for all nursing and personal care staff members specific to the care and services necessary to meet the needs of the residents. A minimum of eight educational hours on the following topics must be completed within three months from the date of hire. Nursing and personal care staff may not be assigned to work independently until they have successfully completed a competency evaluation. The areas to be covered include:

a. Dementia education, including progression of the disease, memory loss, and psychiatric and behavioral symptoms;

b. Techniques for understanding and approaching behavioral symptoms, such as aggravating behaviors, sexual behaviors, and wandering, including alternatives to chemical and physical restraints;

c. Positive therapeutic interventions;

d. Strategies for addressing social needs and providing options for meaningful activities;

e. Information on how to address aspects of care and safety, such as pain, food, fluid, and wandering;

f. Communication issues;

g. Resident rights, including dignity, respect, choice, independence, and privacy; and

h. Strategies for providing person-centered care.

8. Each nursing or personal care staff member shall receive annually a minimum of four hours of educational training in two or more of the topics identified in subsection 7.

9. Nursing or personal care staff members must successfully complete a competency evaluation in the areas identified in subsection 7 annually.

10. For other staff members hired to work in a facility or unit licensed under this section, training upon hire and annual training shall include at a minimum an overview of dementia and communication issues, and may include other topics identified in subsection 7 as needed.

11. Before providing services to residents, a basic care facility licensed to provide specialized services to residents in this section shall comply with the additional requirements in this section and receive approval on a printed new license from the department.

12. The department may issue existing facilities a provisional license not to exceed one year to complete construction or remodel to come into compliance with environmental requirements if it does not pose a danger to the health and safety of the residents. An additional provisional license for no more than six months may be granted at the discretion of the department to complete the project.

13. If the facility or unit is unable to meet the needs of the resident, or the resident no longer meets the criteria for retention, the facility promptly shall make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs.

History: Effective January 1, 2018.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-04, 23-09.3-09

CHAPTER 33-03-24.2
GENERAL STANDARD FOR CONSTRUCTION AND EQUIPMENT FOR BASIC CARE FACILITIES

Section
33-03-24.2-01 Definitions
33-03-24.2-02 Waiver Provision
33-03-24.2-03 Access and Surveillance by the Department
33-03-24.2-04 Plans of Correction
33-03-24.2-05 Emanating Services
33-03-24.2-06 Plans and Specifications
33-03-24.2-07 Codes and Standards
33-03-24.2-08 Fire Safety
33-03-24.2-09 General Building Requirements

33-03-24.2-01. Definitions.

The definitions located in section 33-03-24.1-01 apply to this chapter.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-02. Waiver provision.

The waiver provision located in section 33-03-24.1-04 applies to this chapter.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-03. Access and surveillance by the department.

The provisions located in section 33-03-24.1-03 apply to this chapter.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-04, 23-09.3-05

33-03-24.2-04. Plans of correction.

The provisions located in section 33-03-24.1-03 apply to this chapter.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-05. Emanating services.

1. Sufficient information on the design of other types of facilities physically attached to the basic care facility must be submitted to the department so as to determine that safety from fire and the adequacy of the spaces and services of the facility are not compromised.

2. Occupants of other types of facilities may use service spaces, such as dining and activities in the facility only when the size of such spaces exceeds the standards of this chapter by providing a minimum of fifteen square feet per additional occupant using the space.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-06. Plans and specifications.

1. A facility shall contact the department prior to any substantial changes in or alterations to any portion of the structure to determine to what extent it is subject to review. A substantial change includes alterations affecting the fire safety or structural integrity of the building, changes in service areas or services provided within a service area, changes in bed capacity, or any other change governed by the standards of this chapter. The department may request plans, specifications, or other information as may be required and shall make the final determination on those areas subject to review.

2. A facility shall submit plans and specifications to the department for all construction, remodeling, and installations subject to review. The plans and specifications must be prepared by an architect or engineer licensed in North Dakota, unless otherwise determined by the department.

3. Start of construction prior to approval by the department of the final plans and specifications is not permitted.

4. All construction, remodeling, and installations must be in accordance with the final plans and specifications approved by the department. Modifications or deviations from the approved plans and specifications must be submitted to and approved by the department.

5. The department may make inspections of construction, remodeling, or installations and arrange conferences with the facility to ensure conformance with approved plans and specifications.

6. The construction specifications must require the contractor to perform tests to ensure all systems conform to the approved plans and specifications.

7. Routine maintenance does not require the submission of plans and specifications. For the purpose of this subsection, routine maintenance means repair or replacement of existing equipment, room finishes and furnishings, and similar activities.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-07. Codes and standards.

1. A basic care facility must be designed, constructed, equipped, maintained, and operated in compliance with:

   a. This chapter;

   b. The Guidelines for Residential Health, Care and Support Facilities, 2014 edition, compiled by the facility guidelines institute;

   c. The national fire protection association 101 Life Safety Code, 2012 edition;

   d. North Dakota Century Code section 54-21.3-04.1, relating to accessibility for disabled persons;

   e. The requirements for food and beverage establishments issued by the department;

f. North Dakota Administrative Code article 62-03.1 relating to plumbing standards;

g. North Dakota Administrative Code article 24-02 relating to electrical wiring standards;

h. North Dakota Administrative Code article 45-12 relating to boiler rules and regulations;

i. North Dakota Administrative Code article 33-15 governing air pollution control, relating to incinerators; and

j. North Dakota Administrative Code article 33-10 relating to radiological health.

2. A basic care facility must comply with all applicable building codes, ordinances, and rules of city, county, or state jurisdictions.

3. These standards are established to bring about a desired performance result. If specific limits are prescribed, equivalent solutions may be acceptable if approved in writing by the department as meeting the intent of these standards.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-09

33-03-24.2-08. Fire safety.

1. The basic care facility shall comply with the national fire protection association Life Safety Code, 2012 edition, chapters 32 and 33, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety.

2. Fire drills must be held monthly with a minimum of twelve per year, alternating with all workshifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building.

3. Fire evacuation plans must be posted in a conspicuous place in the facility.

4. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill, including the escape path used and evidence of simulation of a call to the fire department.

5. Each resident shall receive an individual fire drill walk-through within five days of admission.

6. Any variation to compliance with the fire safety requirements must be approved in writing by the department.

7. Residents of facilities meeting a greater level of fire safety must meet the fire drill requirements of that occupancy classification.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 18-01-03.2, 23-09.3-09

33-03-24.2-09. General building requirements.

The basic care facility must be operated in conformance with all state and local laws, rules, and ordinances concerning fire safety and sanitation.

1. Lounge and activity space must be provided at a minimum of fifteen square feet [1.39 square meters] per licensed bed for recreation, visiting, and an activity program. The lounge and activity area may be used to accommodate religious services and activities. Each lounge area for resident use must be provided with an adequate number of reading lamps, tables, and chairs or couches. These furnishings must be well-constructed and accommodate the needs of the residents.

2. Kitchen. Dietary areas and equipment must be designed to accommodate the requirements for sanitary storage, processing, and handling.

3. Dining area.

   a. A minimum of fifteen square feet [1.39 square meters] per licensed bed must be provided for dining. Activity and dining areas must be separate.

   b. Dining room furnishings must be well-constructed, comfortable, in good repair, and must accommodate the needs of the residents. There must be a sufficient number of tables of suitable design to accommodate the needs of all residents using wheelchairs.

4. Resident bedrooms.

   a. All bedrooms used for residents must be dry, well-ventilated, and otherwise suitable for occupancy. Each room must have direct access to a corridor and have an outside wall with natural light provided by a window. Resident bedrooms licensed after the effective date of these rules must be at or above grade level.

   b. The glazed areas of the window may not be less than one-tenth of the floor area of the room. Windows must be easily opened and must be provided with screens. Windows may have stops to prevent full opening that could result in accidental falls or unintended exiting from window openings.

   c. Room size will vary depending on the number of beds, but minimum floor dimensions may not be less than ten feet [3.05 meters]. In computing floor area, only usable floor space may be included. Single rooms must provide at least one hundred square feet [9.29 square meters]. Double rooms must provide at least eighty square feet [7.43 square meters] per bed.

   d. Each resident must be provided with a bed and mattress. Cots, rollaways, or folding beds may not be used. Double beds may be used if requested by the resident and there is adequate space. Each bed must be provided with springs in good repair and a clean, firm, comfortable mattress of appropriate size for the bed, as well as a minimum of one clean, comfortable pillow.

   e. Each bedroom window must have window shades, or an equivalent, in good repair.

   f. Light levels to meet the needs of residents and to allow for reading and safety must be provided.

   g. Each bedroom must be provided with a mirror unless there is a mirror in a toilet room opening into the bedroom. Each resident lavatory must be provided with a mirror. Bedrooms or bathrooms in a secured unit or secured facility may or may not have mirrors based on the assessment of the resident.

   h. For each bed there must be furnished a minimum of two adequately sized dresser drawers, a chair, a bedside table or stand, an individual towel rack, and closet, locker, or wardrobe space for hanging clothing within the room.

5. Toilet rooms and bathing facilities.

   a. Separate toilets for public use must be provided.

   b. Each bath and toilet room must be well-lighted.

6. The facility shall provide for adequate ventilation throughout to assure an odor-free, comfortable environment.

7. Office spaces and other areas must be furnished with desks, chairs, lamps, cabinets, benches, worktables, or other furnishings essential to the proper use of the area.

History: Effective July 1, 2015.
General Authority: NDCC 23-09.3-09, 28-32-02
Law Implemented: NDCC 23-09.3-04

ARTICLE 33-43
NURSE AIDE TRAINING, COMPETENCY EVALUATION, AND REGISTRY

Chapter
33-43-01 Nurse Aide Training, Competency Evaluation, and Registry

CHAPTER 33-43-01
NURSE AIDE TRAINING, COMPETENCY EVALUATION, AND REGISTRY

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33-43-01-01. Definitions.

1. "Abuse" includes mental, physical, sexual, and verbal abuse. "Mental abuse" includes humiliation, harassment, threats of punishment, or deprivation. "Physical abuse" includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. "Sexual abuse" includes sexual harassment, sexual coercion, sexual contact, or sexual assault. "Verbal abuse" includes any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability.

2. "Agency" means home health agency.

3. "Certified nurse aide" means an individual who has successfully completed the requirements for the department-approved certified nurse aide training and competency evaluation program, or department-approved certified nurse aide competency evaluation program to provide

nursing or nursing-related services to residents and is entered on the department's nurse aide registry as a certified nurse aide.

4. "Competence" means the application and integration of knowledge, skills, ability, and judgment necessary to meet standards.

5. "Delegation" means the authorization for performance of selected nursing interventions from a licensed nurse to a certified nurse aide, home health aide, nurse aide, or medication assistant I or II.

6. "Deny" means the department's refusal to issue or renew a current registration on the nurse aide registry.

7. "Department" means the state department of health.

8. "Encumber" means to place on probation.

9. "Health care facility" means any health care facility licensed by the department which provides nursing-related services to consumers of nursing care other than nursing facilities.

10. "Home health aide" means an individual who renders personal related service under the supervision of a registered nurse and is registered on the department's nurse aide registry as a home health aide.

11. "Letter of concern" means a statement of the department's concerns regarding the conduct of a registrant.

12. "Medication administration" means the delivery of medication, by an individual delegated to and supervised by a licensed nurse, to a client whose use of that medication must be monitored and evaluated applying specialized knowledge, skills, and abilities possessed by a licensed nurse.

13. "Medication assistant" means an individual who is registered on the nurse aide registry as a certified nurse aide or nurse aide who has successfully completed the requirements of a department-approved medication assistant program for a specific employment setting. Upon successful completion of a medication assistant program, the certified nurse aide or nurse aide is eligible to be registered on the department's nurse aide registry as a medication assistant I or a medication assistant II.

    a. Medication assistant I is a certified nurse aide or nurse aide who has completed all the requirements for a department-approved medication assistant I program. A medication assistant I is limited to employment in a setting in which a licensed nurse is not regularly scheduled.

    b. Medication assistant II is a certified nurse aide who has completed all the requirements for a department-approved medication assistant II program. A medication assistant II may be employed both in a setting in which a licensed nurse is regularly scheduled and a setting in which a licensed nurse is not regularly scheduled.

14. "Medication assistant training program" means a program of study and clinical practice in the administration of routine, regularly scheduled medications which meets the department's requirements.

15. "Misappropriation of a resident property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, taking or use of a resident's belongings or money, or both, without the resident's consent.

16. "Neglect" includes failure to carry out resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to residents, or failure to carry out resident services through careless oversight.

17. "Nurse aide" means any individual who is registered on the nurse aide registry and who has successfully completed the competency requirements identified by the department to provide nursing or nursing-related services to an individual in a health care facility or other setting and is registered on the department's registry as a nurse aide.

18. "Nurse aide competency evaluation" means a testing mechanism consisting of both a written or oral and a manual skills component, testing the necessary knowledge needed by a certified nurse aide, home health aide, or nurse aide to provide safe care in a nursing facility, other health care facility, or other setting.

19. "Nurse aide registry" means a listing of individuals who the department has determined to have successfully completed the requirements established by the department to be designated as a certified nurse aide, home health aide, or nurse aide or medication assistant I or II.

20. "Nurse aide training program" means a program to train nurse aides offered by a public or private organization that has been approved by the department.

21. "Nursing facility" means a nursing facility licensed by the department, and does not include any institution that is for the care and treatment of persons with intellectual disabilities or persons with related conditions.

22. "Other misconduct" means a conviction of a crime or proof of behavior which has a direct bearing on the individual's ability to care for others or is a threat to the health and safety of patients or clients.

23. "Other setting" includes settings such as a clinic, outpatient service provider, or individual home where the individual on the department's nurse aide registry is employed to provide nursing-related services.

24. "Qualified instructor for a certified nurse aide training program" means a registered nurse with a minimum of two years of nursing experience, at least one year of which must be in the provision of long-term care facility services. Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides. In a nursing facility-based program, the director of nursing is prohibited from performing the actual training. However, a director of nursing who meets the qualified instructor requirements may provide the general supervision for the program. Other health-related professionals who have a minimum of one-year experience in their field may supplement the instructor.

25. "Qualified instructor for a home health aide training program" is a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health care services. Other professionals may be used to provide instruction under the supervision or the qualified instructor.

26. "Qualified instructor for a nurse aide training program" is a registered nurse.

27. "Regularly scheduled presence of a licensed nurse" means that a licensed nurse is present a minimum of eight hours in a twenty-four-hour period of time in a setting where nursing care is continuously delivered.

28. "Revoke" means the withdrawal by the department of the registration of an individual to be employed as a certified nurse aide, home health aide, nurse aide, or medication assistant I or II for a specified period of time of no less than one year. If no specified period of time is

identified by the department, revocation is permanent. For a certified nurse aide, a finding of abuse or neglect will result in permanent revocation, although the finding of neglect may be requested to be removed after one year under section 33-43-01-24.

29. "Routine, regularly scheduled medication" means the components of an identified medication regimen for an individuals or groups of individuals with stable conditions which are administered on a routine basis and do not require determination of need, drug calculation, or dosage conversion.

30. "Significant requirements" means federal certification or state licensure requirements that have a serious or measurable impact on the health and safety of the resident in the facility. This includes a nursing waiver. Significant requirements shall be determined to be out of compliance based on the considerations of severity of the noncompliance issue, frequency of the noncompliance issue, and history of prior noncompliance issues.

31. "Stable" means a situation in which the patient's or client's clinical and behavioral status and nursing care needs are determined by the registered nurse or licensed practitioner to be predictable, nonfluctuating, and consistent or in which the fluctuations are expected and the interventions are planned.

32. "Supervised practical skills training" means manual skills training in a laboratory or other setting in which the nurse aide demonstrates knowledge while performing tasks on an individual while under the direct supervision of a licensed nurse under the general supervision of a qualified instructor.

33. "Supervision" means maintaining accountability to determine whether or not nursing care is adequate and delivered appropriately. Supervision includes the assessment and evaluation of the patient or client's condition and responses to the nursing plan of care and evaluation of the competence of the person providing the nursing or nursing-related care.

    a. "Direct supervision" means that the responsible licensed nurse or licensed practitioner is physically present in the patient or client area and is available to assess, evaluate, and respond immediately.

    b. "Indirect supervision" means that the responsible licensed nurse or licensed practitioner is available through periodic inspection and evaluation or by telecommunication, or both, for direction, consultation, and collaboration.

34. "Suspend" means the withholding or withdrawing by the department of the registration of an individual on the department's nurse aide registry for a specified or indefinite period of time not to exceed one year.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-01, 23-44-02
Law Implemented: NDCC 23-44-01, 23-44-02

33-43-01-02. Conflict with federal requirements.

If any part of this chapter is found to conflict with federal requirements, the more stringent shall apply. Such as finding or determination shall be made by the department and shall not affect the remainder of this chapter.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-03, 23-01-11, 23-44-02
Law Implemented: NDCC 23-01-11, 23-44-02

33-43-01-03. Responsibilities of training programs for screening of potential students.

1. Certified nurse aide, home health aide, nurse aide, and medication assistant training programs must screen potential students or individuals seeking entry into a training program. This screening should be completed prior to beginning the training program and should occur in sufficient advance of the training to minimize delays and allow for changes in career choices in a timely manner.

2. Those applicants with a history including conviction of a crime substantially related to the qualification, functions, or duties of a certified nurse aide, home health aide, nurse aide, or medication assistant or a finding on a state nurse aide registry or federal registry should be informed they might not be allowed to begin the training program or take the test without providing specific information relating to their background, criminal history, or impairment.

3. The training program is responsible to provide sufficient screening to identify those individuals that would be a risk to the vulnerable populations served by the certified nurse aide, home health aide, nurse aide, or medication assistant and to submit that information to the department for review prior to entering the individual into a program.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-04. Nurse aide training program requirements.

1. Any individual employed by a nursing facility to provide nursing or nursing-related services who is not a licensed nurse or volunteer or pursuing nurse aide certification and entry on the nurse aide registry must successfully complete a department-approved certified nurse aide training program consisting of a minimum of seventy-five hours and a department-approved competency evaluation or a department-approved competency evaluation.

   a. The certified nursing aide training program must be under the general supervision of a qualified instructor.

      (1) A qualified instructor for certified nurse aide training is a registered nurse with a minimum of two years of nursing experience, at least one year of which must be in the provision of long-term care facility services.

      (2) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides.

      (3) In a nursing facility-based program, the director of nursing is prohibited from performing the actual training. However, a director of nursing who meets the qualified instructor requirements may provide the general supervision for the program.

      (4) Other health-related professionals who have a minimum of one-year experience in their field may supplement the instructor.

   b. Individuals employed by nursing facilities pursuing registration as a certified nurse aide must complete a minimum of sixteen hours of classroom training in the following areas from a department-approved nurse aide training program prior to any hands-on contact with residents or patients. The areas are:

      (1) Communication and interpersonal skills;

      (2) Infection control;

(3) Safety and emergency procedures, including the Heimlich maneuver;

(4) Promoting residents' independence; and

(5) Respecting residents' rights.

c. The remainder of the seventy-five-hour-approved training and competency evaluation program must be completed within four months of the date of first employment in the facility as a nurse aide and must include at least sixteen hours of supervised practical training.

d. Other areas that are required to be addressed in the certified nurse aide training program include:

(1) Basic nursing skills;

(2) Personal care skills;

(3) Mental health and social service needs;

(4) Care of residents or clients with cognitive impairments;

(5) Basic restorative services; and

(6) Resident or patient rights.

e. Individuals may not perform tasks for which competence has not been determined unless under the direct supervision of a licensed nurse.

f. Individuals trained and determined proficient by the instructor to provide specific services to residents who have not completed the competency evaluation program shall provide these services under the general provision of a licenced nurse.

g. The certified nurse aide training program must ensure that individuals in the training program who are employed by or have an offer of employment from a nursing facility to work as a certified nurse aide are not charged for any portion of the nurse aide training program, including fees for textbooks or other required course materials.

2. Any individual employed by a home health agency to provide home health aide services directly or by contract must successfully completed a home health aide training and competency evaluation program or competency evaluation program.

a. The training program must total at least seventy-five clock hours, with at least sixteen of the seventy-five hours being devoted to classroom training prior to initiating the supervised practical training. At least sixteen hours of the total program hours must be devoted to supervised practical training.

b. The training, including supervised practical training, of the home health aides must be performed under the general supervision of a qualified instructor.

(1) A qualified instructor for a home health training program is a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in the in the provision of home health care services.

(2) Other professionals may be used to provide instruction under the supervision of the qualified instructor.

c. The training must, at a minimum, include the following topics:

(1) Communication skills;

(2) Observation, reporting, and documentation of patient status and care or services furnished;

(3) Reading and recording of temperature, pulse, and respirations;

(4) Basic infection control procedures;

(5) Basic elements of body functioning and changes in body functioning that must be reported to an aide's supervisor;

(6) Maintenance of a clean, safe, and healthy environment;

(7) Recognizing emergencies and knowledge of emergency procedures;

(8) The physical, emotional, and developmental needs of and ways to work with the patients served;

(9) Patient rights;

(10) Appropriate and safe techniques in personal hygiene and grooming which include:

(a) Bed bath;

(b) Sponge, tub, or shower bath;

(c) Sink, tub, or bed shampoo;

(d) Oral hygiene; and

(e) Nail or skin care.

(11) Safe transfer techniques and ambulation;

(12) Normal range of motion and positioning;

(13) Adequate nutrition and fluid intake; and

(14) Any other tasks the agency may choose to have the home health aide perform.

d. The agency must maintain sufficient documentation to demonstrate that the requirements for the training of home health aides of this section are met.

3. Any individual who is not a licensed nurse who is employed directly or by contract to provide nursing or nursing-related services by a health care facility or other setting that is not a nursing facility or a home health agency must successfully complete a nurse aide training program under the direction of a qualified instructor and competency evaluation or competency evaluation.

a. A qualified instructor for a nurse aide training program is a licensed nurse.

b. The training program must, at a minimum, include the following areas:

(1) Infection control;

(2) Safety and emergency procedures;

(3) Collection and documentation of basic subjective and objective client data, including vital signs;

(4) Activities of daily living (bathing, dressing, personal hygiene, oral hygiene, transfer, ambulation, toileting, and eating) applicable to setting.

(5) Decisionmaking skills;

(6) Client rights, including freedom from abuse, neglect, misappropriation of client property, respect, privacy, dignity, and confidentiality;

(7) Communication and interpersonal skills; and

(8) Care of the client with cognitive impairments.

c. The nurse aide may not need to be retrained for each client cared for by the nurse aide, provided the nurse aide's knowledge and skills are maintained.

d. Additional training must be provided to nurse aides by a qualified instructor for clients whose needs or conditions would require variation from the typical manner the nursing-related task would be performed.

e. The nurse aide shall perform the delegated nursing-related task only on the client for whom the delegation is specified, exactly as taught, and in accordance with employers' policies or directives.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-11, 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-01-11, 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-05. Nurse aide competency evaluation.

1. Any individual employed by a nursing facility to provide nursing or nursing-related services, who is not a licensed nurse or volunteer, must successfully complete a department-approved certified nurse aide competency evaluation program to be eligible to apply to be placed on the department's nurse aide registry.

   a. The department-approved certified nurse aide competency evaluation program must allow a nurse aide the option of establishing competency through written or oral and manual skills examination.

   b. The written or oral examination must address all areas required in the department-approved training program.

   c. The written or oral examination must be developed from a pool of test questions, only a portion of which may be utilized in any one examination.

   d. The competency evaluation program must include a demonstration of the randomly selected tasks the individual will be expected to perform as part of the individual's function as a nurse aide.

   e. The competency evaluation program must provide for a system that prevents disclosure of both pool questions and the individual competency evaluations.

   f. The competency evaluation program must ensure that nurse aides employed by or having an offer of employment from a facility are not charged for any portion of the competency evaluation program.

2. Any individual employed by a home health agency to provide home health aide services must complete a home health competency evaluation program to be eligible to apply to be placed

on the department's nurse aide registry. The competency evaluation program consists of the following:

a. The competency evaluation must be conducted by a registered nurse who possesses a minimum of two years of nursing experience, at least one year must be in the provision of home health care.

b. The competency evaluation must address each of the items listed in subdivision c of subsection 2 of section 33-43-01-04.

(1) The items listed in paragraphs 3, 10, 11, and 12 of subdivision c of subsection 2 of section 33-43-01-04 must be completed by observation of the aide's performance of the tasks with a patient or other live individual.

(2) All other items listed in subdivision c of subsection 2 of section 33-43-01-04 can be evaluated through written or oral examination or observation of the aide with a patient.

c. A home health aide is not considered to have successfully passed a competency evaluation program if the aide has an unsatisfactory rating in more than one of the required areas.

(1) A home health aide cannot perform any task for which the aide is evaluated to perform unsatisfactorily unless under the direct supervision of a licensed nurse.

(2) The home health aide must receive training in the areas determined unsatisfactory and pass a subsequent evaluation satisfactorily prior to performing a task without supervision.

d. The agency must maintain documentation that the competency evaluation requirements of this subsection have been met be each home health aide.

3. Any individual who is employed directly or by contract by a health care facility or other setting that is not a nursing facility or a home health agency must successfully complete a nurse aide competency evaluation program to be eligible to apply to be placed on the department's nurse aide registry.

a. The competency evaluation program must be completed by a licensed nurse or employer.

b. The competency evaluation must, at a minimum, address the areas listed in subdivision a of subsection 3 of section 33-43-01-04.

c. A nurse aide is not considered to have successfully passed a competency evaluation program if the individual has an unsatisfactory rating in a required area identified in subdivision a of subsection 3 of section 33-43-01-04.

d. A nurse aide may perform tasks for which the aide has been competency evaluated to perform, and may not perform tasks for which the competency evaluation was unsatisfactory unless under the direct supervision of a licensed nurse.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-11, 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-01-11, 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-06. Administration of nurse aide competency evaluation programs.

1. A certified nurse aide competency evaluation must be administered and evaluated by the department or a department-approved entity that is not a nursing facility licensed by the department.

   a. The entity that administers the competency evaluation must advise the individual in advance that a record of the successful or unsuccessful completion of the evaluation will be included on the department's nurse aide registry.

   b. The skills demonstration portion of the test must be administered in the facility or laboratory setting comparable to the setting in which the individual will function.

   c. The skills demonstration portion of the test must be administered and evaluated by a registered nurse with at least one year of experience in providing care for the elderly or chronically ill of any age.

   d. The department may permit the written or oral examination to be proctored by facility personnel if the department determines that the procedure adopted assures the competency evaluation is:

      (1) Secure from tampering.

      (2) Standardized and scored by a testing, educational, or other organization approved by the department.

      (3) Exempt from any scoring by facility personnel.

   e. The department shall retract the right to proctor nurse aide competency evaluations from facilities in which the department finds any evidence of impropriety, including tampering by facility personnel.

2. A home health aide competency evaluation program must be administered consistent with the requirements in subsection 2 of section 33-43-01-05 and may be evaluated for compliance periodically by the department. However, the department may permit the use of a home health aide competency evaluation program that is standardized and scored by a testing, educational, or other organization approved by the department.

3. A nurse aide competency evaluation program must be administered consistent with the requirements in subsection 3 of section 33-43-01-05 and may be evaluated as determined necessary by the department.

History: Effective July 1, 2011.
General Authority: NDCC 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-07. Withdrawal and approval of nurse aide training program status.

1. Certified nurse aide training program status withdrawal and approval of status is as follows:

   a. The department shall withdraw approval of a nursing facility-based certified nurse aide training program when a determination has been made that the facility has been found to be out of compliance with significant federal certification or state licensure requirements. The facility may apply for reinstatement after providing evidence of remaining in compliance with significant requirements for a period of twenty-four consecutive months.

   b. The department shall withdraw approval of a certified nurse aide training and competency evaluation program if the entity providing the program refuses to permit

announced or unannounced visits by the department to ascertain compliance with program requirements.

c. Approval of a nurse aide training and competency evaluation program shall be granted by the department for a period not to exceed two years.

d. The department may approve only those certified nurse aide training programs that meet the requirements in subsection 1 of section 33-43-01-04.

2. Home health aide training program status withdrawal and approval of training program status is as follows:

a. A home health aide training program must meet the requirements of subsection 2 of section 33-43-01-04 to be considered approved by the department.

b. Home health agencies that have had state or federal enforcement action, other than the citation of deficiencies, filed against them in the past two years are not eligible to operate a home health aide training program.

3. Nurse aide training withdrawal and approval of training status is as follows:

a. Nurse aide training must meet the requirements of subsection 3 of section 33-43-01-04 to be considered approved by the department.

b. Failure to meet the requirements of subsection 3 of section 33-43-01-04 may result in a determination by the department that the entity can no longer provide nurse aide training until the requirements are met.

History: Effective July 1, 2011.
General Authority: NDCC 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-08. Completion of the nurse aide competency evaluation program.

1. To complete the competency evaluation successfully the individual shall, at a minimum, successfully complete the competencies in subsection 1, 2, or 3 of section 33-43-01-05.

2. A record of successful completion of the competency evaluation for individuals seeking registration as a certified nurse aide, home health aide, or nurse aide must be included in the nurse aide registry within fourteen days of the date the individual was found to be competent.

3. If the individual fails to complete the evaluation satisfactorily, the competency evaluation program must advise the individual of the areas of which the individual was adequate or inadequate, and that the individual has not more than three opportunities to take the competency evaluation.

4. If the individual seeking registration fails the competency evaluation on the third attempt, the individual must enroll in and complete a department-approved certified nurse aide training program, home health aide training program, or nurse aide training program prior to taking the competency evaluation again.

History: Effective July 1, 2011.
General Authority: NDCC 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-09. Registry information.

1. The department is responsible for the entering of individual names on the nurse aide registry upon receipt of information verifying completion of a department-approved certified nurse aide training and competency evaluation program or a department-approved certified nurse aide competency evaluation program, a home health aide training and competency evaluation program or a home health aide competency evaluation program, or a nurse aide competency evaluation program.

2. Upon the completion of a department-approved medication assistant I competency evaluation program by a certified nurse aide or nurse aide, or department-approved medication assistant II competency evaluation program by a certified nurse aide and application to the department, the department will add information to the certified nurse aide or nurse aide's registry listing verifying the completion of the medication assistant I or II program.

3. Information included on the registry must include name, address, social security number, birth date, registry categories, the date the nurse aide became eligible for entry on the registry, and the place of employment. The social security number will not be included in registry information released to the public.

4. The department shall include documentation of validated findings of abuse, neglect, misappropriation of resident property, or other misconduct by the certified nurse aide, home health aide, or nurse aide or medication assistant I or II on the registry when validated by the department.

5. Certified nurse aide applicants for the nurse aide registry who submit proof of meeting the requirements of another jurisdiction will be granted reciprocity and entered on the nurse aide registry and may use the title "certified nurse aide". The individual must meet North Dakota requirements for active registry status.

6. Nurse aides meeting the waiver provisions of twenty-four months of continuous employment as a nurse aide prior to December 19, 1989, granted by the department will be listed on the registry with a special designation. This designation will signify the nurse aide has been waived from training and testing requirements but is not certified.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-11, 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-01-11, 23-17.3-08, 23-44-02

33-43-01-10. Disclosure of information.

1. Information contained in the registry will be disclosable to any Medicare or Medicaid participating facility, nursing facility, home health agency, hospital, basic care facility, assisted living facility, ombudsman, other representative of an official agency, or other individuals requesting information, upon request.

2. Upon request, the department shall provide the requester with the following information regarding individuals on the registry:

   a. The date the individual's name was eligible for entry on the registry.

   b. Any documented validated findings of abuse, neglect, misappropriation, or other misconduct, including the nature of the allegation and summary of the evidence supporting the validated finding, the date and outcome of hearing if one occurred, and any statement by the individual disputing the allegation that led to the validated finding.

   c. Any additional information that the department deems necessary.

3. All information contained on the registry regarding a certified nurse aide, home health aide, nurse aide, or medication assistant I or II will be provided to that individual upon written request to the department.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-11. Initial certified nurse aide, home health aide, and nurse aide registration and renewal.

Individuals may not be employed to provide nursing or nursing-related services as a certified nurse aide, home health aide, or nurse aide, or hold themselves out to be a certified nurse aide, home health aide, or nurse aide unless the individual is registered on the department's nurse aide registry according to this chapter.

1. An individual who applies for initial registry status as a certified nurse aide shall submit a completed certified nurse aide application and verification of successful completion of a department-approved certified nurse aide training and competency evaluation program or competency evaluation program. Upon receipt and review for approval of the required information, the individual will be placed on the department's registry with a designation of certified nurse aide.

   a. An individual who is enrolled in a department-approved certified nurse aide training and competency evaluation program may be employed to perform nursing or nursing-related services under the supervision of a licensed nurse for no more than four months without obtaining registry status.

   b. An individual who is not a licensed nurse who is not enrolled in a department-approved certified nurse aide training program may not be employed in a nursing facility to provide nursing or nursing-related services until the individual obtains registry status as a certified nurse aide.

   c. Individuals who have met the requirements for registry listing as a certified nurse aide in other states, have a current registry status, and no validated finding may be endorsed onto the department's registry as a certified nurse aide.

   d. Registry status is limited to twenty-four months. Upon receipt of a completed certified nurse aide renewal application, and verification of employment within the immediate past twenty-four months, the certified nurse aide registry status will be updated to indicate current status.

   e. A certified nurse aide who has not performed at least eight hours of nursing or nursing-related services for pay within a continuous twenty-four-month period shall complete a department-approved training and competency evaluation program or a department-approved competency evaluation to renew current registry status.

   f. An individual seeking initial certified nurse aide registry status or registry renewal as a certified nurse aide on the department's nurse aide registry may not be charged a fee.

2. An individual who applies for initial registry status as a home health aide shall submit a completed home health aide application, a nonrefundable fee of twenty-five dollars, and an attestation from a qualified instructor that the individual has successfully completed a home health aide training and competency program or home health aide competency program. Upon receipt and review for approval of the required information, the individual will be placed on the department's registry with a designation of home health aide.

a. An individual who is in a home health aide training and competency program may be employed to perform nursing or nursing-related services under the supervision of a licensed nurse for no more than four months without obtaining registry status.

b. An individual who is not in a home health aide training program may not be employed by the home health agency to provide home health aide services until the individual obtains registry status as a home health nurse aide.

c. Initial registry listing will be subject to renewal on or before September thirtieth of the second year and every two years thereafter.

d. Upon receipt of a completed home health aide renewal application and a nonrefundable fee of twenty-five dollars, the home health aide registry status will be updated to indicate current status. The home health aide's registry status will be considered temporary until such time the payment is confirmed and may be rescinded if payment is not received.

3. An individual who applies for initial registry status as a nurse aide shall submit a completed nurse aide application, including documentation of verification of competency and a nonrefundable fee of twenty-five dollars. Upon receipt and review for approval of the required information, the individual will be placed on the department's registry with a designation of nurse aide.

a. An individual who is in a nurse aide training and competency evaluation program may be employed to perform nursing or nursing-related services under the supervision of a licensed nurse for no more than four months without obtaining registry status.

b. An individual who is not in a nurse aide training program may not be employed as a nurse aide until the individual obtains registry status as a nurse aide.

c. Initial registry listing will be subject to renewal on or before September thirtieth of the second year and every two years thereafter.

d. Upon receipt of a completed nurse aide renewal application, including verification of competence within the past twelve months and a nonrefundable fee of twenty-five dollars, the nurse aide registry will be updated to indicate current status. The nurse aide's registry status will be considered temporary until such time the payment is confirmed and may be rescinded if payment is not received.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-11, 23-17.3-08, 23-44-02
Law Implemented: NDCC 23-01-11, 23-17.3-05, 23-17.3-08, 23-44-02

33-43-01-12. Supervision and delegation of nursing interventions.

An individual on the department's nurse aide registry may perform nursing interventions which have been delegated by a licensed nurse. An individual on the department's nurse aide registry as delegated and supervised by a licensed nurse:

1. Contributes to the assessment of the health status of clients, including interactions of clients with family members or group members by:

a. Collecting basic subjective and objective data from observations and interviews, including taking vital signs; and

b. Reporting and recording the collected data.

2. Identifies basic signs and symptoms of deviations from normal health status and provides basic information which licensed nurses' use in identification of problems and needs.

3. Contributes to the development of the plan of care for individuals by reporting basic data.

4. Participates in the giving of direct care by:

   a. Assisting with activities of daily living and encouraging self-care;

   b. Providing comfort measures and emotional support to the client whose condition is stable and predictable;

   c. Assisting with basic maintenance and restorative nursing;

   d. Supporting a safe and healthy environment;

   e. Documenting and communicating completion of delegated nursing interventions and client responses; and

   f. Seeking guidance and direction when appropriate.

5. Contributes to the evaluation by:

   a. Documenting and communicating client responses; and

   b. Assisting with collection of data.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16.1
Law Implemented: NDCC 23-44-02, 43-12.1-16.1

33-43-01-13. Medication assistant requirements for supervision.

An individual on the department's nurse aide registry may perform medication administration that has been delegated by a licensed nurse.

1. In a nursing facility, the medication assistant may perform medication assistance only when a licensed nurse is on the unit and available for immediate direction.

2. In a health care facility where the licensed nurse delegates the intervention of giving medications to another individual, the individual on the department's nurse aide's registry may perform the delegated medication assistance only when a licensed nurse is available for direction.

3. In any other setting where the licensed nurse delegates the intervention of medication administration to another individual, the individual on the department's nurse aide registry may perform the delegated medication administration only if the licensed nurse has established in writing the process for providing the supervision in order to provide safeguards for the individual receiving the medication.

4. Individuals on the department's nurse aide registry may not be delegated to or perform medication administration in acute care settings or for individuals with unstable or changing nursing care needs.

5. The medication assistant requirements in this chapter do not apply to an individual who provides medication administration that is not registered under this chapter and is:

   a. Within a correctional facility, in compliance with North Dakota Century Code section 12-44.1-29;

b. Within a psychiatric residential treatment facility for children licensed under North Dakota Century Code chapter 25-03.2 and North Dakota Administrative Code chapter 75-03-17;

c. Within a treatment or care center for intellectual or developmentally disabled persons licensed under North Dakota Century Code chapter 25-16;

d. Within a group home, a residential child care facility, or an adult foster care facility licensed under North Dakota Century Code section 50-11-01 or North Dakota Administrative Code chapter 75-03-16;

e. Within the development center at Westwood Park, Grafton, to the extent the individual who provides medications is a direct training technician or a vocational training technician as approved by the department of human services; or

f. Within a human service center licensed under North Dakota Century Code chapter 50-06.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16
Law Implemented: NDCC 23-44-02, 43-12.1-16

33-43-01-14. Medication assistant I training and competency evaluation program requirements.

The medication assistant I program requirements are applicable to settings in which a licensed nurse is not regularly scheduled and provides direct or indirect supervision. The medication assistant I program consists of the theoretical concepts of medication administration and supervised clinical administration of medication. The curriculum must meet the requirements established by the department and include at a minimum:

1. Instructor. A registered nurse is responsible for the development of the theory, the laboratory or clinical component, and supervision of the medication assistant training program.

2. Course objectives. Described in terms of student outcome competencies, including the following:

   a. Utilize the principles of safety in the administration of medication;

   b. Define terms related to the administration of medications;

   c. Correctly interpret abbreviations commonly used in administration of medication;

   d. Know and apply laws related to medication administration;

   e. Keep accurate records; and

   f. Identify legal parameters of the medication assistant role.

3. Curriculum. The medication assistant program I curriculum for delegated medication administration must include:

   a. Medication concepts:

      (1) Terminology and standardization abbreviations;

      (2) Classification of medication;

      (3) Generic and trade names;

(4) Dosage, range, and action;

(5) Side effects;

(6) Medication routes; and

(7) References and sources of information.

b. Roles, responsibilities, legal aspects, and limitations of medication assistant I and licensed nurse:

(1) Scope of duties for medication assistant I;

(2) Licensed nurse responsibilities in relationship to a medication assistant I;

(3) Client rights, including the right to refuse medication; and

(4) Knowledge of organization policy related to medication administration.

c. Methods for medication packaging.

d. Storage and disposal of medication.

e. Administering and charting medication:

(1) Preparation and administration of medication;

(2) Safety and six rights of medication administration;

(3) Use of medication administration record to:

(a) Administer medications; and

(b) Document medication administration;

(4) Prevention of medication errors; and

(5) Causes and reporting of medication errors.

f. Standard precautions for infection control.

g. An overview of the major classes of medications related to body systems.

h. Additional instruction must include those categories of medications relevant to the health care setting where the medication assistant will be employed.

i. Clinical instruction for the purpose of demonstration of medication administration and evaluation of individual competence.

4. Medication assistant I program students must complete the clinical portion of the medication assistant program within six months of completion of the theory portion. Failure to do so will render the individual ineligible to administer medications.

5. A passing score of eighty-five percent is required on the theory test with an opportunity to retake the test one time. If a student fails on a retake, additional instruction is required before further testing is allowed.

6. Medication assistant I program students shall demonstrate satisfactory performance of medication administration as evidenced by satisfactory completion of the clinical skills checklist.

7. During the clinical learning experience, the licensed nurse shall:

   a. Provide direct over-the-shoulder supervision with initial medication pass;

   b. Observe and evaluate the student's performance until a ninety percent performance standard on the clinical skills checklist is obtained; and

   c. Decreased the amount of supervision only when the student demonstrates the ninety percent performance standard.

8. The medication assistant I program coordinator is required to submit to the department, which two weeks of completion of the course, a list of students successfully completing the medication assistant I program. The information submitted to the department for initial medication assistant I registration for each student must include:

   a. Name and location of the institution and course title;

   b. Date of completion;

   c. Full name, address, and social security number of the student;

   d. The name and qualifications of the instructors;

   e. The clinical facility or employer and address;

   f. The facility clinical coordinator of each student who successfully completes the course;

   g. Copies of the completed theoretical curriculum and clinical performance testing results for the student;

   h. A copy of a certificate of successful completion, if awarded by the teaching institution;

   i. A completed medication assistant I application; and

   j. A nonrefundable fee of twenty-five dollars.

9. Medication assistant I programs shall maintain records that are available for a period of seven years. Those records must include:

   a. Program records, including curriculum and evaluation tools for student performance, both theory and clinical.

   b. Students records, including course start and completion date, clinical skills checklist, examination scores, and a copy of the certificate of successful completion.

10. The medication assistant I program will submit a renewal application for review by the department for a determination on continued approval at least every four years.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-15. Medication assistant II training and competency evaluation program requirements.

The medication assistant II program requirements are applicable to settings in which a licensed nurse may or may not be regularly scheduled. The medication assistant II program consists of a minimal time frame, including forty hours of theory, eight hours of laboratory, and thirty-two hours of

clinical learning experience. The curriculum must meet the requirements in this section, and include at a minimum:

1. Instructor. A registered nurse is responsible for the development of the theory, laboratory component, and supervision of the medication assistant II program. All medication administration as a part of the clinical learning experience must be supervised by a licensed nurse.

2. Course objectives. Described in terms of student outcome competencies, including the following:

   a. Utilize the principles of safety in the administration of medications;

   b. Define terms related to the administration of medications;

   c. Correctly interpret abbreviations commonly used in administration of medications;

   d. Know and apply laws related to medication administration;

   e. Keep accurate records; and

   f. Identify legal parameters of the medication assistant role.

3. Curriculum. The medication assistant program II curriculum for delegated medication administration must include:

   a. Medication concepts:

      (1) Terminology and standardized abbreviation;

      (2) Classification of medication;

      (3) Generic and trade names;

      (4) Dosage, range, and action;

      (5) Side effects;

      (6) Medication routes; and

      (7) References and sources of information.

   b. Roles, responsibilities, legal aspects, and limitations of medication assistant II and licensed nurse:

      (1) Scope of duties for a medication assistant II;

      (2) Licensed nurse responsibilities in relationship to a medication assistant II;

      (3) Client rights, including the right to refuse medication;

      (4) Laws related to medication administration; and

      (5) Knowledge of organization policy related to medication administration.

   c. Methods for medication packaging.

   d. Storage and disposal of medication.

   e. Administering and charting medications:

(1) Preparation and administration of medications;

(2) Safety and six rights of medication administration;

(3) Use of medication administration record to:

(a) Administer medications; and

(b) Document medication administration;

(4) Prevention of medication errors; and

(5) Causes and reporting of medication errors.

f. Standard precautions for infection control.

g. Major classes of medications related to body systems, including:

(1) Cardiovascular;

(2) Endocrine;

(3) Gastrointestinal;

(4) Integumentary;

(5) Musculoskeletal;

(6) Nervous;

(7) Reproductive;

(8) Respiratory;

(9) Sensory; and

(10) Urinary.

h. Additional instruction must include those categories of medications relevant to the heath care setting where the medication assistant will be employed.

i. Laboratory and clinical instruction for the purpose of demonstration of medication administered and evaluation of individual competence.

4. Medication assistant program II students who complete the classroom portion of the medication assistant program have six months from the completion of classroom instruction to successfully complete the clinical portion of the program. Failure to do so will render the individual ineligible to complete the clinical portion of the program.

5. Tests are developed for each unit in the curriculum, including a final test. A passing score of eighty-five percent is required on each unit test with an opportunity to retake each test one time. If a student fails on retake, additional instruction is required before further testing is allowed. The theory portion of the course must be successfully completed before beginning the clinical portion.

6. Medication assistant students shall demonstrate satisfactory performance of medication administration as evidenced by satisfactory completion of the laboratory skills and clinical skills checklist.

7. During the clinical learning experience, the licensed nurse shall:

   a. Provide direct over-the-shoulder supervision with initial medication pass;

   b. Observe and evaluate the student's performance until a ninety percent performance standard on the clinical checklist is obtained; and

   c. Decrease the amount of supervision only when the student demonstrates the ninety percent performance standard.

8. The medication assistant II program coordinator is required to submit to the department, within two weeks of completion of the course, a list of students successfully completing the medication assistant II program. The information submitted to the department for initial medication assistant II registration for each student must include:

   a. Name and location of the institution and course title;

   b. Date of completion;

   c. Full name, address, and social security number of the student;

   d. The name and qualifications of the instructors;

   e. The clinical facility or employer and address;

   f. The facility clinical coordinator of each student who successfully completes the course;

   g. Copies of the completed theoretical curriculum and clinical performance testing results for the student;

   h. A copy of a certificate of successful completion;

   i. A completed medication assistant II application; and

   j. A nonrefundable fee of twenty-five dollars.

9. Medication assistant II programs shall maintain records that are available for a period of seven years. Those records must include:

   a. Program records, including curriculum and evaluation tools for student performance, both theory and clinical; and

   b. Student records, including course start and completion date, laboratory and clinical skills checklist, examination scores, and a copy of the certificate of successful completion.

10. The medication assistant II program will submit a renewal application for review by the department for a determination on continued approval at least every four years.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-16. Specific delegation of medication administration.

An individual on the department's nurse aide registry may accept the delegation of the delivery of specific medication for a specific client by a licensed nurse if the following steps are followed:

1. The individual on the department's nurse aide registry must receive the organization procedural guidelines for the certified nurse aide, home health aide, nurse aide, or medication assistant I or II to follow in the administration of medication by specific delegation.

2. The individual on the department's nurse aide is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction for the specific client's individual medications, including:

   a. The medication trade name and generic name;

   b. The purpose of the medication;

   c. Signs and symptoms of common side effects, warnings, and precautions;

   d. Route and frequency of administration; and

   e. Instructions under which circumstances to contact the licensed nurse or licensed health care practitioner.

3. The individual on the department's nurse aide registry is observed by a licensed nurse administering the medication to the specific client until competency is demonstrated.

4. The individual on the department's nurse aide registry has been verified as competent by a licensed nurse through a variety of methods, including oral quizzes, written tests, and observation. The individual on the department's nurse aide registry must be verified as competent in the following areas:

   a. Knows the six rights for each medication for the specific client, which include right client, right medication, right dosage, right route, right time, and right documentation;

   b. Knows the name of the medication and common dosage;

   c. Knows the signs and symptoms of side effects for each medication;

   d. Knows when to contact the licensed nurse;

   e. Can administer the medication properly to the client; and

   f. Documents medication administration according to organization policy.

5. Documentation that the individual on the department's nurse aide registry has received the training related to the receipt of specific delegation of medication administration for each client must be maintained and updated when further instruction is received as necessary to implement a change.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16
Law Implemented: NDCC 23-44-02, 43-12.1-16

33-43-01-17. Routes or types of medication administration.

1. Administration of the initial dose of a medication that has not been previously administered to the client must be administered according to the organization policy.

2. Medication assistant students and medication assistants may administer medications by the following routes to individuals or groups of individuals with stable, predictable conditions according to the organization policy:

   a. Oral, sublingual, and buccal medications;

b. Eye medications;

c. Ear medications;

d. Nasal medications;

e. Rectal medications and enemas;

f. Vaginal medications;

g. Skins ointments, topical medications, including patches and transdermal medications;

h. Metered hand-held inhalants; and

i. Unit dose nebulizers.

3. Medication assistants I and II may administer medications by the following routes only when specifically delegated by a licensed nurse for a specific client:

a. Gastrostomy;

b. Jejunostomy;

c. Subcutaneous; and

d. Premeasured injectable medication for allergic reactions.

4. Medication assistant students and medication assistants I and II may not administer medications by the following routes:

a. Central lines;

b. Colostomy;

c. Intramuscular injection;

d. Intravenous;

e. Intravenous lock;

f. Intrathecal;

g. Nasogastric tube;

h. Nonmetered inhaler;

i. Intradermal;

j. Nonunit dose aerosol or nebulizer; or

k. Urethral catheter.

5. Medication assistant students and medication assistants I and II may not administer the following kinds of medications:

a. Barium and other diagnostic contrast media;

b. Chemotherapeutic agents except oral maintenance chemotherapy; or

c. Through any medication pumps, or assume responsibility for medication pumps, including client-controlled analgesia.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-18. Pro re nata medications.

1. The decision to administer pro re nata medications cannot be delegated in situations where an onsite assessment of the client is required prior to administration.

2. Some situations allow the administering of pro re nata medications without directly involving the licensed nurse prior to each administration.

   a. The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse.

   b. Written parameters specific to an individual client's care must be written by the licensed nurse for use by the medication assistant when an onsite assessment is not required prior to administration of a medication. The written parameters:

      (1) Supplement the physician's pro re nata order; and

      (2) Provide the medication assistant with guidelines that are specific regarding the pro re nata medication.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16
Law Implemented: NDCC 23-44-02, 43-12.1-16

33-43-01-19. Medication interventions that may not be delegated.

The medication assistant I or medication assistant II, or other individual listed on the department's nurse aide registry, may not perform the following acts even if delegated by a licensed nurse:

1. Conversion or calculation to medication dosage;

2. Assessment of client need for or response to medications; and

3. Nursing judgement regarding the administration of pro re nata medications.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16
Law Implemented: NDCC 23-44-02, 43-12.1-16

33-43-01-20. Medication assistant I and II initial registration and renewal.

Individuals may not be employed as a medication assistant I or medication assistant II or hold themselves out to be a medication assistant I or medication assistant II unless the individual holds a registration as a medication assistant I or medication assistant II on the department's nurse aide registry. Individuals with delegated responsibility for administration of medication to a client as a medication assistant I must hold a current status on the department's registry as a certified nurse aide or nurse aide. Individuals with delegated responsibility for administration of medication to a client as a medication assistant II must hold a current status on the department's registry as a certified nurse aide.

1. An application for registration as a medication assistant I or II and a nonrefundable twenty-five dollar fee must be submitted to the department. Upon receipt of the required information, the

department shall issue a medication assistant I or II registration consistent with the type of training and competency program completed.

a. A medication assistant I may work in settings where the licensed nurse is not regularly scheduled, however, may not work in a nursing facility or acute care setting, including clinics.

b. A medication assistant II may work in the same settings as the medication assistant I and nursing facilities, however, may not work in acute care settings, including clinics.

2. Individuals may obtain initial medication assistant I registration by successfully completing a department-approved medication assistant I program.

3. Individuals may obtain initial medication assistant II registration by successfully completing a department-approved medication assistant II program.

4. A certified nurse aide's initial and renewal medication assistant I or II registry listing will be subject to renewal on the same date as the individual's certified nurse aide registration, not to exceed two years. A nurse aide's initial or renewal medication assistant I registry listing will be subject to renewal on the same date as the individual's nurse aide registration status, on or before September thirtieth of the second year and every two years thereafter.

a. The individual must submit a nonrefundable twenty-five dollar renewal fee along with a completed medication assistant renewal application form, including verification of continued competency by a licensed nurse. The medication assistant's registry status will be considered temporary until such time the payment is confirmed, and may be rescinded if payment is not received.

b. Upon receipt and approval of the required information, the department will update the nurse aide registry to reflect current registration status.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 43-12.1-16
Law Implemented: NDCC 23-44-02, 43-12.1-16

33-43-01-21. Complaint investigations.

1. The department will investigate a complaint reported involving individuals registered on the department's nurse aide registry.

2. The complaint investigation will be conducted according to the department's established complaint investigation policies and procedures.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-22. Disciplinary actions.

1. The department may deny, suspend, revoke, or encumber the registration status of, or issue a letter of concern against, an individual listed on the department's nurse aide registry who:

a. Has obtained or attempted to obtain registration as a nurse aide by fraud, deceit, or intentional misrepresentation;

b. Has been convicted of a crime substantially related to the qualifications, functions, or duties of a nurse aide;

c. Has impersonated a licensed nurse or other licensed health care provider;

d. Has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client;

e. Is incapable of working with reasonable skill, competence, and safety for the public; or

f. Has misappropriated the property of, abused, or neglected a client.

2. An individual denied registration or an individual on the department's registry will be notified of the individual's right to request a hearing regarding the department's decision to deny registration, revoke, suspend, or encumber the individual's registry status within thirty days of the notification.

3. If the employer continues to use the individual during the investigation process, the employer must take reasonable steps to prevent further harm to residents or clients.

4. If an individual listed on the department's nurse aide registry is determined to have practiced with an expired registration, the following actions will be taken:

a. If an individual on the department's nurse aide registry is identified as performing nursing-related services for pay with an expired registration status of thirty days or less, the department will notify the individual and the individual's employer, if known, that the individual must immediately cease to work until the renewal application process is completed and the individual's registry status becomes current.

b. If an individual on the department's nurse aide registry is identified as performing nursing-related services for pay with an expired registration of more than thirty days to six months, the department will notify the state survey agency, the employer, and the individual that the individual must immediately cease to work until the renewal application process is completed and the individual's registry status become current.

c. If an individual on the department's nurse aide registry is identified as performing nursing-related services for pay with an expired registration of more than six months, the department will notify the state survey agency, the employer, and the individual that the individual must immediately cease to work. The individual's registry status will no longer be recognized by the department. To obtain current registry status again, the individual must follow the process for initial application for registry status.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-23. Hearing process for individuals on the nurse aide registry.

1. Individuals who have been denied registry status will be informed of the reasons why and provided an opportunity for a hearing consistent with this section.

2. Individuals registered on the department's registry against whom allegations of abuse, neglect, misappropriation of resident property, or other misconduct are made will be:

a. Informed by the department of the allegations;

b. Informed of the investigation results; and

c. If the allegations are found valid, notified of their right to request a hearing regarding the department's decision to revoke, suspend, or encumber the individual's registry status within thirty days of the notification.

3. If a hearing is not timely requested, the department's finding will be final and the department will submit information specific to validated allegations to the registry.

4. If a hearing is timely requested, the department will apply to the office of administrative hearings for appointment of an administrative law judge. The office of administrative hearings will notify the accused of the date set for the hearing.

5. The administrative law judge will conduct the hearing and prepare recommended findings of fact and conclusions of law, as well as a recommended order. If through the department's investigation process, there is evidence that abuse, neglect, misappropriation of resident property, or other misconduct has occurred, the department will notify law enforcement officials and other officials as determined appropriate.

6. Allegations of abuse, neglect, misappropriation of resident property, or other misconduct by an individual on the department's nurse aide registry, validated by the department or through the hearing process, shall:

   a. Be identified in the nurse aide registry within ten days of the validation; and

   b. Remain on the registry permanently, unless the validation was made in error, the individual was found not guilty in a court of a law, or the department is notified of the nurse aide's death. After a period of one year, an individual with a finding of neglect placed on the individual's registry listing may petition the state to have the finding removed from the individual's registry listing consistent with the process identified in section 33-43-01-24, if determined eligible by the department.

7. Within thirty days following the addition of information regarding a validation to the registry, the department will provide the individual on the department's nurse aide registry with a copy of all information which will be maintained in the registry.

8. Within thirty days of mailing the notification of a finding adverse to an individual on the department's nurse aide registry, the individual may contact the department and correct any misstatements or inaccuracies in the information regarding the individual maintained by the registry.

9. Any Medicare or Medicaid participating nursing facility, home health agency, hospital, basic care facility, assisted living facility, ombudsman, other representative of an official agency, or other individual with a need to know may receive information contained in the registry by making a written request.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 28-32-02(1)
Law Implemented: NDCC 23-44-02

33-43-01-24. Review process for findings of neglect placed on an individual nurse aide's registry listing.

1. An individual on the department's nurse aide registry with a finding of neglect placed on the individual's nurse aide registry listing may petition the department in writing to have the finding removed from the individual's registry listing. The individual must provide the department with authorization for any releases of information the department deems appropriate in conducting the investigation. The department will consider whether to remove the finding from the registry when:

   a. The employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect. For the purposes of this section, a pattern is defined as two or more occurrences of abusive or neglectful behavior toward another individual which

resulted in the potential for a negative outcome or an actual negative outcome to the other individual;

b. The neglect involved in the original finding was a singular occurrence that resulted in a potential or actual negative resident outcome; and

c. A background check, including a criminal history investigation or report, reveals no history of mistreatment findings, including instances of domestic abuse, the granting of a restraining order which has not been overturned, an adverse finding entered on any child abuse information index, or any conviction of any crime involving violence or the threat of violence.

2. Once a determination has been made by the department that the individual has met the criteria identified in subsection 1 and is eligible for review, the following steps will be taken:

a. The individual requesting the review must submit a written statement to the department, in a format prescribed by the department, which includes:

(1) An explanation of the incident;

(2) Why the individual believes the individual would not repeat the incident;

(3) Why the individual believes the individual is not competent; and

(4) Why the department should remove the finding from the individual's nurse aide registry listing, including any education or rehabilitation efforts that the individual has completed since the finding of neglect was placed on the individual's registry listing.

b. The original incident, the written information submitted to the department under subdivision a, and any other information collected by the department shall be reviewed by a committee consisting of a staff member of the state department of health, a provider representative, and the state ombudsman.

(1) The committee may consult with the department's attorney as deemed necessary.

(2) Information obtained by the department from sources other than the petitioning individual and the department's file regarding the original incident will be provided to the individual, who will have thirty days after mailing to respond to the committee in writing.

c. The petition, all information contained in the department's file regarding the original incident, and information received by the department will be reviewed by the committee with consideration given to the following factors:

(1) The degree of negligence;

(2) The severity of the potential negative resident outcome;

(3) The severity of the actual negative resident outcome;

(4) The forthrightness and cooperation of the individual;

(5) The opinion of the individual's employer at the time of the incident regarding removing the finding from the individual's registry listing, including the employer's willingness to rehire the individual;

(6) The resident's opinion as to willingness to be cared for by this individual again, if available;

(7) Any rehabilitation or education completed by the individual since the incident; and

(8) Any other factors or considerations the committee determines to be pertinent to its decision. The committee may request additional information from the individual if more information is required to make a determination or if the committee deems a matter not addressed by the individual to be relevant.

d. Based on the review by the committee, with consideration given to the factors identified in subdivision c, the committee may:

(1) Remove the finding from the individual's registry listing;

(2) Require the individual demonstrates successful completion of a state-approved training and competency evaluation program prior to the finding being removed from the registry;

(3) Require the individual to complete a rehabilitation or education program as identified by the committee prior to the finding being removed from the registry;

(4) Require the individual to provide the committee with documentation that a nursing facility or health care facility has offered to employ the individual once the finding is removed from the individual's registry listing and that the nursing facility or health care facility is willing to monitor the resident care services provided by the individual;

(5) Identify any additional time frame the finding will remain on the registry. The additional time frame identified by the committee may range anywhere from one month to permanent placement on the registry;

(6) Take other action as identified appropriate by the committee; or

(7) Implement any combination of the above actions.

3. The department must provide the individual and the registry with written results of the review within one hundred twenty days from the time the department has determined the individual is eligible for review and has received the written information submitted by the individual consistent with subdivisions a and b of subsection 1 and any additional information collected by the department.

4. The individual has only one opportunity to request the department to review the permanent placement of the neglect finding on the registry and to request the department remove the finding.

5. The review must be conducted based on written documentation submitted to the department. A face-to-face meeting with the individual may be requested by the committee as determined necessary.

6. The committee shall issue a written statement of fact, conclusions of law, and its order based on upon findings and conclusions. This statement must be mailed to the individual requesting the review. An appeal for reconsideration of the order must be filed with the department within thirty days from the date the order is mailed. The department may allow a petition for reconsideration of the order if the petition is received within fifteen days after the statement is mailed. If the department is petitioned for reconsideration, the department will review and reconsider the determination. Upon completion of the review, the determination will become the final order for purposes of appeal.

7. If a new finding of neglect is placed on the individual's registry listing after the previous finding of neglect has been removed, the new finding will remain on the registry permanently with no opportunity for review.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02, 28-32-02(1)
Law Implemented: NDCC 23-01-03, 23-44-02, 28-32-05.2

33-43-01-25. Grandfather provisions.

The department will grandfather the approval and current registry status of the nurse aides, home health aides, and medication assistants I and II and related training programs transferred from the state board of nursing to the state department of health July 1, 2011, until the next renewal date consistent with this chapter.

History: Effective July 1, 2011.
General Authority: NDCC 23-44-02
Law Implemented: NDCC 23-44-02

33-43-01-26. Waiver provision.

Any provisions of this chapter may be waived by the department for a specified period in specific instances, provided such a waiver does not adversely affect the health and safety of the clients and would result in unreasonable hardship upon the entity requesting the waiver. A waiver may be granted for a specific period of time not to exceed one year and shall expire on December thirty-first of the year issued.

History: Effective July 1, 2011.
General Authority: NDCC 23-01-03, 23-44-02, 28-32-02
Law Implemented: NDCC 23-16-01, 23-44-02, 28-32-02

CHAPTER 54-07-02
UNLICENSED ASSISTIVE PERSON REGISTRY

Section
54-07-02-01 Application and Fee for Unlicensed Assistive Person Registration
54-07-02-01.1 Renewal of Registration
54-07-02-01.2 Unlicensed Assistive Person Registration for Students
54-07-02-01.3 Temporary Permit
54-07-02-02 Disciplinary Action of Registry Listing [Repealed]
54-07-02-02.1 Unlicensed Assistive Person Registry Status
54-07-02-02.2 Reactivation of a Registration
54-07-02-03 Limited Registation

54-07-02-01. Application and fee for unlicensed assistive person registration.

Applicants for registration as a unlicensed assistive person must meet board requirements, including the following:

1. Submit a completed application;
2. Submit to a criminal history record check according to chapter 54-07-02.1;
3. Pay a nonrefundable fee of thirty dollars; and
4. Submit verification of completion of a recognized formal training program or hold a current registration or certification by a recognized national body.

History: Effective November 1, 1992; amended effective September 1, 1994; February 1, 1998; June 1, 2002; April 1, 2004; July 1, 2008; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(2)(h)

54-07-02-01.1. Renewal of registration.

Initial registration will be subject to renewal on or before June thirtieth of the second year following and every two years thereafter. Failure to receive the renewal notification does not relieve the registrant of the obligation to renew the registration by the expiration date.

1. An applicant must submit a completed application form.
2. An applicant must pay the nonrefundable renewal fee of thirty dollars.
3. An applicant shall submit verification of competency or verification of current certification or registration by board-recognized national bodies.
4. The registration fee for any practicing unlicensed assistive person will be doubled for any renewal application received in the board office after the expiration date.

History: Effective April 1, 2004; amended effective July 1, 2008; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-10(2)

54-07-02-01.2. Unlicensed assistive person registration for students.

Students may provide limited nursing interventions consistent with their education.

1. In order to meet the requirement for the registry, the nursing student must:

a. Submit evidence of current enrollment in a board-approved nursing education program;

b. Be in good academic standing in the nursing education program; and

c. Provide satisfactory evidence of completion of a course in the fundamentals of nursing.

2. In order to meet the requirement for the registry, the technician student must:

a. Submit evidence of current enrollment in a board-recognized formal training program;

b. Be in good standing in the formal training program; and

c. Provide satisfactory evidence of completion of the theory component of the program.

3. Medical assistant student administering medications must adhere to the requirements in sections 54-07-05-09, 54-07-05-10, and 54-07-05-11.

History: Effective April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-09

54-07-02-01.3. Temporary permit.

Upon receipt of an application for unlicensed assistive person registration, payment of the fee as set by the board, and evidence that the applicant will meet all of the requirements for registration in North Dakota, the board may issue a temporary permit to practice as an unlicensed assistive person in this state. The temporary permit expires at the end of ninety days.

History: Effective April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(2)(h)

54-07-02-02. Disciplinary action of registry listing.

Repealed effective December 1, 1995.

54-07-02-02.1. Unlicensed assistive person registry status.

Unlicensed assistive persons who carry out delegated nursing interventions must hold current registry status either on the board registry or on another state registry recognized by the board.

History: Effective February 1, 1998; amended effective June 1, 2002; April 1, 2004; July 1, 2008; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08

54-07-02-02.2. Reactivation of a registration.

An unlicensed assistive person previously registered in North Dakota who applies for reactivation must meet board requirements and includes the following:

1. Submit a completed application;

2. Submit to a criminal history record check according to chapter 54-07-02.1;

3. Pay the nonrefundable registry fee and thirty dollar reactivation fee; and

CHAPTER 54-07-02.1
CRIMINAL HISTORY RECORD CHECKS FOR REGISTRATION

Section
54-07-02.1-01 Criminal History Record Checks

54-07-02.1-01. Criminal history record checks.

Individuals must submit a set of fingerprints to the board or its agent for the purpose of obtaining a state and federal criminal history record check in the manner provided by North Dakota Century Code section 12-60-24 and as set forth by the board. An authorization and release form must be signed by the applicant authorizing the release of the criminal history record information to the board. The fingerprint card, authorization and release form, and fee for the criminal history record check must be submitted with the application.

1. The following individuals for registration must submit to a criminal history record check:

   a. Applicants for initial unlicensed assistive person registration.

   b. Applicants for reactivation or reinstatement of unlicensed assistive person or medication assistant III registration.

2. The following individuals for registration may be required to submit to a criminal history record check:

   a. Applicants for renewal of unlicensed assistive person.

   b. Applicants for medication assistant registration.

   c. An individual who is under investigation for violation of North Dakota Century Code chapter 43-12.1. If a criminal history record check is required as part of a disciplinary investigation or proceeding, the fingerprint card, authorization and release form, and fee for the criminal history record check must be submitted within twenty days of the request.

History: Effective July 1, 2008; amended effective October 1, 2011; April 1, 2014.
General Authority: NDCC 12-60-24.2(o), 43-12.1-08(1)
Law Implemented: NDCC 43-12.1-09.1

CHAPTER 54-07-03.1
ROLE OF THE UNLICENSED ASSISTIVE PERSON AND TECHNICIAN

Section
54-07-03.1-01 Minimum Competence Requirements for Unlicensed Assistive Persons
54-07-03.1-02 Process for Teaching Nursing Interventions [Repealed]
54-07-03.1-03 Licensed Nurse Delegation to Unlicensed Assistive Persons
54-07-03.1-03.1 Licensed Nurse Interventions that May Not Be Delegated
54-07-03.1-04 Unlicensed Assistive Person's Contribution to the Nursing Process [Repealed]
54-07-03.1-05 Requirements for Unlicensed Assistive Person and Technician

54-07-03.1-01. Minimum competence requirements for unlicensed assistive persons.

Unlicensed assistive person competence means having the required knowledge, skills, and ability to perform delegated nursing interventions safely, accurately, and according to standard procedures. The unlicensed assistive person shall meet the criteria or requirements for their specific roles.

History: Effective February 1, 1998; amended effective June 1, 2002; April 1, 2004; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-07-03.1-02. Process for teaching nursing interventions.

Repealed effective April 1, 2014.

54-07-03.1-03. Licensed nurse delegation to unlicensed assistive persons.

A licensed nurse may delegate a nursing intervention to an unlicensed assistive person only if all the conditions for delegation set forth in chapters 54-05-01, 54-05-02, and 54-05-03.1 and this article are met.

History: Effective February 1, 1998; amended effective June 1, 2002; April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-07-03.1-03.1. Licensed nurse interventions that may not be delegated.

Interventions that require nursing knowledge, skill, and judgment may not be delegated by the licensed nurse to an unlicensed assistive person. These interventions include, but are not limited to:

1. Physical, psychological, and social assessment which requires professional nursing judgment, intervention, referral, or followup.
2. Development of nursing diagnosis and care goals.
3. Formulation of the plan of nursing care.
4. Evaluation of the effectiveness of the nursing care provided.
5. Teaching except for that related to promoting independence in activities of daily living.
6. Counseling, except that the unlicensed assistive person may be instructed to recognize and report basic deviations from healthy behavior and communication patterns, and may provide listening, empathy, and support.
7. Coordination and management of care, including collaborating, consulting, and referring.

8. Triage.

9. Medication administration may not be delegated unless the unlicensed assistive person has met the requirements of chapters 54-07-02 and 54-07-05 or has met the requirements of section 54-07-01-03. The exception is when a licensed nurse specifically delegates to a specific unlicensed assistive person the administration of a specific medication for a specific client according to chapter 54-07-08.

10. Receiving or transmitting verbal or telephone orders.

History: Effective April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

54-07-03.1-04. Unlicensed assistive person's contribution to the nursing process.

Repealed effective April 1, 2014.

54-07-03.1-05. Requirements for unlicensed assistive person and technician.

The unlicensed assistive person and technician shall meet the following requirements:

1. Competently performs nursing interventions and functions as delegated by the nurse and as authorized by the board.

2. Demonstrates honesty and integrity.

3. Performs nursing interventions based on education, training, and the direction of the supervising nurse.

4. Accepts accountability for one's behavior and actions while assisting the nurse and providing services to clients.

5. Assists in observing clients and identifying client needs.

6. Communicates progress toward completing delegated nursing interventions, as well as any problems or changes in a client's status.

7. Seeks clarification if unsure of expectations.

8. Uses educational and training opportunities as available.

9. Takes preventive measures to protect clients, others, and self.

10. Respects client's rights, concerns, decisions, and dignity.

11. Functions as a member of the health care team, contributing to the implementation of an integrated health care plan.

12. Respects patient property and the property of others.

13. Protects confidential information unless obligated by law to disclose the information.

History: Effective April 1, 2014.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

APPLICATION FOR LICENSE TO OPERATE A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
Telephone 701.328.2352
SFN 16855 (R11-14)

ACCOUNTING/DEPARTMENT USE ONLY

Check Number	License Number
Amount	Bed Capacity
Date	Licensure Period

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Return one completed, notarized copy to: ND Department of Health, Division of Accounting, 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200. Keep a copy for your records.

Official Name of Basic Care Facility			NPI Number
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	Bed Capacity
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Bed Capacity Change ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ Other Change:

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation		
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

Name of Exact Ownership of Premises			
Mailing Address	City	State	ZIP Code
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code

Has ownership of this Basic Care Facility changed in the last twelve months? ☐ No ☐ Yes	Has the legal entity responsible for operation of this Basic Care Facility changed in the last twelve months? ☐ No ☐ Yes	Is the Basic Care Facility under a management agreement? ☐ No ☐ Yes

Name of Basic Care Facility's General Liability Insurance Company	Name of Agent		
Mailing Address of Agent	City	State	ZIP Code
Name of Administrator			
Name and Title of Emergency Contact	Emergency Contact's Cell Phone Number		

Does your facility offer the following department approved services:

☐ Memory Care in Secured Unit -- Number of Beds _____ ☐ Bariatrics -- Number of Beds _____

☐ Adult Day Care

☐ Other Services (Specify) _____

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds (with room numbers identified) and services.

Applicant Agrees to the Following:

1. To the inspection of the basic care facility by a representative of the North Dakota Department of Health;
2. To the inspection by other regulatory agencies at the request of the North Dakota Department of Health;
3. To notify the North Dakota Department of Health of any change in ownership immediately or proposed change of location or increase of bed capacity or services;
4. To operate this basic care facility at all times in compliance with the standards established by the North Dakota Department of Health

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility subject to the provisions of North Dakota Century Code Chapter 23-09.3 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

_____ _____

Signature Date

State of _____)
) SS.
County of _____)

On this _____ day of _____, 20_____, before me personally

appeared _____ who having been sworn states that

to the best of his/her knowledge and beliefs the statements in the foregoing application are true.

_____

Notary Public

(Seal)

My commission expires _____

INITIAL APPLICATION FOR THE OPTIONAL ALZHEIMER'S, DEMENTIA, SPECIAL MEMORY CARE, OR TRAUMATIC BRAIN INJURY SERVICES IN A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 61362 (12-17)

DEPARTMENT USE ONLY

License Number
Bed Capacity
Licensure Period

This form does not replace the Basic Care Facility Licensure Application. Complete and submit the Attestation.

INSTRUCTIONS: Type or print clearly. Attach other information as requested with the application. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200. Keep a copy for your records.

Official Name of Basic Care Facility			NPI Number
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	
E-Mail Contact	E-Mail Address		

MANAGEMENT AND PERSONNEL

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Administrator			

Services your facility is requesting to provide:	
☐ Alzheimer's, Dementia, Special Memory Care – Number of Beds _____	☐ Unsecured Unit
☐ Traumatic Brain Injury (TBI) – Number of Beds _____	☐ Unsecured Facility
	☐ Secured Unit
	☐ Secured Facility

ATTESTATION OF COMPLIANCE WITH THE LICENSURE REQUIREMENTS TO PROVIDE OPTIONAL ALZHEIMER'S, DEMENTIA, SPECIAL MEMORY CARE, OR TRAUMATIC BRAIN INJURY SERVICES IN A BASIC CARE FACILITY

Facility			
Address	City	State	ZIP Code

Applicant agrees to the following when providing Alzheimer's, dementia, special memory care, or traumatic brain injury services to one or more residents in a secured or unsecured facility or unit:

1. Ensure training and competency evaluation is completed for all nursing and personal care staff specific to the care and service necessary to meet the needs of the residents;
2. A minimum of eight educational hours on the required training must be completed within three months from the date of hire to provide the service, for all nursing and personal care staff members;
3. Nursing and personal care staff may not be assigned to work independently until they have successfully completed a competency evaluation.
4. Annually nursing and personal care staff members shall receive a minimum of four hours of educational training in two or more of the topics below and successfully complete a competency evaluation.
5. For other staff members hired to work in a facility or unit licensed under this section, training upon hire and annual training shall include at a minimum an overview of dementia and communication issues and may include other topics below, as needed.

This form must be completed and submitted to the Department of Health (DOH) for approval. Upon approval, the DOH will provide a license identifying that the optional Alzheimer's, dementia, special memory care, or traumatic brain injury services in the basic care facility has been approved.

Complete the following questions:

1. The facility has a written policy related to resident rights that complies with the North Dakota Century Code Chapter 50-10.2. ☐ Yes ☐ No
2. The facility has provided that policy to the resident or designee, verbally and in writing? ☐ Yes ☐ No
3. The required staff education training has been completed within the required time frames? ☐ Yes ☐ No

   The documentation for the staff training will be reviewed at the time of the survey. The training must include, but is not limited to:
   - Dementia education, including progression of the disease, memory loss and psychiatric and behavior symptoms;
   - Techniques for understanding and approaching behavioral symptoms such as aggravating behaviors, sexual behaviors, and wandering, including alternatives to chemical and physical restraints;
   - Positive therapeutic interventions;
   - Strategies for addressing social needs and providing options for meaningful activities;
   - Information on how to address aspects of care and safety such as pain, food, fluid, and wandering;
   - Communication issues;
   - Resident rights, including dignity, respect, choice, independence, and privacy; and
   - Strategies for providing person centered care.
4. The following building requirements are met:
   a. Lockable resident room entrance doors. ☐ Yes ☐ No
   b. A secure outdoor space in a secured unit or facility. ☐ Yes ☐ No ☐ N/A
5. If **No** has been marked to any of the above questions, please explain:

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility with the optional service of Alzheimer's, dementia, special memory care, or traumatic brain injury care subject to the provisions of North Dakota Century Code Chapter 23-09.3-09 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and the Attestation of Compliance and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Administrator's Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	

RENEWAL APPLICATION FOR THE OPTIONAL ALZHEIMER'S, DEMENTIA, SPECIAL MEMORY CARE, OR TRAUMATIC BRAIN INJURY SERVICES IN A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN (R10-18)

DEPARTMENT USE ONLY

License Number
Bed Capacity
Licensure Period

This form does not replace the Basic Care Facility Licensure Application. Complete and submit the Attestation.

INSTRUCTIONS: Type or print clearly. Attach other information as requested with the application. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200. Keep a copy for your records.

Official Name of Basic Care Facility		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	
E-Mail Contact	E-Mail Address		

MANAGEMENT AND PERSONNEL

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Administrator			

Services your facility is requesting to provide: ☐ Alzheimer's, Dementia, Special Memory Care – Number of Beds _____ ☐ Traumatic Brain Injury (TBI) – Number of Beds _____	☐ Unsecured Unit ☐ Unsecured Facility ☐ Secured Unit ☐ Secured Facility

ATTESTATION OF COMPLIANCE WITH THE LICENSURE REQUIREMENTS TO PROVIDE OPTIONAL ALZHEIMER'S, DEMENTIA, SPECIAL MEMORY CARE, OR TRAUMATIC BRAIN INJURY SERVICES IN A BASIC CARE FACILITY

Facility			
Address	City	State	ZIP Code

Applicant agrees to the following when providing Alzheimer's, dementia, special memory care, or traumatic brain injury services to one or more residents in a secured or unsecured facility or unit:

1. Ensure training and competency evaluation is completed for all nursing and personal care staff specific to the care and service necessary to meet the needs of the residents;
2. A minimum of eight educational hours on the required training must be completed within three months from the date of hire to provide the service, for all nursing and personal care staff members;
3. Nursing and personal care staff may not be assigned to work independently until they have successfully completed a competency evaluation.
4. Annually nursing and personal care staff members shall receive a minimum of four hours of educational training in two or more of the topics below and successfully complete a competency evaluation.
5. For other staff members hired to work in a facility or unit licensed under this section, training upon hire and annual training shall include at a minimum an overview of dementia and communication issues and may include other topics below, as needed.

This form must be completed and submitted to the Department of Health (DOH) for approval. Upon approval, the DOH will provide a license identifying that the optional Alzheimer's, dementia, special memory care, or traumatic brain injury services in the basic care facility has been approved.

Complete the following questions:

1. The facility has a written policy related to resident rights that complies with the North Dakota Century Code Chapter 50-10.2. ☐ Yes ☐ No
2. The facility has provided that policy to the resident or designee, verbally and in writing? ☐ Yes ☐ No
3. The required staff education training has been completed within the required time frames? ☐ Yes ☐ No

   The documentation for the staff training will be reviewed at the time of the survey. The training must include, but is not limited to:
   - Dementia education, including progression of the disease, memory loss and psychiatric and behavior symptoms;
   - Techniques for understanding and approaching behavioral symptoms such as aggravating behaviors, sexual behaviors, and wandering, including alternatives to chemical and physical restraints;
   - Positive therapeutic interventions;
   - Strategies for addressing social needs and providing options for meaningful activities;
   - Information on how to address aspects of care and safety such as pain, food, fluid, and wandering;
   - Communication issues;
   - Resident rights, including dignity, respect, choice, independence, and privacy; and
   - Strategies for providing person centered care.
4. The following building requirements are met:
   a. Lockable resident room entrance doors. ☐ Yes ☐ No
   b. A secure outdoor space in a secured unit or facility. ☐ Yes ☐ No ☐ N/A
5. If **No** has been marked to any of the above questions, please explain:

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility with the optional service of Alzheimer's, dementia, special memory care, or traumatic brain injury care subject to the provisions of North Dakota Century Code Chapter 23-09.3-09 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and the Attestation of Compliance and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Administrator's Signature	Date

State	County

Signed and swom to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	

Divisions of Health Facilities and Life Safety and Construction
ND Department of Health

POLICY & PROCEDURE MANUAL

EFFECTIVE: June 14, 2019

SECTION: LICENSING

SUBJECT: WAIVER PROCESS FOR BASIC CARE FACILITY

PURPOSE:

This policy applies to basic care facilities licensed by the Division of Health Facilities. Consistent with North Dakota Century Code (NDCC) 23-09.3-04 (1), "The department may waive all or a portion of a licensure standard if the department determines the lack of compliance does not adversely affect health or safety of residents."

POLICY:

This policy and procedure provide a review process for waivers submitted to the State Department of Health by a basic care facility requesting the department to waive all or a portion of a licensure standard if the department determines the lack of compliance does not adversely affect the health or safety of residents.

This waiver process applies to licensure standards only.

PROCEDURE:

1. The basic care facility licensed by the Division of Health Facilities must submit the request for a waiver to all or a portion of a health care or service licensure standard to the Division of Health Facilities for review, or a request for a waiver to a construction standard to the Division of Life Safety and Construction for review.

2. The basic care facility seeking to request a waiver must fully complete and submit the Basic Care Facility Waiver Request Form to the Division of Health Facilities or the Division of Life Safety and Construction dependent upon the licensure standard requested to be waived. Only complete waiver requests will be reviewed. A separate waiver request form for each licensure standard requested to be waived is required.

3. The waiver request must include the following:

   a. Identify the licensure standard or portion of the licensure standard that is requested to be waived.

   b. Documentation from the Department of Human Services that verifies the waiver will not result in the facility being noncompliant with the home and community-based setting requirements.

   c. A description of actions taken by the facility to meet the licensure standard and why the waiver is being requested.

   d. A description of any unreasonable hardship (including financial and work force) caused by not granting the waiver to the basic care facility.

   e. Evidence to support why the requested waiver will not adversely affect the health and safety of the basic care residents.

   f. A description of how the waiver would benefit the basic care facility, residents, and community.

   g. A description regarding actions that will be taken by the facility to monitor and assure the health and safety of residents are not adversely affected if the request for a waiver is approved.

   h. Other information as requested by the State Department of Health.

   i. Signature of authorized representative and date.

4. The request for a waiver will be reviewed, research completed, and additional information gathered by the Division of Health Facilities and/or the Division of Life Safety & Construction as needed to complete the review within 45 days.

5. A meeting will be scheduled with the State Health Officer or designee of the State Department of Health to discuss the recommendations resulting from the review.

6. The State Health Officer or designee will make the final determination related to the approval or denial of the waiver within 60 days of when the complete waiver request was received. The final decision by the State Health Officer designee is not appealable.

   a. If denied, a letter will be sent from the State Health Officer or designee to the basic care facility stating the request has been denied, and the rationale.

b. If approved, a letter will be sent from the State Health Officer or designee to the basic care facility indicating that the waiver request has been approved contingent upon the facility signing an agreement with the State Department of Health. The agreement will identify the basic care facility's responsibility to monitor to ensure that the lack of compliance does not adversely impact health and safety, their understanding that the waiver will be monitored by the department onsite periodically to ensure that lack of compliance has not resulted in an adverse impact on health or safety, and that if an adverse impact on health or safety is identified, the waiver may be rescinded and the facility would be expected to meet the requirement waived.

c. The State Department of Health reserves the right to limit the period the waiver is in effect.

d. The State Department of Health reserves the right to withdraw or modify the waiver if it is determined information submitted by the basic care facility has been misrepresented or the basic care facility fails to comply with their responsibilities to monitor the impacts of the waiver.

7. Time frames identified above may vary dependent upon receipt of a complete waiver request from the basic care facility, the time it takes to complete additional research, and the availability of department staff to complete the steps outlined in this procedure. The basic care facility would be notified five days in advance if an extension on review of the waiver is needed.

8. The waiver request to all or a portion of a basic care licensure standard becomes effective on the date the agreement is signed by both the basic care facility authorized representative and the State Health Officer or designee.

9. All final decisions and agreements will be documented in writing and a copy placed in the facility file.

10. All basic care waiver requests and their disposition will be logged on the division waiver log.

11. A final decision on a waiver of all or a portion of a basic care licensure standard applies to that basic care facility only and should not be construed to apply to other basic care facilities.

Dr. Darleen Bentz
Chief, Health Resources Section

June 14, 2019
Date

BASIC CARE FACILITY REQUEST FOR A WAIVER TO ALL OR A PORTION OF A LICENSURE STANDARD

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISIONS OF HEALTH FACILITIES AND LIFE SAFETY AND CONSTRUCTION
SFN 61649 (06/2019)

INSTRUCTIONS: Complete one form for each waiver you are requesting. Additional documentation may be attached to this form. The Department reserves the right to deny or terminate a waiver. The granting of a waiver does not mean the requirement has been met. Your facility will be considered deficient until the requirement has been met.

Name of Facility		Email Address	
Street Address	City	State	ZIP Code

In order to consider your request for waiver, a satisfactory response to the criteria below is required.

1. Which licensing rule or construction standard would you like waived?

2. If applicable, provide documentation from the North Dakota Department of Human Services that the waiver will not result in the facility being noncompliant with the home and community-based setting requirements.

3. What actions have you taken to meet the requirement and why is the waiver necessary?

4. Describe the hardship (including financial and work force) on your facility if the waiver is not approved.

5. Provide evidence to support why the requested waiver will not adversely affect the health and safety of the basic care residents.

6. Describe how the waiver or lack of compliance would benefit your facility, residents, and community.

7. Describe the actions that will be taken by your facility to monitor and assure the health and safety of residents are not adversely affected if this request for a waiver is approved.

Signature of Authorized Representative:	Date:

FOR OFFICE USE ONLY

Comments		SEND THIS COMPLETED FORM TO:
Signature	Date	DIV. OF HEALTH FACILITIES DIV. OF LIFE SAFETY & CONSTRUCTION ND DEPARTMENT OF HEALTH 600 E. BOULEVARD AVE., DEPT 301 BISMARCK ND 58505-0200

Nurse Aide/Certified Nurse Aide Registry

ND Department of Health launched a paperless nurse aide/certified nurse aide registry for North Dakota on July 26, 2019. The web page for the registry is services.ndnar.org. The online service includes all forms needed to apply or renew an individual's status as a nurse aide, certified nurse aide, or medication assistant I or II.

Renewals

- Renew your registry

Registration Verifications

- Verify a registration

Validated Abuse List

- View the validated abuse list
- Initial Allegation of Abuse Form

Applications

- Apply online

Endorsements

- Endorsements

Print CNA Verification

- Print a CNA verification letter

Print Registration Card

- Print your registration card

Change Address/Name

- Update your address, contact information or name

Section 2
Dietary Regulations

To download a copy of the 2013 FDA Model Food Code, visit the U.S Food and Drug Administration's (FDA) website at:
http://www.fda.gov/food/guidanceregulation/retailfoodprotection/foodcode/ucm374275.htm.
Click the link "Download Food Code 2013" and the link "Download Food Code 2013 Supplement" for a complete copy of the FDA 2013 Model Food Code.

CHAPTER 33-33-04.1
FOOD CODE

Section
33-33-04.1-01 Adoption of the United States Food and Drug Administration 2013 Model Food Code by Reference

33-33-04.1-01. Adoption of the United States food and drug administration 2013 Model Food Code by reference.

The provisions of the United States food and drug administration 2013 Model Food Code and its supplement are adopted by reference into this chapter, with the following modifications:

1. Paragraph 2-102.12 Certified Food Protection Manager. For the purposes of this chapter, is excluded.

2. Paragraph 8-401.10 Establishing Inspection Interval. For the purposes of this chapter, is revised as follows:

   a. Except as specified in subdivisions b and c of this subsection, the regulatory authority, at any time during operation, may inspect a food establishment. The department shall determine the frequency of inspection based on the level of risk categorization, complaints, and previous compliance history.

   b. The regulatory authority may increase the interval between inspections if:

      (1) The food establishment is fully operating under an approved and validated hazard analysis critical control point plan as specified under section 8-201.14 and paragraphs 8-103.12 (A) and (B);

      (2) The food establishment is assigned a less frequent inspection frequency based on a written risk-based inspection schedule that is being uniformly applied throughout the jurisdiction. The food establishment may be contacted by telephone or other means by the regulatory authority to ensure the establishment manager and the nature of food operation are not changed; or

      (3) The establishment's operation involves only coffee service and other unpackaged or prepackaged food that is not time/temperature control for safety food, such as carbonated beverages and snack food, such as chips, nuts, popcorn, and pretzels.

   c. The regulatory authority periodically shall inspect throughout its permit period a temporary food establishment that prepares, sells, or serves unpackaged time/temperature control for safety food and that:

      (1) Has improvised rather than permanent facilities or equipment for accomplishing functions, such as handwashing, food preparation and protection, food temperature control, warewashing, providing drinking water, waste retention and disposal, and insect and rodent control; or

      (2) Has inexperienced food employees.

3. Paragraph 8-405.11 Timely Correction. For the purpose of this chapter, is revised as follows:

a. Except as specified in subdivision b of this subsection, a permit holder at the time of inspection shall correct a violation of a priority item or priority foundation item of this code and implement corrective actions for a hazard analysis critical control point plan provision that is not in compliance with its critical limit.[Pf]

b. Considering the nature of the potential hazard involved and the complexity of the corrective action needed, the regulatory authority may agree to or specify a longer time frame and approve a compliance schedule.

4. Paragraph 8-406.11 Time Frame for Correction. For the purpose of this chapter, is revised as follows:

a. Except as specified in subdivision b of this subsection, the permit holder shall correct core items by a date and time agreed to or specified by the regulatory authority.

b. The regulatory authority may approve a compliance schedule that extends beyond the time limits specified under subdivision a of this subsection if a written schedule of compliance is submitted by the permit holder and no health hazard exists or will result from allowing an extended schedule for compliance.

History: Effective January 1, 2018.
General Authority: NDCC 23-09
Law Implemented: NDCC 23-09

Division of Food and Lodging
North Dakota Department of Health
600 East Boulevard Avenue Dept. 301
Bismarck, ND 58505-0200
701.328.1291/1.800.472.2927

December 15, 2017

TO: Industry and Regulatory Food Safety Professionals and Food Business Owners

FROM: Division of Food and Lodging, ND Department of Health

SUBJECT: The Adoption of the 2013 FDA Model Food Code – Effective January 1, 2018

The North Dakota Department of Health, Division of Food and Lodging, recognizes the U.S. Food and Drug Administration (FDA) Model Food Code as the most practical, science-based guidance for ensuring that food offered at retail and in food service is safe, unadulterated and honestly presented. The current ND Food Code, NDAC 33-33-04, will be repealed and replaced, effective January 1, 2018, with NDAC 33-33-04.1, which adopts the 2013 FDA Model Food Code and its supplement by reference with modifications available online at www.ndhealth.gov/FoodLodging/.

To download a copy of the 2013 FDA Model Food Code, visit the U.S Food and Drug Administration's (FDA) website at:
www.fda.gov/food/guidanceregulation/retailfoodprotection/foodcode/ucm374275.htm.
Click the link "Download Food Code 2013" and the link "Download Food Code 2013 Supplement" for a complete copy of the FDA 2013 Model Food Code.

The enclosed summary provides a synopsis of the major changes from the 2012 North Dakota Food Code (based on the 2009 FDA Food Code) to the newly adopted 2013 FDA Food Code. Please note, the requirement that at least one certified food protection manager is employed at the food establishment (paragraph 2-102.12) has been excluded from the ND Food Code, NDAC 33-33-04.1. For food establishments serving an extensive menu including complex food processes and for those serving a highly susceptible population (for example, infants, toddlers, the elderly, or the immunocompromised), the presence and supervision of a certified food manager is recommended by the Department as a best practice, but is not required unless otherwise specified under local ordinance.

Consultation with inspection staff is available regarding the new food code requirements to licensed food establishments during onsite inspections. Also, food establishments may contact their local health unit or the Food and Lodging Division to address questions about food code changes. Food businesses will be provided with a reasonable time (up to 6 months from the effective date of the rules) to come into compliance with the new requirements.

For questions about the provisions of the 2013 FDA Food Code, please call the Food and Lodging Division at 701.328.1291 or email foodandlodging@nd.gov, or contact your local health unit.

Summary of ND Food Code Changes
North Dakota Administrative Code 33-33-04.1:
Adoption of the 2013 FDA Model Food Code

The North Dakota Department of Health, Division of Food and Lodging, recognizes the U.S. Food and Drug Administration (FDA) model Food Code as the most practical, science-based guidance for ensuring that food offered at retail and in food service is safe, unadulterated and honestly presented. Starting January 1, 2018, the current ND Food Code, North Dakota Administrative Code (NDAC) 33-33-04, is replaced with NDAC 33-33-04.1 which adopts the 2013 FDA Model Food Code and its supplement by reference with modifications.

This summary provides a list of changes from the 2012 North Dakota Food Code (repeal effective on December 31, 2017) to the 2013 FDA Food Code adoption by reference (effective on January 1, 2018). The primary intent of this document is to provide a synopsis of the major changes to the Food Code and should not be relied upon as an absolute comparison that identifies each and every change.

To download the complete 2013 FDA Food Code, visit www.ndhealth.gov/foodlodging or the FDA's website at http://www.fda.gov/food/guidanceregulation/retailfoodprotection/foodcode/ucm374275.htm.

For questions about the provisions of the 2013 FDA Food Code, please call 701.328.1292, or contact your location health department.

Chapter 1 Purpose and Definitions

Added "Core Item", "Priority Item", and "Priority Foundation Item" in place of "Core Item" and "Critical Item."

Amended "**Packaged**" in (1) to delete the term "securely" to avoid undue emphasis on nature of the package; Amended ***"Packaged"*** in (2) to remove the phrase "or other nondurable container" to clarify when foods packaged at retail need to be labeled so that it reads: ***"Packaged"*** *does not include wrapped or placed in a carry-out container to protect the food during service or delivery to the consumer, by a food employee, upon consumer request.*

Deleted **"Enterohemorrhagic *Escherichia coli*" *(EHEC)*** as use of EHEC terminology is outdated.

Deleted the term **Potentially Hazardous Food (Time/Temperature Control for Safety Food)" (PHF/TCS)** and made a universal change throughout the Code to replace it with the term **"Time/Temperature Control for Safety Food" (TCS).** The definition remains the same.

Revised "**Reduced Oxygen Packaging**" subparagraph (2)(e), to delete the phrase "placed in a hermetically sealed, impermeable bag" and replace it with "vacuum packaged in an impermeable bag" so it clearly defines the sous vide process as outlined in Annex 6(2)(B)(4)(b). It now reads: "Sous vide packaging, in which raw or partially cooked food is vacuum packaged in an impermeable bag, cooked in the bag, rapidly chilled, and refrigerated at temperatures that inhibit the growth of psychotropic pathogens."

Revised **"Shiga toxin-producing *Escherichia coli*"** (STEC) to reflect current nomenclature.

Chapter 2 Management and Personnel

2-102.11(A)
Amended to replace "Critical Items" with "Priority Items".

Add the risk designations (Priority (P), Priority Foundation (Pf) and Core (C)) to each applicable code section for reference when recording observations in the inspection report.

2-102.12 (Excluded from ND Food Code NDAC 33-33-04.1)
Requirement of at least one certified food protection manager employed at the food establishment, when applicable.

2-103.11(L)
Added "food allergy awareness" as a part of the food safety training of employees by the Person in Charge

2-201.11, 2-201.12, 2-201.13
Amended to add nontyphoidal *Salmonella* (NTS) as one of the reportable illnesses for action by the Person in Charge; Added Code language to address employee health controls for the exclusion and restriction of nontyphoidal *Salmonella,* and removal of exclusion and restriction from NTS.

2-301.14(H)
Amended to clarify that the requirement to wash hands before donning gloves is specific to the beginning of a task involving working with food and not during the task.

Chapter 3 Food

3-201.16(A)
Amended to remove existing 2009 paragraph (A) language in reserve; Added new paragraph (A) to recognize a regulatory authority's ability to approve the sale of wild mushrooms within a food establishment and regulate wild mushrooms according to their LAW.

3-301.11(D)
Amended to revise subparagraph (D)(2) to clarify that paragraph (B) does not apply where a ready-to-eat food is added as an ingredient to another food that does not contain a raw animal food and the combined product will be heated to at least 63°C (145°F).

3-302.11(A) (1)
Amended language to exempt frozen, commercially processed and packaged raw animal foods from separate storage or display from RTE foods; Added new subparagraph (c) that allows this exemption.

3-304.11
Amended to add a new (C) to clarify that food may contact surfaces of linens and napkins as specified in Paragraph 3-304.13 and added term "Linens" to the tag line.

3-304.13
Amended to clarify that napkins in this section refers to cloth napkins and they are by definition considered linens.

3-401.11(D)
Amended to add new subparagraph (D) (2) to not allow the sale of undercooked, comminuted meat from a children's menu.

3-401.14
Added a new section on Non-continuous cooking of raw animal foods that specifies the criteria for using a non-continuous cooking process.

3-401.14(D)
Amended to revise paragraph (D) to clarify that prior to sale or service, raw animal foods cooked using a non-continuous cooking process shall be cooked to a temperature and for a time as specified under paragraph 3-401.11 (A)-(C).

3-402.11
Amended paragraph 3-402.11(B) to add a new paragraph (2) to clarify that scallop products consisting solely of the shucked adductor muscle are excluded from the requirements for parasite destruction and re-designated existing paragraph (2)-(4) to be new paragraph (3)-(5).

3-403.11
Amended paragraph 3-403.11(C) to clarify that this provision applies to all commercially processed TCS foods that are ready-to-eat. Previous text suggested that it applied only immediately upon removal of the food from a sealed container.

3-501.13
Amended to add new paragraph (E) specifying frozen fish packaged using a ROP method be removed from the ROP environment either prior to initiating thawing procedures under refrigeration as specified in paragraph (A) or prior to, or immediately upon completion of, its thawing using procedures specified in paragraph (B) of this section.

3-501.17
Amended to add new paragraph (F) that exempts raw, live in-shell molluscan shellfish from date marking and re-designated former paragraph (F) as new paragraph (G).

Amended existing subparagraph 3-501.17 (F)(6) to clarify that the exemption from date marking for shelf stable dry fermented sausages produced in USDA-regulated facilities is not dependent on the product retaining the original casing; Renumbered existing paragraph (F)(6) as new paragraph (G)(6) as a result of the addition of new paragraph (F).

3-502.11
Amended to revise paragraph (D) to make clear that only TCS foods prepared under ROP methods that do not control for growth of and toxin formation by *Clostridium botulinum* and the growth of *Listeria monocytogenes* require a variance.

3-502.12
Amended subparagraphs 3-502.12(B)(3)(b) and (B)(4) to delete 14 days and add 30 days.

Amended Paragraph 3-502.12(B) to add new subparagraph 7 specifying that a HACCP plan be provided to the regulatory authority prior to implementation.

Amended Paragraph 3-502.12(D) lead in paragraph to delete the word "FOOD" and replace it with the term "Time/Temperature control for safety food" to clarify that this section applies to TCS food.

Amended subparagraph 3-502.12(D)(2)(b) to specify only the cooking parameters in paragraph 3-401.11(A), (B) and (C) apply.

Amended subparagraph 3-502.12(D)(2)(e)(ii) to allow for cold holding at 41°F for 7 days after cooling to 41°F.

Amended to add new paragraph (F) to identify the conditions under which a HACCP Plan is not required for ROP TCS foods.

3-602.11
Amended paragraph 3-602.11(B)(2),(3),(5), and (7) to clarify the information that a label should include.

Amended subparagraph 3-602.11(B)(2) to clarify what information must be included in the statement of ingredients. The term "sub ingredients" was added to this subparagraph to clarify that individual component ingredients of a main ingredient must be disclosed in the statement of ingredients. This clarification helps to

make clear that all individual ingredients in a packaged food will be disclosed in the statement of ingredients.

Chapter 4 Equipment, Utensils, and Linens

4-302.13
Amended the tag line to add "mechanical warewashing"

Amended to redesignate the existing section into paragraph (A) and new paragraph (B) to require the availability of irreversible registering temperature indicators.

4-501.114(C)(3)
Amended to change "manufacturer's label" to "EPA-registered label use instructions" to harmonize with EPA terminology (CFP 2008-III-010).

4-602.11
Amended paragraph 4-602.11(B) to change the cleaning and sanitizing frequency for food contact surfaces or utensils that are in contact with a raw animal food that is a major food allergen such as fish, followed by other types of raw animal foods. With this change, the exception to existing subparagraph (A)(1) found in paragraph (B) now applies only to raw meat and poultry.

4-802.11
Amended paragraph 4-802.11(C) to clarify that napkins in this section refers to cloth napkins and they are by definition considered linens as mentioned in paragraph 3-304.11(C) and paragraph 3-304.13.

Chapter 5 Water, Plumbing, and Waste - No Changes

Chapter 6 Physical Facilities

6-301.12
Added new Paragraph (D) to allow the use of a high velocity blade of non-heated, pressurized air for hand drying.

Chapter 7 Poisonous or Toxic Materials

7-204.12
Amended paragraph 7-204.12(A) to redesignate paragraph (A) into a lead-in paragraph with four new subparagraphs: Added 21 CFR 173 Secondary Direct Food Additives Permitted in Food for Human Consumption as new subparagraph (A)(1); Added GRAS ingredients as new subparagraph (A)(2); Added effective food contact notifications as new subparagraph (A)(3); Added 40 CFR 156 Labeling Requirements for Pesticides and Devices as new subparagraph (A)(4) to allow the use of other antimicrobial agents allowed under the food contact notification program for washing fruits and vegetables as well as GRAS ingredients permitted as antimicrobials or for general food use.

Chapter 8 Compliance and Enforcement

8-201.13
Amended paragraph 8-201.13(B) to add new language to have the food establishment notify the Regulatory Authority through submission of a HACCP plan that they will be conducting ROP operations that conform with procedures in paragraph 3-502.12.

8-304.11
Amended to add new paragraph (K) to include a requirement for the permit holder to post a sign or placard notifying the public that inspectional information is available for review.

Section 3
Resident Rights and Electronic Monitoring

CHAPTER 50-10.1
LONG-TERM CARE OMBUDSMEN

50-10.1-01. Definitions.

As used in this chapter:

1. "Administrative action" means any action or decision made by an owner, employee, or agent of a long-term care facility, or by a public agency, which affects the provision of services to a resident of a long-term care facility.
2. "Department" means the department of human services.
3. "Long-term care facility" means any skilled nursing facility, basic care facility, nursing home as defined in subsection 3 of section 43-34-01, assisted living facility, or swing-bed hospital approved to furnish long-term care services; provided, that a facility, as defined in section 25-01.2-01, providing services to individuals with developmental disabilities is not a long-term care facility.
4. "Resident" means an individual residing in and receiving personal care from a long-term care facility.

50-10.1-02. Appointment of state and local long-term care ombudsmen.

The department shall employ a state long-term care ombudsman and local long-term care ombudsmen as the department determines necessary within the limits of legislative appropriations.

50-10.1-03. Duties of state long-term care ombudsman.

The state long-term care ombudsman shall:

1. Investigate and resolve complaints about administrative actions that may adversely affect or may have adversely affected the health, safety, welfare, or personal or civil rights of individuals in long-term care facilities or individuals who have been discharged from long-term care facilities within one month of the complaint against the facility.
2. Monitor the development and implementation of federal, state, and local laws, regulations, and policies that relate to long-term care facilities in the state.
3. Gather and disseminate information to public agencies about the problems of persons in long-term care facilities.
4. Train volunteers and assist in the development of citizen organizations to participate in the ombudsman programs.
5. Report to any state agency those factors found by the state long-term care ombudsman to relate to those duties of that agency which impact on the care given to residents of a long-term care facility in this state.
6. Act as an advocate for residents of long-term care facilities.
7. Carry out any activities consistent with the requirements of this chapter, including the delegation to regional or volunteer community long-term care ombudsmen of any duties imposed by this chapter, which the executive director of the department deems appropriate.
8. Adopt rules in accordance with chapter 28-32 consistent with and necessary for the implementation and enforcement of this chapter.

50-10.1-04. Access to facilities and records.

To carry out the powers and duties of this chapter, the state long-term care ombudsman and the ombudsman's authorized agents shall:

1. Have access to all long-term care facilities within the state and shall have private access to any resident within any long-term care facility within the state.
2. Have access to all social and medical records of a resident if:
   a. The ombudsman or the ombudsman's authorized agent has the permission of the resident or the legal representative of the resident;

b. Access to the records is necessary to investigate a complaint and the resident is unable to consent to the review and has no legal representative; or
c. A legal representative of the resident refuses to give the permission and the ombudsman or the ombudsman's authorized agent has reasonable cause to believe that the legal representative is not acting in the best interests of the resident and the state long-term care ombudsman approves access.

50-10.1-05. Information to be posted - Retaliation prohibited.

Information about the ombudsman program must be posted in a conspicuous place in each long-term care facility, along with how to file a complaint concerning administrative actions which affect any resident and the address where a complaint may be filed. Each resident, the spouse of each resident having a spouse, and any designated representative of a resident must be provided with information about the ombudsman program at the time the resident is admitted to the long-term care facility. A long-term care facility, and its agents, may not take or threaten retaliatory action against a resident, employee, or any other person on account of the filing of a complaint by or on behalf of that resident, or on account of the providing of information to a long-term care ombudsman constituting or relating to a complaint.

50-10.1-06. Establishment of reporting system - Recognition of reports by ombudsmen.

The department shall establish a statewide uniform reporting system to collect and analyze information on complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems. The department shall submit this information to the appropriate state agency which is responsible for the licensing or certification of the long-term care facility involved and to the appropriate federal agency. Each state agency responsible for licensing or certification of long-term care facilities shall coordinate its activities with the statewide uniform reporting system by submitting to the department in a timely manner all complaints and information it receives on conditions that adversely affect the health, safety, welfare, or personal or civil rights of residents; provided, that the information is not privileged under the law. The ombudsman program may recognize investigative reports conducted by an appropriate agency or organization.

50-10.1-07. Confidentiality and disclosure of records and files.

Those records and files of the state and local ombudsman, and their authorized agents, which relate to, or identify any resident of a long-term care facility or a complainant, are confidential and may not be disclosed unless:

1. A resident, or a legal guardian or attorney in fact, consents in writing to the release of the information and designates to whom the information must be disclosed;
2. The ombudsman authorizes a disclosure which does not reveal the identity of any complainant or resident; or
3. A court of competent jurisdiction orders the disclosure.

CHAPTER 50-10.2
RIGHTS OF HEALTH CARE FACILITY RESIDENTS

50-10.2-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Authorized electronic monitoring" means the placement and use of an authorized electronic monitoring device, by a resident or resident representative, in the resident's room.
2. "Authorized electronic monitoring device" means video surveillance cameras, monitoring devices, web-based cameras, video phones, or audio recording or transmitting devices, or a combination of these devices, installed in the room of a resident which are designed to acquire, transmit, broadcast, interact, or record video, communications, or other sounds occurring in the room. The term does not include still cameras or devices used for the purpose of the resident having contact with another person but not for the purpose of electronically monitoring a resident.
3. "Conflict of interest" means any type of ownership in a facility or membership on the governing body of a facility by a provider of goods or services to that facility or by a member of that individual's immediate family.
4. "Department" means the department of human services.
5. "Facility" means a skilled nursing care facility, basic care facility, assisted living facility, or swing-bed hospital approved to furnish long-term care services.
6. "Immediate family" means husband, wife, father, mother, brother, sister, son, daughter, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, stepchild, uncle, aunt, niece, nephew, or grandchild.
7. "Remodeling" means any alteration in structure, refurbishing, or repair that would:
   a. Prevent the facility staff from providing customary and required care; or
   b. Seriously endanger or inconvenience any resident with noise, dust, fumes, inoperative equipment, or the presence of remodeling workers.
8. "Resident" means an individual residing in a facility.
9. "Resident representative" means a person authorized to act as a resident's agent under power of attorney for health care or guardianship.

50-10.2-02. Residents' rights - Implementation.

1. All facilities shall, upon a resident's admission, provide in hand to the resident and a member of the resident's immediate family or any existing legal guardian of the resident a statement of the resident's rights while living in the facility. Within thirty days after admission, the statement must be orally explained to the resident and, if the resident is unable to understand, to the resident's immediate family member or members and any existing legal guardian of the resident, and thereafter annually so long as the resident remains in the facility. The statement must include rights, responsibilities of both the resident and the facility, and rules governing resident conduct. Facilities shall treat residents in accordance with provisions of the statement. The statement must include provisions ensuring each resident the following minimum rights:
   a. The right to civil and religious liberties, including knowledge of available choices, the right to independent personal decisions without infringement, and the right to encouragement and assistance from the staff of the facility to promote the fullest possible exercise of these rights.
   b. The right to have private meetings, associations, and communications with any person of the resident's choice within the facility.
   c. The right of each resident, the resident's immediate family, any existing legal guardian of the resident, friends, facility staff, and other persons to present complaints on the behalf of the resident to the facility's staff, the facility's administrator, governmental officials, or to any other person, without fear of reprisal, interference, coercion, discrimination, or restraint. The facility shall adopt a grievance process and make the process known to each resident and, if the

resident is unable to understand, to the resident's immediate family member or members and any existing legal guardian of the resident. An individual making a complaint in good faith is immune from any civil liability that otherwise might result from making the complaint.

d. The right to send and receive unopened personal mail and the right of access to and use of telephones for private conversations.

e. The right to assured private visits by one's spouse, or if both are residents of the same facility, the right to share a room, within the capacity of the facility, unless sharing a room is not medically advisable as documented in the medical records by the attending physician.

f. The right to manage one's own financial affairs if not under legal guardianship, or to delegate that responsibility in writing to the administrator or manager of the facility, but only to the extent of funds held in trust by the facility for the resident. If such a trust is established, then a written quarterly accounting of any transactions made on behalf of the resident must be furnished along with an explanation by the facility to the resident or the person legally responsible for the resident.

g. The right to be fully informed in writing prior to or at the time of admission and during one's stay, of services provided and the charges for those services, including ancillary charges. Residents, or their legal guardians, must be informed at least thirty days prior to any change in the costs or availability of the services. No facility may demand or receive any advance payment or gratuity to assure admission.

h. The right to be adequately informed of one's medical condition and proposed treatment and to participate in the planning of all medical treatment, including the right to refuse medication and treatment, to be discharged from the facility upon written request, and to be notified by the resident's attending physician of the medical consequences of any such actions.

i. The right to have privacy in treatment and in caring for personal needs, to use personal belongings, to have security in storing and using personal possessions, and to have confidentiality in the treatment of personal and medical records. The resident has the right to view, and authorize release of, any personal or medical records.

j. The right to be treated courteously, fairly, and with the fullest measure of dignity.

k. The right to be free from mental and physical abuse and the right to be free from physical or chemical restraint except in documented emergencies or when necessary to protect the resident from injury to self or to others. In such cases, the restraint must be authorized and documented by a physician for a limited period of time and, if the restraint is a chemical one, it must be administered by a licensed nurse or physician. Except as provided in this subdivision, drugs or physical restraints may not be used or threatened to be used for the purposes of punishment, for the convenience of staff, for behavior conditioning, as a substitute for rehabilitation or treatment, or for any other purpose not part of an approved treatment plan.

l. The right not to be transferred or discharged except for:
   (1) Medical reasons;
   (2) The resident's welfare or that of other residents;
   (3) Nonpayment of one's rent or fees; or
   (4) A temporary transfer during times of remodeling.

m. The right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility or the resident's own home, or when the resident is being transferred or discharged because of a change in the resident's level of care; however, advance notice of transfer or discharge may be less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

n. The right to refuse to perform services on behalf of the facility, unless agreed to by the resident or legal guardian and established in the plan of care.
o. The right to a claim for relief against a facility for any violation of rights guaranteed under this chapter.
p. The right to have each facility display a notice that the following information is available for public review and make the information available on request:
(1) A complete copy of every inspection report, deficiency report, and plan of correction the facility received during the previous two years.
(2) The facility's grievance process.
(3) A copy of the statement of ownership, board membership, and partners.
(4) A statement of ownership setting forth any conflict of interest in the operation of the facility.
q. The right to a pharmacist of the resident's choice irrespective of the type of medication distribution system used by the facility.
r. The right to not be discriminated against by a facility in the admissions process or in the provision of appropriate care on the basis of the resident's source of payment to the facility. Any applicant for admission to a facility who is denied admission must be given the reason for the denial in writing upon request.
s. The right of residents and their families to organize, maintain, and participate in resident advisory and family councils.
t. The right of residents receiving services performed by a provider from outside the facility to be informed, on request, of the identity of the provider.

2. Waiver of any of the rights guaranteed by this chapter may not be made a condition of admission to a facility.
3. Each facility shall prepare a written plan and provide staff training to implement this chapter.
4. The department shall develop and coordinate with the facility licensing and regulatory agencies a relocation plan in the event a facility is decertified or unlicensed.

50-10.2-02.1. Authorized electronic monitoring - Penalty.

1. A facility shall permit a resident or the resident representative to conduct authorized electronic monitoring of the resident's room through an authorized electronic monitoring device if:
a. The authorized electronic monitoring device is placed in the resident's room;
b. The electronic monitoring device is placed in a fixed, stationary position; monitors only the area occupied by the resident and not the area occupied by the resident's roommate; and protects the privacy and dignity of the resident;
c. The facility is given written notice of the placement and use which must include an installation plan in compliance with the facility's standards and regulations the facility provides to the resident;
d. A video tape or recording created using an authorized electronic monitoring device records the date and time;
e. All costs, except for electricity, associated with the authorized electronic monitoring device, including installation, operation, removal, repairs, room damage, and maintenance, are paid by the resident or resident representative who initiated the use of the authorized electronic monitoring device; and
f. A signed authorization for the disclosure of protected health information, as defined by title 45, Code of Federal Regulations, part 160, section 103, compliant with the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and consenting to the use of the device is given by each resident occupying the same room, or by that resident's resident representative in accordance with subsection 4.
2. A facility that uses an authorized electronic monitoring device in compliance with this chapter is not guilty of a crime or civilly liable under this code for a violation of a resident's privacy.

3. The facility shall cooperate to accommodate the placement of the authorized electronic monitoring device, unless doing so would place undue burden on the facility.
4. Before placing and using the authorized electronic monitoring device, a resident or resident representative shall obtain the signed authorization of any other resident residing in the room in accordance with subsection 1. The authorization may be signed by that resident's resident representative.
   a. The resident's or the resident representative's authorization may limit the use of an authorized electronic monitoring device to only audio monitoring or only video monitoring and may limit the device's time of operation, direction, and focus.
   b. At any time, a resident or resident representative who did not request the authorized electronic monitoring device in the resident's room may withdraw, in writing, the signed authorization for the use of the device. The resident who requested the device or the resident's resident representative is responsible for having the device disabled in compliance with the facility's standards and regulations after receipt of the written withdrawal.
5. The facility shall make a reasonable attempt to accommodate a resident if a resident or resident representative of a resident who is residing in a shared room wants to have an authorized electronic monitoring device placed in the room and another resident living in the same shared room refuses to authorize the use of the authorized electronic monitoring device.
6. If authorized electronic monitoring is being conducted in the room of a resident, and another resident will be moved into the room, the resident who requested the device or the resident's resident representative is responsible for having the existing authorized electronic monitoring device disabled in compliance with the facility's standards and regulations unless the new resident or the resident's resident representative authorizes the device pursuant to subsections 1 and 4.
7. A facility may not refuse to admit an individual and may not remove a resident from a facility because of authorized electronic monitoring of a resident's room. A person may not intentionally retaliate or discriminate against a resident for authorization of authorized electronic monitoring.
8. A facility clearly and conspicuously shall post a sign where authorized electronic monitoring is being conducted to alert and inform visitors.
9. A facility or staff of the facility may not access any video or audio recording created through an authorized electronic monitoring device placed in a resident's room without the written consent of the resident or resident representative or court order.
10. A person that intentionally hampers, obstructs, tampers with, or destroys a recording or an authorized electronic monitoring device placed in a resident's room, without the express written consent of the resident or resident representative, is subject to a class B misdemeanor. A person that places an electronic monitoring device in the room of a resident or which uses or discloses a tape or other recording made by the device may be guilty of a crime or civilly liable for any unlawful violation of the privacy rights of another. In any civil proceeding, administrative proceeding, or survey process, material obtained through the use of an authorized electronic monitoring device may not be used if a person intentionally hampered, obstructed, or tampered with the material without the express written consent of the resident or resident representative, or if the material was obtained through the operation of an electronic monitoring device which was not compliant with this section.
11. A person may not intercept a communication or disclose or use an intercepted communication of an authorized electronic monitoring device placed in a resident's room, without the express written consent of the resident or the resident representative.

50-10.2-03. Rulemaking authority of department.

The department may adopt rules in accordance with chapter 28-32, consistent with and necessary for the implementation and enforcement of this chapter through the ombudsman program under chapter 50-10.1.

50-10.2-04. Enforcement - Injunction.

Any facility that violates this chapter may be enjoined by a district court. Actions for injunction under this section may be prosecuted by the attorney general or any state's attorney in the name of the state. Actions for injunction under this section must be prosecuted in the county where the case arises.

50-10.2-05. Furnishing financial information.

A facility may request that an applicant for admission, a resident of the facility, or the applicant's or resident's legal representative furnish financial information regarding income and assets, including information regarding any transfers or assignments of income or assets. A facility may deny admission to an applicant for admission who is unable to verify a viable payment source.

A Guide to Your Rights as a Resident of a Basic Care Facility In North Dakota

Distributed by:

Long-Term Care Ombudsman Program

(A free and confidential resident directed advocacy service)

1237 W. Divide Ave. – Suite 6

Bismarck, ND 58501

701-328-4617 or 711 (TTY) or
1-855-462-5465 option 3

The contents of this booklet are a summary of your rights as a resident of a basic care facility as set forth by North Dakota state law. The links listed inside direct you to the complete law.

Updated 08/01/2019

Dear Resident,

This booklet provides a summary of the rights you have in your new home in the basic care facility. You keep the rights you had before this move and are still in charge of your choice and lifestyle. If you experience memory and understanding changes your power of attorney documents may be triggered or a court may determine a guardian needs to manage your health and/or financial decisions. Even if you have such a representative you should still be informed and consulted about decisions made that involve you.

Remember and respect that the other residents in the facility have the same rights as you. Your choices and actions should not interfere with their rights.

While living in the basic care facility you may choose a family member or friend to be included/involved in the decision-making and sharing of your information, but you must put this in writing – the facility cannot automatically share information with your family member(s) or others.

If you, or any of your family or friends, have questions about the rights and how they apply to a situation, you may ask facility staff, or you may call the Long-Term Care Ombudsman Program at 701-328-4617 or 1-855-462-5465 (choose option 3).

Sincerely,

The Long-Term Care Ombudsmen

NORTH Dakota | Human Services
Be Legendary.

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North Dakota Century Code and Administrative Rules

- North Dakota Century Code 50-10.2 Rights of Health Care Facility Residents

Scan below with your smart phone to connect with web site

NDCC 23-09.3 ND Century Code Basic Care Facilities
NDAC 33-03-24.1 ND Administrative Code Basic Care Facilities

RESIDENT RIGHTS INFORMATION

- The facility is required to provide you and a member of your immediate family, or any existing legal guardian,
  - a written statement of your rights,
  - the responsibilities of both you and the facility, and
  - the rules governing your conduct, at the time you are admitted.

  Within 30 days after your admission, the statement must be verbally explained to you and if you are unable to understand, it should be explained to your immediate family member or any existing legal guardian. This should also happen every year for as long as you live in the facility.

- The facility's staff shall fully encourage and assist you in exercising your rights.

ADMISSION

- You cannot be discriminated against in the admission process based upon your source of payment.

- If you are denied admission to a facility, the facility must provide, **in writing**, the reason for the denial.

- You cannot be required to give advance payment, gratuity, or gift to the facility to assure admission.

- You cannot be asked to waive or give up any of your rights as a condition of admission.

INVOLVEMENT IN HEALTH CARE

- The facility must provide room and board and health, social and personal care to assist you in attaining and maintaining your highest level of functioning, consistent with your assessment and care plan. The facility shall provide for a prescribed diet if needed.

- There must be staff in the facility, awake, and prepared to assist residents twenty-four hours a day.

- You should be assessed within 14 days of admission and then no less frequently than quarterly. A care plan should be developed from the assessment and updated at least quarterly.

- If you receive services from someone outside of the facility, you have the right to know who they are and what agency they work for.

- It is your choice who provides services to you. You can choose your doctor, pharmacist and dentist.

- You should be informed about your total health status including your medical care, nursing care, nutritional status, activities potential, rehabilitation potential, and any physical impairments.

- You should be informed in advance of any care or treatment to be provided and be given the opportunity to participate in decisions regarding proposed care or treatment.

- You can give yourself certain medications and drugs unless professionals have determined it is not safe for you to do so.

- You should choose who you want involved in or notified about your care.

- You can refuse to take medications and participate in a treatment. Your medical provider should notify you of any medical consequences of your decisions.

- You have access to view your personal or medical records and to authorize release of those records.

COST OF CARE

- You have the right to see in writing, information about any services you are provided by the facility and the costs of those services.

- You have to be informed by the facility at least 30 days before any change in the costs or availability of any services.

- The facility needs to assist you in filing for additional sources of payment you may be eligible for.

GROUPS AND ACTIVITIES

- You can participate in social, religious, and community activities of your choice, if they do not interfere with the rights of other residents. You should able to continue normal activities.

- There must be a planned and meaningful activity program designed to your needs and interests. These activities may be inside or outside of the facility and should include day, evening, and weekend activities.

- You may participate and help organize resident and family council meetings. For resident and family councils, the facility must provide a space and staff person to assist when requested.

- The facility cannot force you to work or perform services for them. If you so choose to work and perform services, it must be documented in your care plan.

FREEDOM FROM ABUSE, NEGLECT, EXPLOITATION & RESTRAINTS

- You cannot be subjected to verbal, sexual, physical, or mental abuse. This includes the use of corporal punishment or involuntary isolation.

- You may request a copy of the facility's written policies/procedures regarding how they will prevent employment of persons convicted of mistreatment, neglect and abuse of residents.
- Chemical and Physical Restraints may not be used for the convenience of the staff or for disciplinary reasons and may be used ONLY:
  1. When ordered, in writing, by a doctor for a **specified and limited period of time** to treat a medical symptom and to ensure your safety or that of others.
  2. In Emergency situations during which your behavior has placed, or could place, yourself or others in danger of physical harm and the situation could not have been anticipated. Restraints can be applied in emergency situations only until a written order can be promptly obtained from your doctor.

Federal Law defines physical and chemical restraints as follows:

Physical Restraints are "any manual or physical or mechanical device, material, or equipment attached or adjacent to your body that you cannot remove easily and which restricts freedom of movement or normal access to your body".
Physical restraints include, but are not limited to, hand mitts, soft ties and rests, wheelchair safety bars, bed rails, or chairs that prevent rising. Also included as restraints are facility practices such as tucking in a sheet so tightly that a bed-bound resident cannot move, or placing a wheelchair-bound resident so close to wall that the wall prevents the resident from rising.

Chemical Restraints means a "psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms".

TRANSFER & DISCHARGE

- In cases of transfer or discharge, you must receive a **written** notice.

- The facility must prepare you for a safe and orderly transfer or discharge from the facility.

- A facility cannot transfer or discharge you from the facility against your wishes, unless it is for the following reasons:
  1. Your doctor documents your needs cannot be met by the facility,
  2. The safety and welfare, of individuals in the facility is threatened.
  3. Non-payment of your bill, whether by you or outside paying source.
  4. The facility ceases to operate.
  5. During times of remodel – can be temporary only.

- Written notice of Transfer or Discharge should be given **at least 30 days in advance** of the transfer or discharge. **However, the written notice may be less than 30 days if**:
  1. The resident has urgent medical needs that require a more immediate transfer or discharge or,
  2. A more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

PERSONAL & PRIVACY RIGHTS

- The facility staff must treat you courteously, fairly and with dignity.

- You should have privacy in visits with your spouse and can share a room with your spouse if you both agree and a room is available.

- You should have privacy in medical treatment and personal care along with confidentiality of those records. Your personal and medicals records can only be released to persons of your choice.

- You have the right to safe, clean and comfortable surroundings, allowing you to keep and securely store your personal belongings to the extent space permits. The facility must provide you with reasonable accommodation for your personal needs and preferences.

- You can send and receive unopened personal mail.

- You can manage your own financial affairs, if not under legal guardianship, or choose someone to handle them for you.

- You have the right to visitors, to attend meetings, and to communicate with people of your choosing.

- The facility must provide a telephone in a private area for your use for communication.

- If you so choose, besides your legal resident representative you can have your family representative involved in your health care.

- You can make choices about how you want to live your life that are significant to you. This includes deciding how you want to spend your time, what you would like your daily schedule and routine to be and what your health care wishes are that are consistent with your personal beliefs, values, interests, as well as assessments and plans of care.

- You can have immediate access at any time without restrictions to:
  1) Your personal doctor;
  2) Representative from state and federal agencies;
  3) Representatives from the Ombudsman program, Developmental Disabilities, or Mental Health Advocacy Programs; and
  4) Immediate family or other relatives you want to visit

- You have the right to civil and religious liberties, including knowledge of available choices (civil liberties include your right to vote, marry, divorce, sign papers, obtain and dispose of property, etc.)

GRIEVANCES AND COMPLAINTS

- You can present complaints and discuss problems, concerns, grievances, or suggestions with anyone you choose without fear of retaliation or reprisal. This includes your local long-term care ombudsman.

- The facility must provide you with a statement about your right to file a complaint with the Department of Health concerning resident abuse, neglect and misappropriation of your property in the facility.

- You must be provided a copy of the facilities grievance procedures.

- You must be given information about other agencies and organizations, such as the State Ombudsman Program or Medicaid Fraud that may assist you with resolving a complaint or providing information and assistance

- You have a right to claim relief against the facility for any violation of rights guaranteed by State Law.

ACCESS TO FACILITY INFORMATION

- The facility must make available every inspection report, deficiency report and the approved plan of correction for the past two years.

- You can request a copy of the facility's grievance process.

- You can request a copy of the names of the statement of ownership, board members, and partners of the facility.

- You may ask for a statement setting forth any conflict of interest in the operation of the facility, such as, an owner's family member being employed or doing business with the facility.

Effective August 1, 2019;
Notice of Right to Place and Use an Electronic Monitoring Device in your Room at a Long-Term Care Facility (assisted living, basic care, nursing home, swing bed)

WHO has the right to place and use an authorized electronic monitoring device in your room?

- A resident of a facility; or
- A resident representative of the resident (if the resident is not able to consent to electronic monitoring).
    - Must be a power of attorney for health care (agent must be in effect as per the terms of the POA document); or
    - Guardian of the resident

WHEN can you exercise this right to install and use an authorized electronic monitoring device?

- The authorized electronic monitoring law goes into effect on August 1, 2019.
- Then must complete and submit the applicable notices and authorizations.
- Also, you may choose to install an authorized electronic monitoring device in your room at any time while you reside in the long-term care facility if all the necessary documentation is completed and submitted.

WHAT should be considered before giving consent? You should know what you are giving consent to.

Video device

All residents in the room should consider the following.

- Who, and what, may be captured on video e.g. visitors, equipment in room, personal cares provided, intimate relations, etc.
- With whom will you share the recording? What restrictions do you want placed on sharing of the video recording?
- If there will be intimate times with a significant other do you want the recording turned off during those times?

Audio device

All residents in the room should consider the following.

- The device will likely record conversations with staff, family and friends, etc. for both the resident wanting the recording and for any other resident sharing the room. This may mean private information about finances, family relationships, and health information may be recorded.
- With whom will you share the recording? Do you want all conversations and possibly private information being on a recording? Do you plan to go to a family room or conference room for private conversations?

WHAT is the process to use an authorized electronic monitoring device in your room at the facility? **ALL** the following is required by law.

1. **WRITTEN NOTICE GIVEN TO LONG-TERM CARE FACILITY**
    a. You, the resident, or your resident representative, must complete and give a Notice to Facility of your intent to place and use an authorized electronic monitoring device.
    b. You, or your resident representative, must give the facility an **installation plan** that follows the facility's regulations and policies.
2. **DOCUMENTATION OF CONSENT**
    a. You, the resident, or the resident representative, completes a document showing consent.
    b. Each of the resident's roommates, or his/her resident representatives, must also complete a document of consent.
        i. The roommate may put limits on the authorized electronic monitoring device and all of the limits must be followed for the authorized electronic monitoring device to be used.
    c. The documentation of consent includes:
        i. Written consent for the placement and use of the authorized electronic monitoring device and
        ii. written authorization for disclosure of protected health information and
        iii. written release of liability of the facility for violation of a resident's privacy resulting from the use of an authorized electronic monitoring device.

3. **PAYMENT**

   a. You, the resident, or your resident representative, are responsible to pay for the authorized electronic monitoring device, and all installation, operation, maintenance, and removal costs associated with the device except for electricity.

4. **INFORMATION REQUIRED ON VIDEO RECORDINGS**

   a. All recordings from a video electronic monitoring device must include the date and time of the recording.

5. **AUTHORIZED ELECTRONIC MONITORING DEVICE**

   a. The authorized electronic monitoring device shall be in a fixed, stationary position.

   b. The authorized electronic monitoring device shall be directed only on the resident who initiated the installation and use of the authorized electronic monitoring device.

   c. The authorized electronic monitoring device shall be placed for maximum protection of the privacy and dignity of the resident and the roommate.

A person may be subject to a Class B misdemeanor if he

- Intentionally hampers, obstructs, tampers with or destroys a recording or an authorized electronic monitoring device placed in a resident's room without the express written consent of the resident or resident representative.

A person may be guilty of a crime or civilly liable if he

- Unlawfully violates the privacy rights of another by placing an electronic monitoring device in the room of a resident or by using or disclosing a tape or other recording made by the device.

- You can choose at any time to revoke your consent to have an authorized electronic monitoring device in your room by written notice.
- The roommate must agree to the use of an authorized electronic monitoring device in the room or it can't be used. You can request to move to a different room with a roommate that will agree to the use of an authorized electronic monitoring device
- A facility cannot refuse to admit you or discharge you if you choose to have an authorized electronic monitoring device.

A facility, or staff of the facility, may not access any recording from the authorized electronic monitoring device without written permission from you or your resident representative, or a court order.

- A facility, or staff of the facility, may not access any recording from the electronic monitoring device without written permission from you or your resident representative, or a court order.

Alzheimer's, dementia, special memory care, or traumatic brain injury facility or units

A basic care facility or unit that admits or retains only residents with Alzheimer's, dementia, or special memory care needs in a secured or unsecured facility or unit, or a facility that admits and retains only residents with traumatic brain injury has the additional requirements according to NDAC 33-03-24.1-24.

The facility shall ensure each resident's right to privacy, dignity and respect, and freedom from coercion and restraint by promoting

- individual initiative,
- autonomy, and
- independence in making life choices related to daily activities, physical environment, and with whom to interact.

The facility or unit must also fulfil the following.

a. Residents must be provided privacy in their sleeping or living area, including entrance doors lockable by the individual, with only appropriate staff having keys to the doors;

b. Residents sharing a room with another resident must have a choice of roommate in that setting;

c. Residents must be granted the freedom to furnish and decorate their sleeping unit or living area to the extent allowable based on facility policy and fire code requirements;

d. Residents must have the freedom and support to control their schedules and activities and have access to food any time and eat where they choose;

e. Residents can have visitors of their choosing at any time;

f. Residents must have access to the community; and

g. Residents must have access to outdoor space. Residents in a secured facility or unit must have access to a secured outdoor space.

IMPORTANT AGENCIES and CONTACT INFORMATION

Long-Term Care Ombudsman Program
Phone: 1-855-462-5465 (toll free), option 3
701-328-4617
Address: 1237 W Divide Ave Suite 6
Bismarck ND 58501
E-mail: dhsagingombud@nd.gov
Link for online complaint reporting:
www.nd.gov/eforms/Doc/sfn01829.pdf.

ND Department of Health (Survey & Certification – Regulatory Agency & Licensing Agent)
Phone: 1-701-328-2352
Address: 600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505- 0200
E-mail: LTCconcerns@nd.gov

Protection and Advocacy Project
Phone: 1-800-472-2670 or 1-701-328-2950
Address: 400 East Broadway Suite 409
Bismarck ND 58501
E-mail: **panda_intake@nd.gov**

Legal Services of North Dakota
Phone: **Under age 60** call toll-free **1-800-634-5263** (Monday, Tuesday, and Thursday between 9 a.m. - 3 p.m. CST).
Age 60+ call toll-free **1-866-621-9886** (Monday - Thursday between 8 a.m. - 5 p.m. CST. Friday between 8 a.m. - 2 p.m. CST.)

Vulnerable Adult Protective Services

Phone: Central intake line 1-855-462-5465 (choose option 2)
Address: 1237 W. Divide Ave Suite 6
Bismarck ND 58501
E-mail: SFN 1607 Report of Vulnerable Adult Abuse, Neglect, or Exploitation https://www.nd.gov/eforms/Doc/sfn01607.pdf ;
Send the completed form to carechoice@nd.gov or **FAX** it to 701-328-8744
Link for online reporting: https://fw2.harmonyis.net/NDLiveIntake/

NOTE: The Aging and Disability Resource LINK (ADRL) - Vulnerable Adult Protective Services intake line is answered weekdays between 8 a.m. and 5 p.m., Central Time. *Please leave a message, including your contact information, if you call after hours.*

Medicaid Fraud

Phone: 1-800-755-2604 or 1-701-328-4024
Address: Surveillance Utilization Review Administrator
c/o Medical Services Division
600 E Boulevard Ave Dept. 325
Bismarck ND 58505-0250
E-mail: medicaidfraud@nd.gov

State Health Insurance Counseling Program (SHIC)

Offers free help with Medicare and other health insurance including long term care insurance.

Phone: 1-888-575-6611 or 1-701-328-2440
Address: 600 E Boulevard Ave
Bismarck ND 58505-0320
E-mail: ndshic@nd.gov

The next three pages show a comparison of the different levels of long-term care facilities available in North Dakota.

	ASSISTED LIVING (most independent)	BASIC CARE (needing more assistance)	SKILLED NURSING HOME (needing skilled nursing care)
Definition	An apartment setting that provides or coordinates individualized support services (see Features) to meet the resident's needs and abilities to maintain as much independence as possible.	A residence that provides room and board to people who because of impaired ability for independent living, require health, social, or personal care services. Basic Care residents do not require regular 24-hour medical or nursing services. Staff are available to respond at all times to meet the 24-hour per day scheduled and unscheduled needs of a resident. Some Basic Care facilities are Alzheimer's, dementia, or memory care units.	A facility that provides room and board AND 24-hour care/supervision to its residents. This facility is under the supervision of a licensed health care practitioner and has 24-hour nursing care.
Features	Services (commonly referred to as Service Plan/Contract/Level/Package) are purchased at costs above rental fees according to the resident's needs. Services MAY include meals, housekeeping, laundry, activities, 24-hour supervision, personal care, medication reminders, and varying levels of health care services. This setting is NOT appropriate for memory-impaired (advanced stage) residents. Residents may choose additional in-home care agencies to supplement services.	Provides room and board as well as health and social services. Assistance with Activities of Daily Living (ADLs) is provided 24-hours per day. Also includes recreational and therapeutic activities, dietary consultation, and medication administration.	Provides room and board and ALSO nursing, medical, rehabilitative care, recreational activities, social services, assistance with Activities of Daily Living (ADLs), and protective supervision 24-hours a day.

License	*Licensed by ND Dept. of Human Services*	*Licensed by ND Dept. of Health*	*Licensed by ND Dept. of Health*
Regulation/ Oversight	*No state oversight - Landlord Tenant Law and ND Contract Law apply. It is up to the resident to manage their contract/lease and monitor costs and services.*	*Surveyed by ND Dept. of Health every 3-5 yrs.*	*Surveyed annually by ND Dept. of Health*
Payment	*Housing is a landlord/tenant rental agreement, so billed separately from Services. Usually private pay (resident's own income sources/assets) or may be covered partially through Long Term Care insurance.*	*One rate is billed for room and board, personal care, and ADL assistance. May be private pay (resident's own income sources/assets) or paid through the state's Basic Care program.*	*Individual rates include room and board, personal cares, nursing and ADLs assistance. May be private pay (resident's own income sources/assets), through Long Term Care insurance, through the state Medicaid Program, or Medicare. There may be limits on the types of services paid for or the length of time benefits can be utilized.*
Nursing Staff Availability	*NO set requirement or regulation. May not have any after-hours or overnight staff on duty.*	*RESPONSE staff are available at all times to meet the 24-hour per day scheduled and unscheduled needs to residents.*	*Sufficient qualified nursing personnel on duty at all times to meet the nursing care needs of the residents. Required staff are at least 1 registered nurse on duty 8 consecutive hrs. per day, 7 days a week, AND at least 1 licensed nurse on duty and designated to work charge 24-hours a day, 7 days a week.*

Additional Facts	***Most issues with lease agreement or lease contract need to be resolved between tenant and facility due to NO oversight by a state entity. Residence in an ALF with an attached Basic Care or SNF facility does not guarantee you placement in that level of care should you require it - placement depends upon availability and facility admission protocol. There can be many additional costs associated with this level of care.***	***Not required to have regular 24-hour medical or nursing services; only RESPONSE staff.***	***Not staffed by a physician; a physician is available for consultation at all times. There are differences among SNFs with regard to services provided (i.e.. IV therapy, wound care, etc.) Nursing homes should disclose to residents/potential residents its special characteristics or service limitations. There is no mandated staff to resident ratio - facilities are required to be staffed to adequately meet the needs of the total number of residents.***
Activities of Daily Living (ADLs): Eating, Bathing, Dressing, Toileting, Transferring (walking) and Continence.			

Effective August 1, 2019;
Notice of Right to Place and Use an Electronic Monitoring Device in your Room at a Long-Term Care Facility (assisted living, basic care, nursing home, swing bed)

WHO has the right to place and use an authorized electronic monitoring device in your room?

- A resident of a facility; or
- A resident representative of the resident (if the resident is not able to consent to electronic monitoring).
    - Must be a power of attorney for health care (agent must be in effect as per the terms of the POA document); or
    - Guardian of the resident

WHEN can you exercise this right to install and use an authorized electronic monitoring device?

- The authorized electronic monitoring law goes into effect on August 1, 2019.
- Then must complete and submit the applicable notices and authorizations.
- Also, you may choose to install an authorized electronic monitoring device in your room at any time while you reside in the long-term care facility if all the necessary documentation is completed and submitted.

WHAT should be considered before giving consent? You should know what you are giving consent to.

Video device

All residents in the room should consider the following.

- Who, and what, may be captured on video e.g. visitors, equipment in room, personal cares provided, intimate relations, etc.
- With whom will you share the recording? What restrictions do you want placed on sharing of the video recording?
- If there will be intimate times with a significant other do you want the recording turned off during those times?

Audio device

All residents in the room should consider the following.

- The device will likely record conversations with staff, family and friends, etc. for both the resident wanting the recording and for any other resident sharing the room. This may mean private information about finances, family relationships, and health information may be recorded.

- With whom will you share the recording? Do you want all conversations and possibly private information being on a recording? Do you plan to go to a family room or conference room for private conversations?

WHAT is the process to use an authorized electronic monitoring device in your room at the facility? **ALL** the following is required by law.

1. **WRITTEN NOTICE GIVEN TO LONG-TERM CARE FACILITY**
    a. You, the resident, or your resident representative, must complete and give a Notice to Facility of your intent to place and use an authorized electronic monitoring device.
    b. You, or your resident representative, must give the facility an **installation plan** that follows the facility's regulations and policies.
2. **DOCUMENTATION OF CONSENT**
    a. You, the resident, or the resident representative, completes a document showing consent.
    b. Each of the resident's roommates, or his/her resident representatives, must also complete a document of consent.
        i. The roommate may put limits on the authorized electronic monitoring device and all of the limits must be followed for the authorized electronic monitoring device to be used.
    c. The documentation of consent includes:
        i. Written consent for the placement and use of the authorized electronic monitoring device and
        ii. written authorization for disclosure of protected health information and
        iii. written release of liability of the facility for violation of a resident's privacy resulting from the use of an authorized electronic monitoring device.
3. **PAYMENT**
    a. You, the resident, or your resident representative, are responsible to pay for the authorized electronic monitoring device, and all installation, operation, maintenance, and removal costs associated with the device except for electricity.

4. **INFORMATION REQUIRED ON VIDEO RECORDINGS**

   a. All recordings from a video electronic monitoring device must include the date and time of the recording.

5. **AUTHORIZED ELECTRONIC MONITORING DEVICE**

   a. The authorized electronic monitoring device shall be in a fixed, stationary position.

   b. The authorized electronic monitoring device shall be directed only on the resident who initiated the installation and use of the authorized electronic monitoring device.

   c. The authorized electronic monitoring device shall be placed for maximum protection of the privacy and dignity of the resident and the roommate.

A person may be subject to a Class B misdemeanor if he

- Intentionally hampers, obstructs, tampers with or destroys a recording or an authorized electronic monitoring device placed in a resident's room without the express written consent of the resident or resident representative.

A person may be guilty of a crime or civilly liable if he

- Unlawfully violates the privacy rights of another by placing an electronic monitoring device in the room of a resident or by using or disclosing a tape or other recording made by the device.

- You can choose at any time to revoke your consent to have an authorized electronic monitoring device in your room by written notice.
- The roommate must agree to the use of an authorized electronic monitoring device in the room or it can't be used. You can request to move to a different room with a roommate that will agree to the use of an authorized electronic monitoring device
- A facility cannot refuse to admit you or discharge you if you choose to have an authorized electronic monitoring device.
- A facility, or staff of the facility, may not access any recording from the authorized electronic monitoring device without written permission from you or your resident representative, or a court order.

INSTALLATION PLAN
FOR ELECTRONIC MONITORING
(Must be in compliance with facility regulations and policies)

Requested date of installation: _____

Type of Electronic Monitoring Device: _____

Person or company installing device: _____

Approximate time needed to install device: _____

Materials needed for installation (to be provided by the resident or if provided by the facility resident will be billed): _____

_____

_____

Requested Location in Resident Room: _____

Monitoring Device has at least 128-bit encryption and enable a secure socket layer ("SSL"):
Yes ____ No ____

Electronic Device is placed in a fixed, stationary position:
Yes ____ No ____

- monitors only the area occupied by the resident and not the area occupied by the resident's roommate:
  Yes ____ No ____
- protects the privacy and dignity of the resident:
  Yes ____ No ____
- screenshot to be provided of camera view to ensure monitoring restrictions. Screenshot provided by facility:
  Yes ____ No ____

Restrictions on use of the device requested by resident or resident's representative (i.e. only audio, only video, time of operation, not operated during daily care, direction and focus): _____

_____

_____

Restrictions on use of the device (i.e. only audio, only video, time of operation, direction and focus) by non-requesting resident (roommate) occupying the same room: _____

_____

_____

If internet access required, resident or resident's representative has contracted with necessary internet provider (internet access will not be permitted through guest wifi connections or through facility or corporate networks):
Yes ____ No ____

Instructions on disabling device should resident expire, require hospitalization or to comply with ND statutes and regulations: _____

_____

_____

Resident and/or Resident's Representative acknowledges and agrees no recording, or portion of a recording, from an authorized electronic monitoring device may be shared or posted on any social media.

Resident and/or Resident's Representative understands all costs associated with installation, operation, internet access, removal, repairs, room damage and maintenance are paid by the resident or resident's representative who initiated the use of the authorized electronic monitoring device.

Resident and/or Resident's representative understands all restrictions by resident and/or Resident's representative or resident's roommate, is the responsibility of the resident or the resident's representative. The facility is not responsible for the operation or disabling of the electronic monitoring device. Also, any time the device must be disabled as a result of resident's roommate withdrawing consent or new roommate moving into the room, the electronic monitoring device must be disabled until consent is obtained from new roommate.

By signing below you agree to comply with the installation plan and any and all facility codes, guidelines and regulations related to the use or installation of an electronic monitoring device. You also agree to comply with all laws and regulations related to the use of an electronic monitoring device. You also agree the facility may disable the device in limited circumstances where the resident expires, requires hospitalization or to comply with North Dakota law, rules or regulations.

Room #: _____

_____ _____

Resident or Resident's Representative Date

FOR FACILITY USE ONLY

Placement of the device and equipment in compliance with electrical wiring standards:
Yes ____ No ____

Placement of the device and equipment in compliance with fire safety codes:
Yes ____ No ____

Placement of the device and equipment in compliance with general facility guidelines:
Yes ____ No ____

Comments: _____

_____

_____

Electronic Monitoring Documentation

Section I: Notice to Facility

Section I and II may be completed and signed only by the resident wanting to place and use an authorized electronic monitoring device in the resident room, or the person authorized to act as the resident's agent through a power of attorney for health care document (must be in effect according to the terms of the document), or the resident's guardian.

Name of Resident: _____ Room Number: _____

Name of Resident Representative (if resident doesn't have capacity to consent):

_____

Check One: Power of Attorney for Health Care _____ OR Guardian _____

Contact Number of Resident Representative: _____

This serves as notice to _____
Name and location of facility

that I have chosen to place and use an authorized electronic monitoring device in the resident room indicated above in accordance with ND Century Code 50-10.2.

Section II: Consent by Resident

The monitoring device is a just a video monitoring device. (circle one) Yes No

The monitoring device is just an audio recording device. (circle one) Yes No

The monitoring device records both video and audio. (circle one) Yes No

Please initial each statement below to indicate you have read and understand its contents.

_____I hereby understand and agree to the following requirements from ND Century Code 50-10.2 for an authorized electronic monitoring device.

The authorized electronic monitoring device shall be in a fixed, stationary position;
The authorized electronic monitoring device shall monitor only the area occupied by the resident requesting the monitoring and not the area occupied by the roommate;
The authorized electronic monitoring device will be placed for maximum protection of the privacy and dignity of the resident and the roommate.

(07/2019)

____I understand that if I have a roommate and my roommate does not consent to authorized electronic monitoring, I may not place or use an authorized monitoring device. I understand that if my roommate limits the use of the authorized electronic monitoring device, I must comply with the limits.

____I understand I must disable the authorized electronic monitoring device if my roommate withdraws consent in compliance with the facility's standards and regulations after receipt of the written withdrawal.

_____I understand if there is audio recording used it will likely record conversations with staff, other health care providers, family and friends, and other parties in the facility. This may mean private information about finances, family relationships, and protected health information may be recorded.

____I hereby release the facility from liability for violations of my right to privacy regarding the use of the authorized electronic monitoring device, and I hereby waive my right to privacy in connection to the use of the authorized electronic monitoring device.

_____I understand I must submit and follow an installation plan that complies with the facility's standards and regulations.

_____I understand I am responsible for all costs, except for electricity, associated with the authorized electronic monitoring device.

_____I understand I am responsible to contract with an Internet provider, if that is needed as part of the authorized electronic monitoring and must comply with facility policy.

_____ I understand that facility staff may not access any video or audio recording created through the authorized electronic monitoring device without my written consent or the written consent of my resident representative

____I understand I may not use or disclose a tape or other recording made by the authorized electronic monitoring device if there would be any unlawful violation of the privacy rights of another.

_____I understand I can revoke this decision to place and use an authorized electronic monitoring device at any time during my stay in the facility by submitting a written notice.

A person may be subject to a Class B misdemeanor if they:

- Intentionally hamper, obstruct, tamper with or destroy a recording or an authorized electronic monitoring device placed in a resident's room without the express written consent of the resident or resident representative.

A person may be guilty of a crime or civilly liable if they:

- Unlawfully violate the privacy rights of another by placing an electronic monitoring device in the room of a resident or by using or disclosing a tape or other recording made by the device.

(07/2019)

I hereby consent to the placement and use of an electronic monitoring device in my room in accordance with ND Century Code 50-10.2.

(This may be signed only by the resident or the resident representative.)

_____ _____

Resident Signature Date

OR

_____ _____

Resident Representative Signature Date

Does the resident have a roommate? Yes_____ No _____

If the resident has a roommate, **Section III must be completed and signed before an authorized electronic monitoring device can be placed and used in the resident's room**. If a new roommate has moved into the room the authorized electronic monitoring device cannot be used until Section III is completed and signed by the new roommate.

(07/2019)

Section III: Consent by Roommate

I, _____, live in the same
Roommate Name

room as _____, room
resident

number _____ at _____
(name and location of facility)

I understand that _____wants to place
resident

and use an authorized electronic monitoring device in the room.

I **do not** consent to the placement and use of an authorized electronic monitoring device in the room.

_____ _____
Signature of Roommate or Resident Representative Date

***If you have chosen to not consent to the placement and use of an authorized electronic monitoring device, return this to the resident named on page 1. You do not need to complete the remainder of the form.**

Complete the remainder of Section III if you are choosing to consent to the placement and use of an electronic monitoring device.

I require the following **limits** on the use of the authorized electronic monitoring device.

____ Audio recording only.

____ Video recording only.

____Limit the use of the authorized electronic monitoring device to the following times:_____

____ Limit the direction and focus of the authorized electronic monitoring device to the following conditions: _____

_____

_____.

(07/2019)

Please initial each statement below to indicate you have read and understand its contents.

_____I hereby understand and agree to the following requirements from NDCC 50-10.2- for an authorized electronic monitoring device.

The authorized electronic monitoring device shall be in a fixed, stationary position;
The authorized electronic monitoring device shall monitor only the area occupied by the resident requesting the monitoring and not the area occupied by the roommate;
The authorized electronic monitoring device will be placed for maximum protection of the privacy and dignity of the resident and the roommate.

_____I understand if there is audio recording used it will likely record conversations with staff, other health care providers, family and friends, and other parties in the facility. This may mean private information about finances, family relationships, and protected health information may be recorded.

_____I must sign an authorization for the disclosure of protected health information prior to placement and use of the monitoring device.

_____I hereby release the nursing home from liability for violations of my right to privacy regarding the use of the authorized electronic monitoring device, and I hereby waive my right to privacy in connection to the use of the authorized electronic monitoring device

_____I understand that facility staff may not access any video or audio recording created through the authorized electronic monitoring device without the written consent of the resident who requested the use of the authorized monitoring device, or the written consent of the resident representative, or a court order.

_____ I understand that any limits I have listed above must be fully complied with.

_____I understand a tape or other recording made by the authorized electronic monitoring device may not be used or disclosed if there would be any unlawful violation of the privacy rights of another.

_____I understand I may revoke my consent for the placement and use of an authorized electronic monitoring device at any time by giving a written notice. Revocation of my consent means the authorized electronic monitoring device will be disabled in compliance with the facility's standards and regulations and I will be given written assurance by the resident, or resident representative, that the device has been disabled.

A person may be subject to a Class B misdemeanor if they:

- Intentionally hamper, obstruct, tamper with or destroy a recording or an authorized electronic monitoring device placed in a resident's room without the express written consent of the resident or resident representative.

A person may be guilty of a crime or civilly liable if they:

- Unlawfully violate the privacy rights of another by placing an electronic monitoring device in the room of a resident or by using or disclosing a tape or other recording made by the device.

(07/2019)

I hereby consent to the placement and use of an authorized electronic monitoring device in compliance with NDCC 50-10.2 and with any limits listed above.

_____ _____
Resident Signature Date

OR

_____ _____
Resident Representative Signature Date

For Facility Use:

Date Written notice received: _____

Date Resident written consent received: _____

Date Installation plan received: _____

Date Roommate's written consent received (if applicable): _____

_____
Signature and Title – Facility Representative

_____
Date

(07/2019)

Section IV: Revocation of Consent for the Placement and Use of an Authorized Electronic Monitoring Device

I, _____,
(name of resident or resident representative)

OR

I, _____
(name of roommate or resident representative)

hereby revoke my consent for an authorized electronic monitoring device to be placed and used in the room. The authorized electronic monitoring device must be disabled in compliance with the facility's standards and regulations upon receipt of this written revocation notice of the consent.

For Facility Use:

Date Revocation of Consent received: _____

_____
Signature and Title of Facility Representative

_____
Date

(07/2019)

Roommate Authorization to Disclose Protected Health Information
Authorized Electronic Monitoring Device

Name of Resident: _____ **Date of Birth:** ____/____/____

Name of Facility: _____

Street Address: _____

City: _____ **State:** ND **Zip Code:** _____

I hereby authorize the facility listed above and any and all my current and future medical and healthcare providers to disclose to:

_____
(Name of Resident or Resident Representative Utilizing the Authorized Electronic Monitoring Device)

The following Protected Health Information: My likeness (video, audio, photograph) and any and all information regarding my past, present, or future physical or mental health that is individually identifiable that may be captured, recorded, maintained or transmitted by the authorized electronic monitoring device. This includes but is not limited to, information such as symptoms, diagnoses, treatments, prognosis, lab results, other test results, medications, durable medical equipment, and information regarding insurance, claims, and payment.

For the purpose of permitting my roommate or roommate's resident representative to conduct authorized electronic monitoring in our shared room.

Duration/Revocation: This authorization is voluntary and remains in effect for one year from the signature date. I may revoke this authorization by providing written notice to the facility named above, at any time. Revocation will not apply to disclosures of Protected Health Information that occur before the written revocation notice is received by the facility. A photocopy of this authorization is as effective as the original.

Treatment, payment, enrollment, or eligibility for applicable health benefits will not be conditioned upon my providing this authorization unless otherwise required by law. Any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.

Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. I have a right to receive a copy of this authorization.

_____ _____

Signature of Resident Date

Resident Representative: If you are signing this authorization on behalf of the resident, documentation demonstrating your authority must be on file with the facility or attached to this document.

_____ _____

Signature of Resident Representative (if applicable) Date

Type of Authority: ☐ Power of Attorney for Healthcare **OR** ☐ Guardian

ELECTRONIC MONITORING
DRAFT PROPOSED POLICY

Adopted on: , 2019	Approved by:
Last Reviewed by:	Last Reviewed on and Updated:

Purpose: To establish guidelines with North Dakota Century Code §50-10.2-01 and North Dakota Administrative Rule §75-03-40 as residents or their representatives request electronic monitoring of the personal area of their room. This policy provides guidance on the installation and operation of devices, completion of necessary forms, consents and signage required for electronic monitoring.

Non-Retaliation or Discrimination Provision

At no time will any staff refuse to admit a resident, remove a resident, retaliate or discriminate against any resident or resident's representative for authorizing electronic monitoring. Facility will cooperate to accommodate the placement of the electronic monitoring device unless doing so would place an undue burden on the facility. A resident must have the consent of any and all residents occupying the same room prior to installation and operation of an electronic monitoring device. Consent from a new resident moving into a room is required for continued operation of an electronic monitoring device. Facility will make reasonable attempts to accommodate a resident if others sharing the room refuse to consent to the use of an electronic monitoring device. However, if appropriate consents for shared rooms cannot be obtained, the resident or resident's representative requesting the electronic monitoring device will be responsible for any additional costs for a single room if available.

Request for Electronic Monitoring and Consent

Every resident is presumed to have capacity to consent to electronic monitoring and to

execute the required forms if the resident understands and appreciates the nature and consequences of their decision. If a resident has capacity to consent only the resident may authorize electronic monitoring in the resident's room. If it is unclear whether a resident has the capacity to consent to electronic monitoring, the resident's representative must obtain written certification from the resident's attending physician, that the resident lacks capacity to consent to electronic monitoring. If a resident clearly does not have capacity to consent or the resident's attending physician certifies in writing the resident lacks capacity to consent to electronic monitoring, the resident representative's with authority to consent to electronic monitoring may consent or not consent to electronic monitoring.

A resident's representative for purposes of consent to electronic monitoring is limited to the following individuals in the following order of priority:

1. A guardian appointed by the court; or

2. An agent or alternative agent (if applicable) named in power of attorney for healthcare.

No other individuals, other than listed above have the authority to act as the resident's representative with regard to consent for electronic monitoring.

Any resident representative must make decisions in accordance with the resident's wishes, values, preferences, or directions. If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident regarding the authorization or use of electronic monitoring, the facility shall report this concern in the manner required to the Department of Human Services.

Process Prior to Installation

A resident or the resident's representative may install and use an electronic monitoring device only after all necessary forms have been completed. The resident or the resident's representative must complete the following forms:

1. SFN ___ Authorization and Consent Form for Electronic Monitoring;

2. SFN ___ HIPAA (Health Insurance Portability and Accountability Act) Release of Information Form signed by any and all residents occupying the same room as the resident requesting electronic monitoring;

3. Form ____ Installation Plan (compliant with facility's standards and regulations).

A new SFN ___ and SFN ____ must be completed every time a new resident moves into a room where the current resident has an electronic monitoring device. The electronic monitoring device must be disabled until the new resident or resident's representative consents to its operation with or without restrictions.

Installation of the Electronic Monitoring Device

The Electronic Monitoring Device must comply with the following:

1. Electronic Monitoring Device is limited to the following:

a. Video Surveillance Camera;

b. Monitoring Devices;

c. Web-based Cameras;

d. Video phones;

e. Audio recording or transmitting devices or a combination of these devices.

An Electric Monitoring Device does not include still cameras or devices used for the purpose of the resident having contact with another person but not for the purpose of electronically monitoring a resident.

2. The electronic monitoring device must be placed in a fixed, stationary position; monitors only the area occupied by the resident and not the area occupied by the resident's roommate; and **protects the privacy and dignity of the resident**. If possible and as part of the installation Plan, after device is installed, or any time the facility has reason to believe the position of an electronic monitoring device may be in violation of law or this policy, a screenshot should be provided to ensure the area covered by the device monitors only the area occupied by the resident and protects the privacy and dignity of the resident.

3. All costs, except for electricity associated with the authorized electronic monitoring device, including installation, operation, internet access, disabling, removal, repairs, room damage, and maintenance, are paid by the resident or resident representative who initiated the use.

4. If resident or resident representative chooses to install a monitoring device that uses internet technology. The monitoring device must have at least 128-bit encryption and enable a secure socket layer ("SSL"). The resident or resident's representative is responsible for contracting with an internet provider if that is needed as part of the electronic monitoring system. The facility is not required to allow internet

access.

5. It is the responsibility of the resident or the resident's representative to obtain all necessary consents from any other resident occupying the room as required on SFN____. The facility may but is not required to facilitate communications between residents or resident's representatives, to complete the Authorization and Consent Form for Electronic Monitoring SFN___ and HIPAA consent form, SFN ___.

Signage

Facility will post a sign at the entryway of the facility which states: "Electronic Monitoring devices including security cameras and audio devices may be present to record persons and activities". Facility will also post a sign outside and inside each resident's room where electronic monitoring is occurring.

Disabling or Monitoring Operation of the Electronic Monitoring Device

At any time a resident, resident's representative or other resident residing in a room where an electronic monitoring device is used, may withdraw their consent for the use of the device. It is the responsibility of the resident or resident's representative to disable any device if the required consents have been withdrawn and provide confirmation of same. It is also the responsibility of the resident or resident's representative requesting the electronic monitoring device to ensure the device is operating with the restrictions on SFN ____ required by the resident or resident's representative or any other residents residing in the room.

Facility may disable a device should the resident expire, is hospitalized or is absent for an extended period of time and unable to disable the device.

Access to Recordings or Tampering with Electronic Monitoring Device

A facility or staff of the facility may not access any video or audio recording created through an authorized electronic monitoring device placed in a resident's room without the written consent of the resident or resident representative or court order.

It is a Class B Misdemeanor to intentionally hamper, obstruct, tamper with or destroy a recording or an authorized electronic monitoring device placed in a resident's room without the express written consent of the resident or resident representative. Use or disclosure of a tape or other recording made by a resident's electronic monitoring device, without the resident's written consent may be a crime or a violation of law by invading the privacy rights of another.

Recordings obtained through an electronic monitoring device which are not in

compliance with North Dakota law, or which have been altered in some way without the consent of the resident or the resident's representative cannot be used in any civil proceeding, administrative proceeding or survey process. All recordings used in any proceedings or survey process must be date and time stamped.

No recordings or portion of a recording may be shared or posted on any social media.

All documentation and recordings related to the use of Electronic Monitoring shall be maintained in accordance with the facility's record retention policies and practices.

References:

N.D. Cent. Code §50-10.2

North Dakota Administrative Rules Section 75-03-40

Basic Care & Assisted Living

Transfer and Discharge Rights

Questions & Answers

Revised 01/2017

The NDLTCA requested that answers to commonly asked questions regarding the Requirements for Transfer and Discharge be provided to all facilities in writing.

This information was compiled in 1994 by:
Jo Hildebrant, State Ombudsman, ND Department of Human Services, Division of Aging Services
Joan Coleman, ND Department of Health, Division of Health Facilities

Reviewed/Revised in 1998 by:
Joan Coleman, ND Department of Health Facilities, Division of Health Facilities
Helen Funk, State Ombudsman, ND Department of Human Services, Division of Aging Services
Lloyd Suhr, ND Department of Human Services, Legal Advisory Unit

Reviewed/Revised in 2010 and 2013 by:
Joan Ehrhardt, State Ombudsman, Division of Aging Services
Joan Coleman, ND Department of Health, Division of Health Facilities

Reviewed/Revised August 14, 2014 by:
Joan Ehrhardt, State Ombudsman, ND Department of Human Services
Lucille Rostad, Manager, Division of Health Facilities, ND Department of Health

Reviewed/Revised December 2016 by:
Karla Backman, State LTC Ombudsman, Division of Aging Services, ND Department of Human Services
Joan Coleman, Division of Health Facilities, ND Department of Health

Reviewed/Revised for Basic Care and Assisted Living Facilities January 2017 by:
Karla Backman, State LTC Ombudsman, Division of Aging Services, ND Department of Human Services
Joan Coleman, Division of Health Facilities, ND Department of Health

Disclaimer

The information provided in this document is only intended to be a general summary, and not intended to take the place of statutes, regulations, rules, and/or other policy materials. Please review the specific statutes, regulations, rules, and other interpretive materials for a full and accurate statement of their contents. Any future revisions/updates made by the North Dakota Department of Human Services could result in portions of this document no longer being correct/accurate.

50-10.2-01. Definitions [Basic Care and Assisted Living]

"Department" means the department of human services.

"Facility" means a skilled nursing care facility, **basic care facility**, **assisted living facility**, or swing-bed hospital approved to furnish long-term care services.

"Immediate family" means husband, wife, father, mother, brother, sister, son, daughter, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, stepchild, uncle, aunt, niece, nephew, or grandchild.

"Resident" means a person residing in a facility.

50-10.2-02. Residents' Rights – Implementation [Basic Care and Assisted Living]

1. All facilities shall, upon a resident's admission, provide in hand to the resident and a member of the resident's immediate family or any existing legal guardian of the resident a statement of the resident's rights while living in the facility. Within thirty days after admission, the statement must be orally explained to the resident and, if the resident is unable to understand, to the resident's immediate family member or members and any existing legal guardian of the resident, and thereafter annually so long as the resident remains in the facility. The statement must include rights, responsibilities of both the resident and the facility, and rules governing resident conduct. Facilities shall treat residents in accordance with provisions of the statement. The statement must include provisions ensuring each resident the following minimum rights: . . .

l. The right not to be transferred or discharged except for:

(1) Medical reasons;
(2) The resident's welfare or that of other residents;
(3) Nonpayment of one's rent or fees; or
(4) A temporary transfer during times of remodeling.

m. The right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility or the resident's own home, or when the resident is being transferred or discharged because of a change in the resident's level of care; however, advance notice of transfer or discharge may be less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility. . . .

o. The right to a claim for relief against a facility for any violation of rights guaranteed under this chapter.

Chapter 75-02-07.1 Ratesetting for [Basic Care Facilities] published by the North Dakota Department of Human Services states the following:

75-02-07.1-01. Definitions.
"Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

"Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the facility premises.

"Facility" means a provider licensed as a basic care facility, not owned or administered by state government, which does not meet the definition of an Alzheimer's and related dementia facility, traumatic brain injury facility, or institution for mental disease, which is enrolled with the department as a basic care assistance program provider.

"Medical care leave day" means any day that a resident is not in the facility but is in a licensed health care facility, including a hospital, swing bed, nursing facility, or transitional care unit, and is expected to return to the facility.

"Resident" means a person who has been admitted to the facility but not discharged.

"Therapeutic leave day" means any day that a resident is not in the facility or in a licensed health care facility.

Chapter 75-02-07.1-04. Participation Requirement [Basic Care]

- A facility may not receive aid to vulnerable aged, blind, and disabled person's assistance payments unless it complies with all provisions of this section.
- A facility may charge to hold a bed for a period in excess of the periods covered under subsection 2 or 3 of section 75-02-07.1-05 if:
  - The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge; and
  - For an eligible beneficiary, the payment comes from sources other than from the beneficiary's monthly income.
- A facility may not violate any resident rights as set forth in North Dakota Century Code section 50-10.2-02.

Chapter 75-03-34 Licensing of Assisted Living Facilities - 75-03-34-01. Definitions [Assisted Living]
"Assisted living facility" means a building or structure containing a series of at least five living units operated as one entity to provide services for five or more individuals who are not related by blood, marriage, or guardianship to the owner or manager of the entity and which is kept, used, maintained, advertised, or held out to the public as a place that provides or coordinates individualized support services to accommodate the individual's needs and abilities to maintain as much independence as possible. An assisted living facility does not include a facility that is a congregate housing facility, licensed as a basic care facility, or licensed under chapter 23-16 or 25-16 or section 50-11-01.4.

Chapter 75-03-34 Licensing of Assisted Living Facilities - 75-03-34-02. Licensing [Assisted Living]
4. In order to receive and maintain a license, an assisted living facility shall:
   d. Certify that operation of its facility is in compliance with all applicable federal, state, and local laws . . .

1. QUESTION:

What requirements must basic care and assisted living facilities follow in regard to a transfer or discharge?

ANSWER:

Requirements of North Dakota Century Code Chapter 50.10.2.

2. QUESTION:

Define a transfer versus a discharge.

ANSWER:

N.D. Administrative Code 75-01-03-08.1 (1) defines discharge and transfer as:

- "Discharge" means movement from a facility to non institutional setting when the discharging facility ceases to be legally responsible for the care of the resident. (Examples include but are not limited to: resident's home, adult foster care, children's home).

- "Transfer" includes movement from a facility to another institutional setting when the legal responsibility for care of the resident changes from transferring facility to the receiving institutional setting. (Examples include but are not limited to: hospital, another basic care facility, swing bed unit, ICF for Individuals with Intellectual Disabilities (IID).

PLEASE NOTE: Transfer and discharge includes movement of a resident to a bed outside of the licensed facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same licensed facility (i.e. a room change in the same licensed facility).

3. QUESTION:

What does the contents of the written notice for transfer or discharge need to include?

ANSWER:

NDCC 50-10.2-02 (1.)(m) states that residents in a skilled nursing care facility, basic care facility, assisted living facility and swing-bed hospital have the right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility or the resident's own home, or when the resident is being transferred or discharged because of a change in the resident's level of care; however, advance notice of transfer or discharge may be less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

NDCC 50-10.2 does not specify the contents of the written notice for transfer or discharge.

It is recommended the contents of the written notice include:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- The location to which the resident is transferred or discharged;
- Transfer and discharge rights;
- The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

  State Long-Term Care Ombudsman
  Aging Services Division
  1237 W Divide Ave Ste 6
  Bismarck, ND 58501-1208
  dhsagingombud@nd.gov
  701-328-4617 or 1-855-462-5465

- For residents with intellectual and developmental disabilities, and/or with a mental disorder, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of these individuals (established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq. and the Protection and Advocacy for Mentally Ill Individuals Act); and

  Office of Protection and Advocacy
  400 E Broadway Ste 409
  Bismarck, ND 58501-4071
  panda_intake@nd.gov (underscore between panda and intake)
  701-328-2950 or 1-800-472-2670

- The names of who received the notice (i.e. the resident **and** the member of the resident's immediate family or any existing legal guardian of the resident), and the dates when the notice was provided to these appropriate parties.
- In addition, if the information in the notice changes prior to effecting the transfer or discharge, the facility should update the recipients of the notice as soon as practicable once the updated information becomes available.

To meet the rule, it is important the contents of the written notice be in a language and manner the resident **and** a member of the resident's immediate family or any existing legal guardian of the resident understands. Key issues to consider would be language barriers, visual handicaps (i.e. notice should be typed using at least a 12 point font), and physical limitations.

PLEASE NOTE: There are no appeal rights for basic care and assisted living residents, so information related to appeals should not be included in their transfer or discharge notices.

4. QUESTION:

A 30 day notice must be issued for a change in a resident's level of care. Can a resident be transferred to a higher level of care prior to 30 days, if the resident agrees to the transfer?

ANSWER:

Yes. A 30 day notice must be issued for a change in the resident's level of care. However, the resident can agree to the transfer prior to the end date of the notice.

5. QUESTION:

At what point in time is the written transfer or discharge notice given?

ANSWER:

The state requirements are as follows:

NDCC 50-10.2-01 (3) defines facility as "a skilled nursing care facility, **basic care facility**, **assisted living facility**, or swing-bed hospital approved to furnish long-term care services." The rights of residents in these health care facilities related to provision of the written transfer or discharge notices is as follows:

NDCC 50-10.2-02 (1.)(m) states the right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility or the resident's own home, or when the resident is being transferred or discharged because of a change in the resident's level of care; however, advance notice of transfer or discharge may be less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

North Dakota Department of Health, Division of Health Facilities finds it acceptable if, for example, a resident is transferred on an emergent basis for medical reasons, or incompatibility which affects a resident's welfare or that of another on Saturday early a.m. but the transfer notice is not given until Monday morning (approximately 32-36 hours later). This will meet the requirements for provision of the written transfer notice in skilled nursing facility, basic care facility, assisted living facility, or swing-bed hospital consistent with NDCC 50-10.2-02(1)(m) discussed above.

There are also times when a resident is transferred to a hospital, and based on assessment, the determination is made that the resident's needs exceed the services that can be provided by the skilled nursing facility, basic care facility, assisted living facility, or swing-bed hospital on more

than a temporary basis. In this instance, the facility should notify the resident and a member of the resident's immediate family or any existing legal guardian of the resident as soon as the determination is made, and then issue a written discharge notice.

6. QUESTION:

Who has to receive the transfer notice when a resident is hospitalized?

ANSWER:

The state requirements for skilled nursing care facilities, basic care facilities, assisted living facilities and swing-bed hospitals at NDCC 50-01.2-02 (1) identify that the resident **and** a member of the resident's immediate family or any existing legal guardian of the resident should be notified of the residents rights. This would include notification of transfers and discharges.

7. QUESTION:

Will a telephone call to the hospitals discharge planner constitute a discharge or transfer notice?

ANSWER:

No. NDCC 50-10.2-02 (1.) (m) states the notification must be in writing. Therefore a telephone call **does not** constitute an acceptable transfer or discharge notice.

8. QUESTION:

If facility staff feel a resident is not capable of understanding the discharge or transfer notice, then does a notice need to be given to the resident?

ANSWER:

Yes. NDCC 50-10.2-02 (1.) (m) states, in part, ". . . each resident the following minimum rights: ... The right to receive at least a thirty-day written advance notice of any transfer or discharge . . ."

The resident and a member of the resident's immediate family or any existing legal guardian of the resident is to receive a written notice. This requirement **does not** allow for facility staff to determine which residents have the cognitive or physical status to receive a transfer or discharge notice.

9. QUESTION:

Does anyone, including a resident, resident representative, a durable power of attorney for health care, or a guardian, have to sign the transfer/discharge notice?

ANSWER:

No. NDCC 50-10.2-02 states, the resident and a member of the resident's immediate family or any existing legal guardian of the resident is to be notified of a transfer or discharge in writing. This requirement **does not** require a transfer or discharge notice be signed by a resident and/or a member of the resident's immediate family or any existing legal guardian of the resident.

The facility **does need** to demonstrate that the requirements in 50-10.2-02 regarding transfer and discharge rights are met, however the facility has various options available to demonstrate compliance with these regulations. The provision that a resident and a member of the resident's immediate family or any existing legal guardian of the resident sign the notices would be a facility policy to verify that a transfer or discharge notice was given to the resident and a member of the resident's immediate family or any existing legal guardian of the resident.

10. QUESTION:

Can a facility transfer or discharge a resident due to a "significant change" in the resident's condition, or if a resident "refuses treatment?"

ANSWER:

The facility is prohibited from initiating a transfer or discharge unless at least one of the four criteria stated in NDCC 50-10.2-02 are met. The four criteria are as follows:

- Medical reasons;
- The resident's welfare or that of other residents;
- Nonpayment of one's rent or fees; or
- A temporary transfer during times of remodeling.

Therefore, unless a "significant change" in the resident's condition or unless a resident who is "refusing treatment" meets at least one of the four criteria listed above, the facility may not transfer or discharge a resident.

11. QUESTION:

Does a transfer notice have to be given to a resident who is being transferred to a psychiatric unit in a hospital because his/her welfare cannot be met in the basic care or assisted living facility? When should this notice be given?

ANSWER:

- Yes a transfer notice must be given. A facility is prohibited from initiating a transfer or discharge unless at least one of four criteria at NDCC 50-10.2-02 are met. Two of the four criteria are:
    - Medical reasons;
    - The resident's welfare or that of other residents;

If the facility initiates a transfer or discharge based on these reasons or any of the other criteria outlined at NDCC 50-10.2-02, the facility must provide notice in accordance with the requirements at NDCC 50-10.2-02.

- The timing of the notice depends upon specific circumstances regarding the resident condition. NDCC 50-10.2-02 (1.)(m) states the right to receive at least a thirty-day written advance notice of any transfer or discharge when the resident is being discharged to another facility or the resident's own home, or when the resident is being transferred or discharged because of a change in the resident's level of care; however, advance notice of transfer or discharge may be less than thirty days if the resident has urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

12. QUESTION:

Does a transfer or discharge notice have to be given if it is the resident's choice to be discharged to their home, a board and care facility, or another basic care facility?

ANSWER:

Transfer and Discharge requirements apply when the facility **initiates** the transfer or discharge. The purposes of the requirements are to ensure that residents remain in the facility in the absence of any of the four criteria in NDCC 50-10.2-02 and to inform residents of their rights to question the decision of a facility relating to their transfer or discharge. If a resident or a member of the resident's immediate family or any existing legal guardian of the resident **initiates** a transfer or discharge voluntarily, then these requirements do not apply.

13. QUESTION:

Clarify the difference between a resident's choice to be transferred or discharged, and a facility's choice to transfer or discharge a resident.

ANSWER:

A resident's choice to be transferred or discharged is when a resident or a member of the resident's immediate family or any existing legal guardian of the resident initiates the transfer or discharge voluntarily. Transfer and discharge requirements do not apply in this circumstance. If there is documentation in the resident record that the resident or a member of the resident's immediate family or any existing legal guardian of the resident initiated the transfer or discharge and is in agreement with the transfer or discharge, then this is sufficient.

A facility's choice to transfer or discharge a resident is when the facility initiates (i.e. starts the discussion about) the transfer or discharge. The facility is prohibited from initiating a transfer or discharge unless at least one of four criteria stated in NDCC 50-10.2-02 are met. If the facility initiates a transfer or discharge based on at least one of the four criteria, the facility must provide

notice in accordance with the requirements.

- ✓ Initiated voluntarily (by a resident or a member of the resident's immediate family or any existing legal guardian of the resident) means **the facility has not influenced the decision to transfer or discharge in any way**.

14. QUESTION:

When a resident goes on therapeutic leave, does a discharge or transfer notice need to be given?

ANSWER:

No. A transfer or discharge notice **does not** need to be given when a resident goes on therapeutic leave.

15. QUESTION:

Can a resident waive his/her right to an involuntary 30 day transfer or discharge notice?

ANSWER:

No. A resident cannot waive any of his/her rights under the rules/requirements.

16. QUESTION:

Does a notice of transfer need to be provided to a resident and a member of the resident's immediate family or any existing legal guardian of the resident, when a resident is going to receive outpatient services?

ANSWER:

A notice of transfer for hospitalization does not need to be provided when a resident is going to receive outpatient services if the resident is not staying overnight in the hospital.

- ✓ A notice of transfer does not need to be given for a 23 hour hold.

17. QUESTION:

If a resident is hospitalized, can a facility say they will not allow the resident to return to the facility due to the fact they cannot provide the services this resident needs?

ANSWER:

Basic Care
NDCC 23-09.3-08.1 Admission of Residents to Basic Care Facility – Restrictions states the following: A basic care facility may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's practicable level of functioning. A basic care facility may admit or retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements.

Basic care facilities must follow their policies and procedures on transfer, discharge, discharge planning, and referral services that are required through NDAC 33-03-24.1-09

Assisted Living
Chapter 75-03-34 Licensing of Assisted Living Facilities - 75-03-34-02. Licensing states,
4. In order to receive and maintain a license, an assisted living facility shall:
b. Maintain a written agreement with each tenant that includes the rates for rent and services provided to the tenant, payment terms, refund policies, rate changes, tenancy criteria, and living unit inspections;
d. Certify that operation of its facility is in compliance with all applicable federal, state, and local laws . . .

Chapter 50-32 Assisted Living Facilities - 50-32-05. Assisted living facilities - Duties - Educational requirements states,
1. Each assisted living facility must have clear, concise, and understandable tenancy criteria that is fully disclosed to all tenants, in writing, before the tenancy agreement is signed. Before a facility unit is rented, the facility or landlord shall evaluate the tenant's ability to meet the facility's tenancy criteria.

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BASIC CARE AND ASSISTED LIVING
GUIDE FOR IMPLEMENTATION OF TRANSFER OR DISCHARGE REQUIREMENTS

1. Each facility must develop facility policies and procedures for transfer or discharge.

2. The notice is to be written in a language and manner the resident and a member of the resident's immediate family or any existing legal guardian of the resident understands. Be conscientious of language barriers, visual barriers, and/or physical limitations.

3. The notification form should be typed using at least 12 point font and include the facility identification information (name and location).

One (1) transfer and discharge form has been developed for Basic Care and Assisted Living. This is not a required form. Basic Care and Assisted Living Facilities can develop their own transfer and discharge notices, as long as it meets all of the requirements. The notice was designed to print 2-sided.

GUIDELINES FOR COMPLETING TRANSFER AND DISCHARGE NOTICE

Facility identification information: Enter your facility name and location.

Resident Name: Enter resident's full name.

Transfer or Discharge Information: Under this section, you need to:

1. Check one (1) of the authorized reasons for the transfer or discharge as specified in NDCC 50-10.2-02.
   - ☐ Medical reasons;
   - ☐ The resident's welfare or that of other residents;
   - ☐ Nonpayment of one's rent or fees; or
   - ☐ A temporary transfer during times of remodeling.

2. Enter the location (i.e. place and town/city) where the resident is being transferred or discharged. Location must be appropriate and able to meet the resident's needs (i.e., the resident's home, swing bed, nursing facility, or basic care (facility);
3. Enter the date the transfer or discharge will occur; and
4. Enter the specific reason(s) for the transfer or discharge.

Persons Notified:

Resident: Enter resident's name and date the notice was given to the resident.
Resident Representative(s): Enter name(s) of the member of the resident's immediate family or any existing legal guardian of the resident, and the date the notice was given to this person.
Facility Representative Who Completed the Form: The person completing the form must sign and date it.

The original notice must be given to the resident, with a copy given to a member of the resident's immediate family or any existing legal guardian of the resident, and a copy placed in the resident's record.

Developed January 2017 by Joan Coleman, Health Facilities and Karla Backman, State Long-Term Care Ombudsman.

Developed: 01/2017

NOTICE OF TRANSFER OR DISCHARGE

From: (facility name and location) _____

To: (resident's name): _____

Transfer or Discharge Information:

Authorization for this transfer or discharge is specified in NDCC 50-10.2-02. **CHECK ONE BOX**

- ☐ Medical reasons;.
- ☐ The resident's welfare or that of other residents;
- ☐ Nonpayment of one's rent or fees; or
- ☐ A temporary transfer during times of remodeling.

You are being transferred or discharged to (specific location) _____

on (date) _____ because (specific reason(s) _____

_____

Transfer and Discharge Rights:
You have the right to receive at least a thirty-day written advance notice of any transfer or discharge when you are being discharged to another facility or your own home, or when you are being transferred or discharged because of a change in your level of care; however, advance notice of transfer or discharge may be less than thirty days if you have urgent medical needs that require a more immediate transfer or discharge, or a more immediate transfer or discharge is required to protect the health and safety of residents and staff within the facility.

Questions on Transfer and Discharge Rights:

If you have questions on your transfer and/or discharge rights, you may contact:

State Long-Term Care Ombudsman
Aging Services Division
1237 W Divide Ave Ste 6
Bismarck, ND 58501-1208
dhsagingombud@nd.gov
701-328-4617 or 1-855-462-5465

If you are a resident with intellectual and developmental disabilities or related disabilities, or a mental disorder or related disabilities, you may also contact:

Office of Protection and Advocacy
400 E Broadway Ste 409
Bismarck, ND 58501-4071
panda_intake@nd.gov (underscore between panda and intake)
701-328-2950 or 1-800-472-2670

Persons Notified In Writing:

_____ _____
(Resident) (date)

_____ _____
(Resident Representative) (date)

_____ _____
(Facility Representative Who Completed Form) (date)

Resident Rights Guidelines

The facility's policies and procedures on Resident rights are reviewed as part of the survey process or in the event of a complaint by surveyors and/or ombudsmen. Following are suggested guidelines for developing practices, policies and procedures.

- Facility documents that Resident Rights information has been provided to a resident upon admission and annually thereafter
- Facility explains Resident Rights information within 30 days of admission
- Resident receives a copy of rules governing resident conduct
- Facility has a grievance process and documents a resident receives a copy of the process
- When Facility manages resident's money:
    - Facility receives written delegation to manage funds
    - Resident funds are held in an interest bearing account separate from Facility operating funds (resident's funds may be comingled with other residents' funds)
    - Resident receives a quarterly statement of transactions
- Facility provides a written list of services, including ancillary charges to resident upon admission and whenever changes are made
- Facility receives written agreement by a resident to perform services on behalf of the facility and such services are part of the resident's plan of care
- Facility displays a notice that the following information is available for public view and is available upon request:
    - A complete copy of every inspection report, deficiency report, and plan of correction received during the previous two years
    - The facility's grievance policy
    - A copy of the statement of ownership, board membership and partners
    - A statement of ownership setting forth any conflict of interest in the operation of the facility.
- Facility documents the resident's right to choose a pharmacist of choice
- Facility provides written notice of transfer and discharge
- Facility provides written procedures on electronic monitoring

Section 4
End of Life Care

NORTH DAKOTA
DEPARTMENT of HEALTH

HEALTH RESOURCES SECTION
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
Fax: 701.328.1890
www.ndhealth.gov

MEMORANDUM

TO: Shelly Peterson, NDLTCA President

FROM: Lucille Rostad Lucille Rostad

DATE: December 11, 2015

TOPIC: Hospice Services in a Basic Care Facility NOT Licensed to provide End of Life Care Services

This memorandum is in response to your request for clarification related to how long a resident electing Hospice Services can stay in a Basic Care facility that is not licensed to provide End of Life Care Services.

A resident in a Basic Care facility can elect Hospice Services and stay in a Basic Care facility that is not licensed for End of Life Care Services as long as the resident meets the basic care level of care.

What does this mean?

NDCC 23-09.3-08.1 Admission of residents to basic care facility – Restrictions. A basic care facility may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning. A basic care facility may admit and retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements.

This statute is further clarified in North Dakota Administrative Code 33-03-24.1-01. Definitions. 2., 5., 6., and 16. Based on this information, the admission and retention criteria for a resident in a Basic Care facility includes that the individual may need assistance with activities of daily living which means that the resident is able to help with most of an activity, but cannot do it entirely alone. This includes eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.

The decision of some Basic Care facilities to provide twenty-four-hour a day nurse staffing should not be interpreted to mean that the resident's condition requires twenty-four hour a day nursing care. If the resident declines to the level where continuous, twenty-four-hour a day nursing or medical care is needed, the individual can no longer assist with their own activities of daily living, or the resident is no longer capable of self preservation, with or without assistance, the resident is no longer appropriate to remain in a Basic Care facility.

In summary, a basic care resident can elect to receive Hospice Services and stay in a Basic Care facility that is not licensed to provide End of Life Care Services, until the resident no longer meets the definition of a basic care resident as discussed above, and the care required exceeds the basic care level. If a Basic Care facility becomes licensed to provide End of Life Care Services, the resident who elects Hospice Services would be able to remain in the facility even when the resident exceeds the basic care level of care and requires skilled nursing care.

If you have questions, please contact Lucille Rostad at 701-328-2352.

Basic Care Networking Session
Basic Care Facility Admission Requirements & End of Life Care
September 13th, 2018

Basic Care - Who Can You Admit?

NDCC 23-09.3-08.1 Admission of residents to basic care facility – Restrictions.
"A basic care facility may admit and retain only an individual for whom the facility provides, directly or through contract, appropriate services within the facility to attain or maintain the individual at the individual's highest practicable level of functioning. A basic care facility may admit and retain only an individual whose condition and abilities are consistent with the national fire protection association 101 life safety code requirements."

So what does that mean?

Based on NDAC 33-03-24.1-01. Definitions. 2., 5., 6., and 16., the admission criteria to a Basic Care Facility, by statute and regulation includes that the individual:

- May need assistance with activities of daily living, which means that the resident is able to help with most of an activity but cannot do it entirely alone. This includes eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.

- May need supervision of nutrition and medication management.

- Is capable of self-preservation, with or without assistance; and

- Does not have a condition that requires continuous, twenty-four-hour a day nursing or medical care.

This criteria can also be viewed as the discharge criteria. When the resident no longer meets the above criteria, placement in another setting needs to be considered.

Basic Care – When Do You Discharge?

- As a resident's condition declines, the basic care facility needs to consider if the resident is still at the basic care level of care and the facility's ability to continue to meet the needs of the resident; and the ramifications to the facility's E-score if a resident is kept beyond the basic care level of care.

- Basic care is not skilled care. Each level of care was designed to meet resident needs at a specific level of care.

- It is expected that Basic Care Facilities develop and implement discharge criteria to ensure that residents are not retained longer than appropriate for a basic care facility.

- Basic care facilities are required to assist the resident to attain or maintain their highest level of functioning based on the assessment and care plan.

- The services provided by the facility can be provided either directly or by contract.

End of Life Services in Basic Care

Definition:

- "End of life care" (in a basic care facility) "means a program of palliative and supportive care for a resident with a physician or nurse practitioner's order identifying a terminal illness or condition with a limited prognosis of six or fewer months to live that has elected to receive hospice services through a licensed and Medicare certified hospice agency".

Key Concepts:

- A basic care facility that intends to retain residents who require end of life care must meet the requirements, apply for the end of life care license as specified by the department, and receive written approval from the department prior to providing the services.

- Individuals in need of end of life care who require skilled nursing care or are not capable of self-preservation may not be admitted. (This optional service is for existing basic care residents).

- The basic care facility and the licensed and Medicare certified hospice agency shall enter into an agreement that delineates responsibilities, with the hospice agency retaining the professional responsibility for the hospice service.

- An interdisciplinary care plan is to be developed and implemented.

- Department is to be notified within 48 hours of election of hospice, the name of the resident, date hospice was elected, and name of hospice agency.

- Facility to notify department within 48 hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable for self-preservation.

- Facility required to be equipped with an approved sprinkler system or meet the NFPA 101 LSC, 2012 ed., health care occupancy requirements.

- Facility evacuation or E scores shall be completed a minimum of weekly or when there is a significant change in the resident's condition. Staffing to be adjusted based on E scores.

- Hospice staff, family members, volunteers, or other non-facility staff cannot replace required facility staff.

- The care must be under supervision of an RN and the facility must have 40 hours Licensed Nurse onsite coverage each week.

- Basic care staff training related to end of life services must be completed for all nursing and personal care staff prior to department approval, within 30 days of employment, and annually.

- If the facility is unable, or becomes unable, to meet the needs of the resident, the resident rescinds election of the hospice benefit, or the facility is unable to comply with these requirements, the facility shall make arrangements to discharge or transfer the resident to a safe/appropriate environment.

Basic Care Facility Requirements for Provision of End of Life Services Including Sprinklers and E-Scores

33-03-24.1-23. Optional End of Life Care Services.

●A facility that retains a resident requiring end of life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 life safety code, 2012 edition, health care occupancy requirements.

●Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self-evacuation when a resident is receiving end of life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation, capability. Hospice staff, family members, volunteers, or other non-facility staff cannot replace required facility staff.

Roles and Responsibilities of the Basic Care Facility Application and Notification

●A basic care facility that intends to retain residents who require end of life care must complete an application, and receive written approval from the department prior to providing the services.

●A basic care facility must notify the department within 48 hours of election, the name of the resident, the date hospice was elected, and the name of the hospice agency.

●A basic care facility must notify the department within 48 hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable of self-preservation.

Nursing Coverage

●A basic care facility that is providing hospice care to a resident must ensure supervision by an RN and provide 40 hours of licensed nurse onsite coverage each week.

Staff Training

●A basic care facility that provides end of life care must ensure staff training in the following areas:

1. Universal precautions
2. Assistance with ambulation, including transfers using a gait belt
3. Changing an occupied bed
4. Partial bed bath
5. Repositioning
6. Toileting using a bedpan/commode
7. Catheter care and emptying urinary drainage bag

APPLICATION FOR THE OPTIONAL SERVICES OF END OF LIFE CARE IN A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60906 (04-15)

DEPARTMENT USE ONLY

License Number
Bed Capacity
Licensure Period

This form does not replace your Basic Care Facility Licensure Application. Need to complete Attestation.

INSTRUCTIONS: Type or print clearly. Attach other information as requested with the application. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200. Keep a copy for your records.

Official Name of Basic Care Facility		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	Bed Capacity
E-Mail Contact	E-Mail Address		

MANAGEMENT AND PERSONNEL

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Name of Basic Care Facility's General Liability Insurance Company		Name of Agent	
Mailing Address of Agent	City	State	ZIP Code
Name of Administrator			
Name and Title of Emergency Contact		Emergency Contact's Cell Phone Number	

PLEASE ATTACH A COPY OF THE FACILITY'S POLICY AND PROCEDURES REGARDING END OF LIFE CARE.

Applicant agrees to the following when providing end of life care to one or more residents:

1. To complete E-Scores weekly or with a significant change in the resident's evacuation capability and adjust facility staffing accordingly;
2. To provide 40 hours of onsite licensed nurse staffing;
3. To submit initial notification to the department when the resident elects end of life;

ATTESTATION OF COMPLIANCE WITH THE LICENSURE REQUIREMENTS TO PROVIDE OPTIONAL SERVICES OF END OF LIFE CARE IN A BASIC CARE FACILITY

Facility			
Address	City	State	ZIP Code

Prior to providing end of life care to any resident in the basic care facility this form must be completed and submitted with the requested information to the Department of Health (DOH) for approval. DOH will review your submitted information. Upon approval DOH will provide a new license identifying that the optional services of end of life care in the basic care facility has been approved.

Provide an answer or submit the requested information to DOH:

1. The facility has a written agreement with a state licensed and Medicare certified hospice provider delineating responsibilities? ☐ Yes ☐ No

Provider's Name

A written agreement is required for each certified hospice provider chosen by the resident or family. Availability of the written agreement(s) will be requested at the time of the survey.

2. The required staff education training has been completed within the required time frames? ☐ Yes ☐ No

The documentation for the staff training will be reviewed at the time of the survey. The training must include, but is not limited to:

- Ambulation assistance, including transfers with a gait belt;
- Universal precautions;
- Changing an occupied bed;
- Repositioning;
- Toileting using a bedpan/commode;
- Partial bed bath;
- Catheter care and emptying a urinary drainage bag;
- Hospice philosophy;
- Ethical and privacy consideration;
- Hospice eligibility and services;
- Communication techniques;
- Spiritual care services;
- Bereavement and grief explorations; and
- Alternative therapies.

3. Is the facility located in a building that meets the health care occupancy requirements of the Life Safety Code? ☐ Yes ☐ No

4. Is the facility located in a building equipped with a NFPA 13 or 13R automatic sprinkler system? ☐ Yes ☐ No

5. Does the facility have additional staffing available to respond to changes in E-scores as the resident's condition changes? ☐ Yes ☐ No

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility with the optional service of end of life care subject to the provisions of North Dakota Century Code Chapter 23-09.3 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Administrator's Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	

NOTIFICATION TO THE DEPARTMENT OF HEALTH REGARDING THE PROVISION OF END OF LIFE SERVICES TO A BASIC CARE RESIDENT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60907 (04-15)

Optional Service of End of Life Care for Basic Care residents who have elected Hospice services. Notification to the Department of Health must occur within 48 hours of the resident electing hospice services or upon discharge, transfer, death, or when the resident is no longer capable of self-preservation.

Provider's Name		Telephone Number	
Address	City	State	ZIP Code
Total number of residents receiving end of life services (including this resident)			

INITIAL NOTIFICATION

Provide the following dates:	
Date	When the physician identified the terminal illness.
Date	When the resident elected Hospice.
Date	When the hospice services were implemented in the basic care facility.
Date	When the required training and competency evaluation was completed.
Date	When the contract was signed with the Medicare Certified Hospice agency chosen by the resident or family members.

Contact Person for the Medicare Certified Hospice Agency		Telephone Number	
Address	City	State	ZIP Code

THE RESIDENT IS NO LONGER CAPABLE OF SELF-PRESERVATION

On what date did the resident become no longer capable of self-preservation?	
Does the end of life plan of care provide for adequate 24 hour bedside care by facility staff?	☐ Yes ☐ No
E-Scores completed weekly and with a significant change in the resident's evacuation capability and facility staff adjusted accordingly.	☐ Yes ☐ No

FINAL NOTIFICATION

Provide the date for the resident's:		
Discharge Date	Transfer Date	Date of Death
Administrator's Signature		Date

Submit completed form to: North Dakota Department of Health
Division of Health Facilities
600 E Boulevard Ave, Dept. 301
Bismarck, North Dakota 58505-0200
Fax: 701.328.1890

Section 5 Pharmacy and Medication Administration

CHAPTER 61-03-02
CONSULTING PHARMACIST REGULATIONS FOR LONG-TERM CARE FACILITIES (SKILLED, INTERMEDIATE, AND BASIC CARE)

Section
61-03-02-01 Definitions
61-03-02-02 Absence of Provider or Consulting Pharmacist
61-03-02-03 Physical Requirements of Provider Pharmacy Licensed on Premises or Other Pharmacy
61-03-02-04 Distribution and Control

61-03-02-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Consulting pharmacist" means a pharmacist in a long-term care facility, who:
   a. Establishes the procedures and rules for distribution and storage of drugs;
   b. Supervises the distribution and storage of drugs;
   c. Visits the facility on a regularly scheduled basis;
   d. Monitors the therapeutic response and utilization of all medications prescribed for the patients, utilizing as guidelines the indicators of the health care financing administration;
   e. Provides regular pharmacy educational opportunities to the institution.
2. "Provider pharmacist" means a pharmacist who supplies medication to a patient in a long-term care facility and maintains separate pharmacy patient profiles from the facility.

History: Effective August 1, 1983.
General Authority: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)
Law Implemented: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

61-03-02-02. Absence of provider or consulting pharmacist.

1. **General.** During such time at the long-term care facility that the pharmacist is not available, arrangements shall be made in advance by the consulting and provider pharmacist for provision of drugs to the staff of the institutional facility by use of an emergency medication kit located at the facility.
2. **Emergency medication kit.**
   a. Emergency medications defined. Emergency medications are those medications which may be required to meet the immediate therapeutic needs of patients and which are not available from any other authorized source in sufficient time to prevent risk of harm to patients because of delay resulting from obtaining such medications from such other source.
   b. Supply pharmacist. All emergency medications shall be provided by a provider pharmacist.
   c. Medications included. The consulting pharmacist and the physicians representing the facility shall jointly determine and prepare a list of medications, by identity and quantity, to be included in such emergency supply. Such list of medications shall be reviewed quarterly by the pharmaceutical services committee. Only prepackaged drugs shall be available therein, in amounts sufficient for immediate therapeutic requirements.

d. Storage. The emergency medication kit shall be stored in areas suitable to prevent unauthorized access and to ensure a proper environment for preservation of the medications within them, as required in official compendia.

e. Labeling - Exterior. The exterior of an emergency kit shall be labeled to clearly and unmistakably indicate that it is an emergency drug kit and it is for use in emergencies only; such label shall also contain a listing of the name, strength, and quantity of the drugs contained therein and an expiration date.

f. Labeling - Interior. All drugs contained in the emergency medication kit shall be labeled in accordance with subsection 7 of North Dakota Century Code section 43-15-01.

g. Removal of medication. Medications shall be removed from the emergency medication kit only pursuant to a valid prescriber order and by authorized personnel, or by the provider pharmacist.

h. Notifications. Whenever an emergency medication kit is opened or has expired, the provider pharmacist shall be notified and the pharmacist shall replace the medication within a reasonable time so as to prevent risk of harm to the patients.

i. Expiration date. The expiration date of an emergency kit shall be the earliest expiration date on any drug supplied in the kit. Upon the occurrence of the expiration date, the provider pharmacist shall open the kit and replace expired drugs.

j. Procedures. The consulting pharmacist shall, in communication with the appropriate committee, develop and implement written policies and procedures to ensure compliance.

History: Effective August 1, 1983.
General Authority: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)
Law Implemented: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

61-03-02-03. Physical requirements of provider pharmacy licensed on premises or other pharmacy.

1. **Area.** The pharmacy serving a long-term care facility as an institutional drug outlet shall have floor space allocated to it to ensure that drugs are prepared in sanitary, well-lighted and enclosed places, and meet the other requirements of this section. Floor space shall be allotted to conduct the activities involved with the scope of pharmaceutical services provided.

2. **Equipment and materials.** The pharmacy serving a long-term care facility as an institutional drug outlet shall have equipment and physical facilities for proper compounding, dispensing, and storage for drugs, including parenteral preparations. As a minimum, the pharmacy shall have the following:

   a. Minimum equipment listed in section 61-02-01-03.

   b. Drugs to meet the needs of the patients of the long-term care facility.

   c. A pharmacy policy and procedures manual in compliance with section 61-02-01-18.

   d. Pharmaceutical reference books, which shall include one recent edition (not over five years from publication date) from at least two of the following categories, one of which must include dispensing information:

      (1) Drug dispensing information from one of the following:

         (a) United States pharmacopoeia dispensing information.

(b) Facts and comparisons.

(c) Hospital formulary.

(2) Categories to choose from:

Drug interactions - poison and antidote information - chemistry toxicology - pharmacology - bacteriology - sterilization and disinfection - patient counseling - rational therapy - parenteral admixtures.

3. **Drug room.** The drug room of a long-term care facility may utilize the technical equipment and other requirements of a licensed pharmacy for compliance.

4. **Storage.**

a. All drugs shall be stored in designated areas within the pharmacy to ensure proper sanitation, temperature, light, ventilation, moisture control, and security.

Unattended areas: In the absence of a pharmacist, and whenever any area of a pharmacy serving a long-term facility as an institutional drug outlet is not under the personal and direct supervision of a pharmacist, such areas shall be locked. All areas occupied by a pharmacy serving a long-term care facility as an institutional drug outlet shall be capable of being locked by key or combination, so as to prevent access by unauthorized personnel.

b. When drugs to be dispensed are stored in a long-term facility drug room, the consulting pharmacist shall verify that space will be available at each unit for storage, safeguarding, and preparation of medication doses for administration and shall include provision of at least the following:

(1) A locked drug cabinet or room shall be equipped to ensure physical separation of individual patient prescribed medications. Medications may be stored in these secured individual patient storage areas, or secured portable storage carts providing separate compartments for individual patients may be used.

(2) A container or compartment which is capable of securing controlled substances with a lock or other safeguard system shall be permanently attached to storage carts or medication rooms.

History: Effective August 1, 1983; amended effective October 1, 2014.
General Authority: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)
Law Implemented: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

61-03-02-04. Distribution and control.

1. General. The consulting pharmacist shall establish written procedures for the safe and efficient distribution of pharmaceutical products; which shall be on hand for inspections.

2. Responsibility of consulting pharmacist. The consulting pharmacist shall be responsible for the safe and efficient distribution of, control of, and accountability of medications by developing procedures subject to the approval of the pharmaceutical services committee of the long-term care facility, to include:

a. Establishment of specifications for the storage, distribution, and procurement of medications and biologicals.

b. Participation in those aspects of the long-term care patient evaluation program which relate to drug utilization and effectiveness.

c. Providing information on a twenty-four-hour basis for assistance in emergency situations.

d. Assuring all medication shall be stored in a locked area or locked cart.

e. Review, evaluate, and make recommendations monthly regarding drug utilization to the pharmaceutical services committee.

f. Minimum standards that all provider pharmacists must meet to include the following:

(1) Expected delivery times for new orders and reorders.

(2) Procedures to ensure accountability during delivery.

(3) Methods to document receipt of medications by the facility.

(4) Procedure to obtain emergency medications and for the provider pharmacist to receive orders.

(5) Procedures used by the facility to reorder medications and for the provider pharmacist to receive reorders.

(6) Expected scope of services and medications to be provided by the provider pharmacist. If the provider pharmacist cannot provide the complete scope of services and medications, the provider pharmacist shall designate alternative sources.

g. Procedures that allow for use of or repackaging of medications received which are not in the packaging system used by the facility.

h. Policy that is included as a part of the patient admissions packet that describes the responsibility of the patient or provider pharmacist to compensate a secondary pharmacist for medications or packaging services that the provider pharmacist chosen by the patient is either unwilling or unable to provide.

3. Responsibility of provider pharmacist. All provider pharmacists shall meet the minimum standards established by the consulting pharmacist.

4. Discontinued drugs.

a. The consulting pharmacist shall develop and implement policies and procedures to ensure that all discontinued or outdated drugs or containers with worn, illegible or missing labels are destroyed or disposed of so as to render them unusable. Controlled drugs shall be destroyed by the consulting pharmacist subject to guidelines and approval of the state board of pharmacy.

b. Controlled drugs shall be destroyed at the specific institution. Noncontrolled drugs may be destroyed at the institution or returned to the provider pharmacy, for possible credit or destruction. A log must be made when the drugs are discontinued. If drugs are destroyed at the institution, two professionals must sign the destruction log.

5. Practitioner's orders. A pharmacist shall review the medication order, or a copy thereof.

a. Authorization. Any licensed practitioner authorized by law to prescribe drugs within the scope of the practitioner's license may prescribe for the practitioner's patient in a long-term facility.

b. Abbreviations. Orders employing abbreviations or chemical symbols will be only those which are customarily used in the practice of medicine and pharmacy or those on a list of

approved abbreviations developed by the pharmaceutical services committee of the facility.

c. Requirements. Orders for drugs for use by patients of the facility shall, at a minimum, contain patient name, drug name and strength, directions for use, date of order, and name of prescriber. On the facility reorder form, include all of the above except for directions.

d. Emergency medication order. In cases where an emergency medication order is written when pharmacy services are unavailable, the medication order shall be reviewed by the pharmacist as soon as reasonably possible.

e. Verification. Verification of the accuracy of any medication dispensed and of any transcriptions made of that order shall be done by handwritten initials of the pharmacist so certifying.

f. Duration. The prescribed medications should be for a specific time.

6. An automated dispensing system is authorized for use in long-term care facilities to store controlled bulk drugs.

a. Drugs in the automated dispensing system are not considered dispensed until taken out by authorized personnel at the long-term care facility, once released by the pharmacy pursuant to a prescription.

b. Only single doses may be removed from the automated dispensing system at one time.

c. The pharmacy must have a separate drug enforcement administration number for the automated dispensing system at each location.

d. All records of dispensing must be kept at the central pharmacy.

e. The automated dispensing system shall permit access to only one controlled substance at each authorized entry.

f. Only retail pharmacies are authorized to use an automated dispensing system.

g. Pharmacies cannot share an automated dispensing system at a long-term care facility.

h. North Dakota controlled substance registration is required.

7. Controlled drug accountability. The consulting pharmacist shall establish and implement effective procedures and assure that adequate records be maintained regarding use and accountability of controlled substances which meet federal and state laws and regulations, and which shall at least specify the following:

a. Name of drug.

b. Dose.

c. Prescriber.

d. Patient.

e. Date and time of administration.

f. Person administering the drug.

8. Recall. The consulting pharmacist shall develop and implement a recall procedure that can readily be activated to assure the medical staff of the facility, the provider pharmacy, and the consulting pharmacist that all drugs included in the recall, located within the facility, are returned to the provider pharmacy for proper disposition.

9. Records and reports. The consulting pharmacist shall supervise the maintenance of such records and reports as are required to ensure patient health, safety, and welfare and, at a minimum, the following:

   a. Pharmacy patient profiles and medication administration records.

   b. Reports of suspected adverse drug reactions.

   c. Inspections of drug storage areas.

   d. Controlled drug and accountability reports, including board of pharmacy destroyed medication forms for controlled and noncontrolled medications.

   e. Such other and further records and reports as may be required by law and this chapter.

10. Labeling.

   a. All stock drugs intended for use within the facility shall be in appropriate containers and adequately labeled as to identify at a minimum: brand name or generic name and manufacturer, and strength. An internal code which centrally references manufacturer and lot number can be utilized.

   b. Whenever any drugs are added to parenteral solutions, whether within or outside the direct and personal supervision of a pharmacist, such admixtures shall be labeled with a distinctive supplementary label indicating the name and amount of the drug added, date and time of addition, expiration date, administration time and infusion rate when applicable, and name or initials of person so adding. This excludes any single dose medication prepared and totally administered immediately.

History: Effective August 1, 1983; amended effective October 1, 1999; December 1, 2003; October 1, 2007.
General Authority: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)
Law Implemented: NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

Guidance for Controlled Medication Counts

This guidance is intended for facilities where two nurses are not available to do a narcotic count yet a count for verification must be completed.

The first choice and best practice would be a nurse-to-nurse count at the end of each shift. However, this is not always possible or practical in Assisted Living facilities. In these circumstances, it is allowed that the two people counting the controlled substances be:

- Nurse to CMA
- CMA to CMA
- In the event that there are just CNAs or no overnight coverage, the last CMA or Licensed Nurse to have access to the narcotics must make sure that all narcotics are double locked and there will be no access to narcotics. A system must be in place to verify the narcotic count when another CMA or Licensed Nurse returns.

The licensed nurse must:

- Have an audit system in place where verification is made by a nurse confirming that the counts are being completed and are accurate. Example would be the nurse coordinator audits counts weekly.
- Have a procedure in place that if a count discrepancy occurs in the change of shift verification, an investigation is made immediately to determine the error by the staff person associated with the medication delivery system. If there was no CMA or Licensed staff to complete a shift verification, policies must be in place regarding how the facility will verify the narcotic count upon return of the CMA or Licensed Nurse and a procedure for any discrepancies.

If a count cannot be reconciled:

- Anyone associated with the administration or assistance of medication may not leave the facility. When the verification is completed upon the arrival of the CMA or Licensed Nurse as the prior shift was a CNA or no coverage, the last person having access to the narcotics will be called in. Only the charge nurse or Administrator may dismiss the staff person involved in the controlled medication count if a count discrepancy occurs.
- The on call nurse will be notified if needed.
- They must document on a Medication Error /Discrepancy Report and report any discrepancies to the Director of Nursing Services.

AT NO TIME SHOULD CNAs OR OTHER STAFF HAVE ACCESS TO CONTROLED SUBSTANCES WITHOUT A LICENSED NURSE OR CMA.

All of these items must be addressed in the policies and procedures of the facility

Options for Medication Management when a Resident Unexpectedly Goes out of a Facility on a Short Pass (Four hours or Less)

When a Resident or their Family Member unexpectedly requests medications to be prepared so they can go out on pass from the **Assisted Living Facility or Basic Care Facility** for a short period of time, not to exceed four hours, and there is no licensed nurse or practitioner available to prepare the medications, the following options can be implemented, consistent with facility policy.

Option 1. In situations where there is a licensed nurse working or on call, the licensed nurse could repackage medications consistent with the "Procedures for Residents/Patients Going on Pass from Long-Term-Care, including Basic Care and Assisted Living Facilities Guidelines" developed by the North Dakota Board of Pharmacy in conjunction with the North Dakota Board of Nursing and North Dakota Department of Health.

Option 2. The pharmacy or facility licensed nurse can prepared ahead of time for such occurrences. One day of medications for the resident can be prepared ahead of time for such occurrences, with medication placed in acceptable containers consistent with the facility's policies, and labeled with the resident's name, medication name(s) and dose, and time of administration.

If the resident or family member would like to take the resident out on short pass over a medication administration time, the medication aide could provide the resident or family member with the prepackaged medications prepared and labeled for this person by the pharmacist or licensed nurse for the four hour period, and document that the medications were sent with the resident or family.

Option 3. Medications may be given up to one hour before or one hour after the scheduled administration time. If possible, provide the resident with their medications prior to leaving the facility or when they get back if consistent with this timeframe.

Option 4. If the resident self administers his or her medications and uses the medi-planner, the resident may take the medi-planner with him or her and continue to take their medications as scheduled.

This memorandum was prepared by the North Dakota Department of Health, and reviewed and approved by staff from the North Dakota Board of Pharmacy and North Dakota Board of Nursing.

Release Date: April 1, 2014

PROCEDURES FOR RESIDENTS/PATIENTS GOING ON PASS FROM LONG-TERM-CARE, including Basic Care and Assisted Living Facilities

Developed by the North Dakota Board of Pharmacy in conjunction with the North Dakota Board of Nursing and the North Dakota Department of Health

The first choice in any resident medication administration scenario is for the provider pharmacy to package the medication and label it with a complete pharmacy label according to North Dakota Administrative Code 61-04-06 and North Dakota Century Code 19-02.1-14.1 subsection 2. It is the standard of practice for those administering medications to administer them out of a pharmacy labeled container; or if administered by a licensed nurse or practitioner out of a pharmacy labeled container or a manufacturer's original container.

This guidance is intended for instances where a proper pharmacy labeled container **cannot** be provided because the resident's family or others have arrived at the Long- term-care facility wanting to take the resident out on pass and there is not time or feasibility to provide a pharmacy labeled container for their medications.

Licensed Nurses:

In these circumstances, it is allowed that the licensed nurse may provide up to a 96 hour supply of medication in these exigent instances.

- These medications may be furnished to the resident, to the resident's family or caregiver who will accompany them during the pass.
- The medication can be provided in containers provided by the provider pharmacy or the Long-Term-Care facility.
- The facility must designate the types of acceptable containers in their policies.
- Multiple medications may be provided in the same container, if they are to be administered to the same resident and at the same time.
- The container must be labeled with a minimum of the resident's name, date, and time of administration.

The licensed nurse must:

- Provide a list of the resident's medications to the resident, the resident's family, or caregiver. This may be accomplished by printing a list from the nursing home medication administration record or in the alternative, if that is not possible, a typed or handwritten list of medications.
- The written list must include the name of the medication, the dosage, time of administration and of course, the resident's name.
- The name of the licensed nurse who prepared the medications and phone number for the facility, if questions arise, must be included on the medication list.

Child resistant packaging should be the first choice, unless the resident or their family requests an easy open container. This request must be documented by the licensed nurse.

All of the items above **must be** addressed in the policies of the long term care facility, including a procedure to identify any medication returned to the facility.

The Board of Nursing will not allow delegation by nurses for repackaging of medications by Unlicensed Assistive Person.

Supported by the North Dakota Board of Nursing- November 21, 2013.

CHAPTER 54-07-08
SPECIFIC DELEGATION OF MEDICATION ADMINISTRATION

Section
54-07-08-01 Specific Delegation

54-07-08-01. Specific delegation.

A licensed nurse who delegates the delivery of specific medication for a specific client to an unlicensed assistive person shall:

1. Supply organization procedural guidelines for the unlicensed assistive person to follow in the administration of medication by specific delegation.
2. Teach each unlicensed assistive person for each specific client's medication administration which includes verbal and written instruction for the specific client's individual medications:
   a. The trade name and generic name;
   b. The purpose of the medication;
   c. Signs and symptoms of common side effects, warnings, and precautions;
   d. Route of administration; and
   e. Instructions under which circumstances to contact the licensed nurse or licensed practitioner.
3. Observe the unlicensed assistive person administering the medication to the specific client until competency is demonstrated.
4. Verify the unlicensed assistive person's competency through a variety of methods, including oral quizzes, written tests, and observation. The nurse verifies that the unlicensed assistive person:
   a. Knows the six rights for each medication for the specific client:
      (1) Right client;
      (2) Right medication;
      (3) Right dosage;
      (4) Right route;
      (5) Right time; and
      (6) Right documentation.
   b. Knows the name of the medication and common dosage;
   c. Knows the signs and symptoms of side effects for each medication;
   d. Knows when to contact the licensed nurse;
   e. Can administer the medication properly to the client; and
   f. Documents medication administration according to organization policy.

5. Document the training of the unlicensed assistive person related to the specific delegation of medication administration for each client.

6. Evaluate the client when medication orders change and determine if further instruction for each unlicensed assistive person is necessary to implement the change.

History: Effective May 1, 1999; amended effective April 1, 2004.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(1)

Medication Assistants I or II

Medication Assistants I or II must be on the Department of Health's registry as a nurse aide or CNA and have a medication assistant registration on the registry. An individual must be a CNA to be registered as a CMA II.

On line registration is available. The initial application to register as a CMA I or II is SFN55962 Initial Application Medication Assistant I and II. The renewal application for an individual who is a nurse aide is SFN59965 Nurse Aide and Medication I Renewal and the renewal for an individual who is a CNA is SFN59966 CNA Registration and Medication I or II Renewal.

North Dakota Department of Health

Medication Assistant I

Scope of Delegated Medication Administration Statement

Registry Requirements:

- Must hold a current registration on the ND Department of Health Nurse Aide Registry as a Nurse Aide or Certified Nurse Aide prior to entry into the Medication Assistant I Training Program ,
- Must have completed a medication assistant I training and competency program (study and clinical practice in the administration of routine, regularly scheduled medications which meets the department's requirements), and
- Must hold a current registration on the department's registry as a Medication Assistant I.

Required Licensed Nurse Supervision and Delegation:

- May perform medication administration that has been delegated and supervised by a licensed nurse, consistent with completion of a department approved training program, scope of practice defined by regulation, and facility policies and procedures.
- May not perform medication administration if not under the supervision and delegation of a nurse.

Settings where a Medication Assistant I <u>can be employed</u> to provide delegated medication administration:

- Settings where the licensed nurse is <u>not</u> regularly scheduled including Assisted Living Facilities and Basic Care Facilities, however, none of the settings listed in the next section.
- If considering employment in a setting other than Basic Care or Assisted Living, contact the Department of Health to determine if it is an allowable setting for a Medication Assistant I to work in.

Settings where a Medication Assistant I <u>cannot be employed to provide medication administration</u>:

- Skilled Nursing Facilities,
- Acute Care setting,
- Clinics,
- Home Health Agency setting, and
- Private Home setting.

Medication administration that may be delegated to a Medication Assistant I who is supervised by a nurse include:

- Routine, regularly scheduled medication for individuals or groups of individuals with stable conditions which are administered on a routine basis and do not require determination of need, drug calculation, or dosage conversion.
- A stable patient is a patient the registered nurse has determined to have a predictable, non-fluctuating, and consistent clinical and behavioral status, and may have fluctuations that are expected with planned interventions.

Routine, regularly scheduled medications may be delegated by a licensed nurse to a Medication Assistant I for administration to individuals or groups of individuals with stable, predictable conditions via the following routes according to facility policies and procedures:

- Oral, sublingual, and buccal medications;
- Eye medications;
- Ear medications;
- Nasal medications;
- Rectal medications and enemas;
- Vaginal medications;
- Skin ointments, topical medications, including patches and transdermal medications;
- Metered hand-held inhalants; and
- Unit dose nebulizers.

<u>When specifically delegated by a licensed nurse to a Medication Assistant I for a specific</u> patient with a stable predictable condition, regularly scheduled medications via the additional following routes:

- Gastrostomy;
- Jejunostomy;
- Subcutaneous; and
- Premeasured injectable medication for allergic reactions.

A Medication Assistant I <u>may not administer medications via the following routes</u>:

- Central lines;
- Colostomy;
- Intramuscular injection;

A Medication Assistant I may not administer medications via the following routes (Cont.):

- Intravenous;
- Intravenous lock;
- Intrathecal;
- Nasogastric tube;
- Nonmetered inhaler;
- Intradermal;
- Non-unit dose aerosol or nebulizer; or
- Uretheral catheter.

A Medication Assistant I may not administer the following kinds of medications:

- Barium and other diagnostic contrast media;
- Chemotherapeutic agents except oral maintenance chemotherapy; or
- Through any medication pumps, or assume responsibility for medication pumps, including patient-controlled analgesia.

A Medication Assistant I cannot be delegated the decision to administer a pro re nata (PRN) medication in situations where an onsite assessment of the patient is needed prior to administration.

- For example, if a chemical restraint (medication) is needed for a documented emergency or to prevent injury to the resident or others, the chemical restraint must be authorized and documented by a physician for a limited period of time and the chemical restrain must be administered by a licensed nurse or physician.
- Some situations allow administration of PRN medications without directly involving the licensed nurse prior to each administration based on the following:
  - The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse.
  - Written parameters specific to an individual patient's care must be written by the licensed nurse for use by the Medication Assistant I when an onsite assessment is not required prior to administration of a medication. The written parameters: 1) Supplement the physician's PRN order; and 2) Provide the medication assistant with guidelines that are specific regarding the PRN medication.

A Medication Assistant I, or other individual on the department's registry, may not perform the following acts even if delegated by a licensed nurse:

- Conversion or calculation of medication dosage;
- Assessment of patient need for or response to medications; and
- Nursing judgment regarding the administration of pro re nata medications.

Specific Delegation of Medication Administration from a licensed nurse to a Medication Assistant I must comply with department regulation and facility policies and procedures. (Please note the four additional routes of medication administration that can be delegated through specific delegation by the licensed nurse.) The delegation must be for the delivery of a specific drug to a specific patient, and include the following steps:

1. The Medication Assistant I must receive a copy of the facility policies and procedures to follow regarding specific delegation.
2. The Medication Assistant is taught by the licensed nurse for each specific patient's medication administration with both verbal and written instructions (beyond the physicians order). The specific instructions include: a)The medication trade name and generic name; b) The purpose of the medication; c) Signs and symptoms of common side effects, warnings, and precautions; d) Route and frequency of administration; and e) Instructions under which circumstances to contact the licensed nurse or licensed health care provider.
3. The Medication Assistant I must be observed by a licensed nurse administering the medication to the specific patient until competency is demonstrated.
4. Areas the Medication Assistant I must be verified to be competent include: a) Knows the six rights for each medication for the specific patient, including the right patient, right medication, right dosage, right route, right time, and right documentation; b) Knows the name of the medication and common dosage; c) Knows the signs and symptoms of side effects for each medication; d) Knows when to contact the licensed nurse; e) Can administer the medication properly to the patient; and f) Documents medication administration according to organization policy.
5. Documentation that the Medication Assistant I has received the training related to specific delegation of medication administration for each patient must be maintained and updated when further instruction is received as necessary to implement a change.

Regulatory sources:

- NDCC Chapters 23-44 and 50-10.2
- NDAC ARTICLE 33-43
- Link to Applicable Rules: http://www.ndhealth.gov/HF/PDF_files/Nurse%20Aide%20Registry/Medication_Rules_10-22-2012.pdf

Effective Date: July 1, 2011

North Dakota Department of Health

Medication Assistant II

Scope of Delegated Medication Administration Statement

Registry Requirements:

- Must hold a current registration on the ND Department of Health Nurse Aide Registry as a Certified Nurse Aide prior to entry into the Medication Assistant II training and competency program,
- Must have completed a medication assistant II training and competency program (study and clinical practice in the administration of routine, regularly scheduled medications which meets the department's requirements), and
- Must hold a current registration on the department's registry as a Medication Assistant II.

Required Licensed Nurse Supervision and Delegation:

- May perform medication administration that has been delegated and supervised by a licensed nurse, consistent with completion of a department approved training program, scope of practice defined by regulation, and facility policies and procedures.
- May not perform medication administration if not under the supervision and delegation of a nurse.

Settings where a Medication Assistant II <u>can be employed</u> to provide <u>delegated</u> medication administration:

- Settings where the licensed nurse is either scheduled regularly or not regularly including Skilled Nursing Facilities, Assisted Living Facilities and Basic Care Facilities, however, none of the settings listed in the next section.
- If considering employment in a setting other than Nursing Facility, Basic Care Facility, or Assisted Living, contact the Department of Health to determine if it is an allowable setting for a Medication Assistant II to work in.

Settings where a Medication Assistant II <u>cannot be employed to provide medication administration</u>:

- Acute Care setting,
- Clinics,
- Home Health Agency setting, and
- Private Home setting.

Medication administration that may be delegated to a Medication Assistant II who is supervised by a nurse include:

- Routine, regularly scheduled medication for individuals or groups of individuals with stable conditions which are administered on a routine basis and do not require determination of need, drug calculation, or dosage conversion.
- A stable patient is a patient the registered nurse has determined to have a predictable, non-fluctuating, and consistent clinical and behavioral status, and may have fluctuations that are expected with planned interventions.

Routine, regularly scheduled medications may be delegated by a licensed nurse to a Medication Assistant II for administration to individuals or groups of individuals with stable, predictable conditions via the following routes according to facility policy and procedures:

- Oral, sublingual, and buccal medications;
- Eye medications;
- Ear medications;
- Nasal medications;
- Rectal medications and enemas;
- Vaginal medications;
- Skin ointments, topical medications, including patches and transdermal medications;
- Metered hand-held inhalants; and
- Unit dose nebulizers.

<u>When specifically delegated by a licensed nurse to a Medication Assistant II for a specific</u> patient with a stable predictable condition, regularly scheduled medications via the additional following routes:

- Gastrostomy;
- Jejunostomy;
- Subcutaneous; and
- Premeasured injectable medication for allergic reactions.

A Medication Assistant II <u>may not administer medications via the following routes</u>:

- Central lines;
- Colostomy;
- Intramuscular injection;
- Intravenous;
- Intravenous lock;

A Medication Assistant II <u>may not administer medications via the following routes (Cont.)</u>:

- Intrathecal;
- Nasogastric tube;
- Nonmetered inhaler;
- Intradermal;
- Non-unit dose aerosol or nebulizer; or
- Uretheral catheter.

A Medication Assistant II <u>may not administer</u> the following kinds of medications:

- Barium and other diagnostic contrast media;
- Chemotherapeutic agents except oral maintenance chemotherapy; or
- Through any medication pumps, or assume responsibility for medication pumps, including patient-controlled analgesia.

A Medication Assistant II <u>cannot be delegated the decision to administer a pro re nata (PRN) medication</u> in situations where an onsite assessment of the patient is needed prior to administration.

- For example, if a chemical restraint (medication) is needed for a documented emergency or to prevent injury to the resident or others, the chemical restraint must be authorized and documented by a physician for a limited period of time and the chemical restraint must be administered by a licensed nurse or physician.
- Some situations allow administration of PRN medications without directly involving the licensed nurse prior to each administration based on the following:
  - The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse.
  - Written parameters specific to an individual patient's care must be written by the licensed nurse for use by the Medication Assistant II when an onsite assessment is not required prior to administration of a medication. The written parameters: 1) Supplement the physician's PRN order; and 2) Provide the medication assistant with guidelines that are specific regarding the PRN medication.

A Medication Assistant II, or other individual on the department's registry, <u>may not perform the following acts even if delegated</u> by a licensed nurse:

- Conversion or calculation of medication dosage;
- Assessment of patient need for or response to medications; and
- Nursing judgment regarding the administration of PRN medications.

<u>Specific Delegation of Medication Administration from a licensed nurse to a Medication Assistant II</u> must comply with department regulation and facility policies and procedures. (Please note the four additional routes of medication administration that can be delegated through specific delegation by the licensed nurse.) The delegation must be for the delivery of a specific drug to a specific patient, and include the following steps:

1. The Medication Assistant II must receive a copy of the facility policies and procedures to follow regarding specific delegation.
2. The Medication Assistant II is taught by the licensed nurse for each specific patient's medication administration with both verbal and written instructions (beyond the physicians order). The specific instructions include: a)The medication trade name and generic name; b) The purpose of the medication; c) Signs and symptoms of common side effects, warnings, and precautions; d) Route and frequency of administration; and e) Instructions under which circumstances to contact the licensed nurse or licensed health care provider.
3. The Medication Assistant II must be observed by a licensed nurse administering the medication to the specific patient until competency is demonstrated.
4. Areas the Medication Assistant II must be verified to be competent include: a) Knows the six rights for each medication for the specific patient, including the right patient, right medication, right dosage, right route, right time, and right documentation; b) Knows the name of the medication and common dosage; c) Knows the signs and symptoms of side effects for each medication; d) Knows when to contact the licensed nurse; e) Can administer the medication properly to the patient; and f) Documents medication administration according to organization policy.
5. Documentation that the Medication Assistant II has received the training related to specific delegation of medication administration for each patient must be maintained and updated when further instruction is received as necessary to implement a change.

Regulatory sources:

- NDCC Chapters 23-44 and 50-10.2
- NDAC ARTICLE 33-43
- Link to Applicable Rules: http://ndhealth.gov/HF/PDF_files/Nurse%20Aide%20Registry/Medication_Rules_10-22-2012.pdf

Effective Date: July 1, 2011

Office Use Only

Class Roster Match with app	
Yes ____	No ____

INITIAL MEDICATION ASSISTANT I & II APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59962 (R2-2012)

Please Check One	☐ Medication Assistant I - Must be an NA or CNA - (Non-Refundable Fee $25.00) ☐ Medication Assistant II - Must be a CNA - (Non-Refundable Fee $25.00)

PLEASE CHECK THE REGISTRY CATEGORY YOU CURRENTLY HOLD:

☐ Certified Nurse Aide (CNA):Registry Number _____ Expiration Date _____
☐ Nurse Aide (NA) Registry Number _____ Expiration Date _____

APPLICANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name		Maiden/Middle Initial	M ☐	F ☐
Current Mailing Address (Include C/O Address)			County		
City	State	Zip Code	Social Security Number (Required)		
Date of Birth	E-Mail Address				
Home Phone	Work Phone		Cell Phone		
Name of Employer			City	State	
Employer's Contact Name			Employer's Phone Number		

ALL QUESTIONS BELOW MUST BE COMPLETED BY APPLICANT

1.	Have you ever been arrested, charged, or convicted of a felony (*You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action)* within the last two years?	☐ Yes	☐ No	
2.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	Have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No	
4.	Have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	Have you been denied registration or licensure by any other jurisdiction?	☐ Yes	☐ No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	☐ Yes	☐ No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	☐ Yes	☐ No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	☐ Yes	☐ No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. **Have you attached the appropriate documents?**	☐ Yes	☐ No	☐ NA

APPLICATION CERTIFICATION

I certify the information provided is true, correct, and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.

Applicant Signature	Date

FOR STATE USE ONLY Date Received _____ Amount Received $_____ Cash MO or CK#_____

Medication Assistant Training Program

Name of Medication Assistant Training Program			
Address	City	State	Zip Code
Date of Enrollment	Date of Completion		

Registered Nurse Instructor/Program Supervisor

Name	Registered Nurse Number
E-mail Address	Phone Number
Signature	Date

NOTE: Please attach a copy of a Certification of Completion and/or a Class Roster or letter demonstrating successful completion of an approved Medication I or II Training Program.

Please remit $25 (U.S. dollars) Non-refundable Fee

Make checks and/or money orders payable to the North Dakota Department of Health.

All completed forms and checks or money orders must be sent or delivered together to:

North Dakota Department of Health
Division of Accounting
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov

NURSE AIDE & MEDICATION I RENEWAL APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59965 (R2-2012)

Online renewal is available and encouraged for all types of nurse aides and medication assistants.
Please use the following web address: http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm

REGISTRANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name		Maiden/Middle Initial	M ☐	F ☐
Current Mailing Address (Include C/O Address)			County		
City	State	Zip Code	Social Security Number (Required)		
Date of Birth	E-Mail Address				
Home Phone	Work Phone		Cell Phone		
Name of Employer			City	State	
Employer's Contact Name			Employer's Phone Number		
Registrant ID #			Current Expiration Date		

ALL QUESTIONS MUST BE COMPLETED BY REGISTRANT

1.	Have you ever been arrested, charged, or convicted of a felony (*You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action)* within the last two years?	☐ Yes	☐ No	
2.	Since you last renewed, or if this is your first renewal, has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	Since you last renewed, or if this is your first renewal, have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No	
4.	Since you last renewed, or if this is your first renewal, have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	Since you last renewed, or if this is your first renewal, have you been denied registration or licensure by any other jurisdiction?	☐ Yes	☐ No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	☐ Yes	☐ No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	☐ Yes	☐ No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	☐ Yes	☐ No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. **Have you attached the appropriate documents?**	☐ Yes	☐ No	☐ NA

REGISTRATION CERTIFICATION

I certify the information provided is true, correct and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.

Applicant Signature	Date

FOR STATE USE ONLY Date Received: _____ Amount Received: $_____ Cash MO or CK#_____

THE FOLLOWING IS TO BE COMPLETED BY A LICENSED NURSE OR EMPLOYER

VERIFICATION OF COMPETENCE

For each area, the licensed nurse or employer verifies that the nurse aide has demonstrated competencies in the following areas. **Signature of Employer** _____ **Date** _____ **OR** **Signature of Licensed Nurse** _____ **Date** _____ **AND** **ND Nurse License Number** _____	**Date of satisfactory competency verification (within the last year)** **MM/DD/YYYY**	Comments
1. Infection control.		
2. Safety and emergency procedures.		
3. Collection and documentation of basic objective and subjective client data.		
4. Activities of daily living (applicable to setting).		
5. Decision-making skills.		
6. Client rights.		
7. Communication and interpersonal skills.		
8. Client cognitive abilities and age specific needs.		

REGISTRANT EMPLOYMENT INFORMATION

Employment Status ☐ Employed ☐ Not-Employed	Date of Hire as a Nursing Assistant **(MM/DD/YYYY)**

EMPLOYER INFORMATION AND SIGNATURE

Employer (If applicable)		Phone Number	
Address	City	State	Zip Code
Employer or Licensed Nurse Signature		Date	

Medication Assistant Competency Verification

The section below must be completed by a licensed or registered nurse.

This Medication Assistant I has completed the necessary competency verification within the past year, as indicated by NDAC 33-43-01-14. I certify the competency of this Medication Assistant I by my signature below.

Signature	Date
Licensed Nurse or Registered Nurse Number	Expiration Date

Please remit $50 (U.S. dollars) Non-refundable Fee
($25.00 for Nurse Aide Renewal and $25 for Medical Assistant I Renewal)

Make checks and/or money orders payable to the North Dakota Department of Health.
All completed forms and checks or money orders must be sent or delivered together to:

North Dakota Department of Health
Division of Accounting
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov

CERTIFIED NURSE AIDE REGISTRATION AND MEDICATION I OR II RENEWAL APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59966 (R2-2012)

Online renewal is available and encouraged for all types of nurse aides and medication assistants. Please use the following web address: **http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm**

Please check the appropriate Medication Assistant box to the right	☒ Certified Nurse Aide (No Fee) ☐ Medication Assistant I (Non-Refundable Fee $25.00) ☐ Medication Assistant II (Non-Refundable Fee $25.00)

REGISTRANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name		Maiden/Middle Initial	M ☐	F ☐
Current Mailing Address (Include C/O Address)			County		
City	State	Zip Code	Social Security Number (Required)		
Date of Birth	E-Mail Address				
Home Phone	Work Phone		Cell Phone		
Registrant ID #			Current Expiration Date		

ALL QUESTIONS MUST BE COMPLETED BY REGISTRANT

1.	Have you ever been arrested, charged, or convicted of a felony (*You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action)* within the last two years?	☐ Yes	☐ No	
2.	Since you last renewed, or if this is your first renewal, has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	Since you last renewed, or if this is your first renewal, have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No	
4.	Since you last renewed, or if this is your first renewal, have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	Since you last renewed, or if this is your first renewal, have you been denied registration or licensure by any other jurisdiction?	☐ Yes	☐ No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	☐ Yes	☐ No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	☐ Yes	☐ No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	☐ Yes	☐ No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. **Have you attached the appropriate documents?**	☐ Yes	☐ No	☐ NA

APPLICATION CERTIFICATION

I certify the information provided is true, correct and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.	
Applicant Signature	Date

FOR STATE USE ONLY

Date Received: _____ **Amount Received: $**_____ **Cash MO or CK#**_____

THE BOX BELOW MUST BE COMPLETED BY A NORTH DAKOTA EMPLOYER ONLY

The registrant below has *competently* performed a minimum of eight (8) hours of nursing or nursing related services for pay for the employer specified below.

Last date /shift worked in North Dakota during certification period
(Cannot be later than the expiration date)

(THE NEW EXPIRATION DATE WILL BE EXTENDED 2 YEARS FROM LAST DATE WORKED)

Employer Type:
- ☐ Long Term Care Facility
- ☐ Hospital
- ☐ Other (Specify)_____

Last Date Worked

Month	Day	Year

Name of Facility/Employer		**City**
Supervisor's Signature	**Date**	**Phone Number**
My signature above indicates the information is true and correct to the best of my knowledge.		**Employer E-mail**

Medication Assistant Competency Verification

This Certified Nurse Aide has been validated to meet the competency requirements as a Medication Assistant consistent with NDAC 33-43-01-14 or 33-43-01-15 during the past year as indicated by my signature below.

Signature	Date
Licensed Nurse or Registered Nurse Number	Expiration Date

Medication Assistant Employment Verification

Employer	Phone Number	
E-mail Address		
Signature	License Number	Date

Make checks and/or money orders payable to the North Dakota Department of Health.

All completed forms and checks or money orders must be sent or delivered together to:

North Dakota Department of Health
Division of Accounting
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov

Section 6
Basic Care Survey Procedures

Survey Protocol for Basic Care Facilities

ND Department of Health
Division of Health Facilities
Revision August 2007 for Tier I and Tier II
Revised May 2018

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I. Introduction

Introduction

Basic Care facilities are required to be in compliance with the requirements in NDCC Chapter 23-09 and NDAC Chapter 33-03-24.1. To license a Basic Care facility, complete at least a:

- Life Safety Code (LSC) survey; and
- Standard Survey

The Department shall conduct announced surveys for all Life Safety Code inspections. For the health portion of the survey, half of the surveys must be announced and the other half of the surveys must be unannounced. For purposes of complaints related to health and life safety, all surveys must be unannounced. Conduct standard surveys and complete them on consecutive workdays, whenever possible. Surveys may be conducted at any time including weekends, 24 hours a day. When surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the entrance conference and initial tour should be modified in recognition of the residents' activity (e.g., sleep, religious services), and types and numbers of staff available upon entry.

Use the standard survey procedure discussed in this section for all standard surveys of Basic Care facilities, whether freestanding or distinct parts of a facility.

When the surveyor suspects serious quality of care which threaten or have the potential to cause harm, expand the standard (or abbreviated) survey sample as necessary to determine scope. If actual or potential harm is verified, inform the Administrator and conduct an extended (or partial extended) survey.

A. Surveys

If a possible noncompliant situation related to any requirement is identified while conducting the information gathering tasks of the survey, investigate the situation to determine whether the facility is in compliance with the requirements.

1. Standard Survey

A standard survey is composed of Tasks 1 - 7, and is a resident-centered, outcome-oriented inspection which relies on a sample of residents to gather information about the facility's compliance with participation requirements. Outcomes include both actual and potential negative outcomes, as well as failure of a facility to help residents achieve their highest practicable level of well-being. Based on the specific procedures detailed in this guideline, a standard survey assesses:

- Compliance with residents' rights and quality of life requirements;
- The accuracy of residents' assessments and the adequacy of care plans based on these assessments;
- The quality of care and services furnished, as measured by indicators of medical, nursing, drug therapy, dietary and nutrition services, activities and social participation, sanitation and infection control; and
- The effectiveness of the physical environment to empower residents, accommodate resident needs, and maintain resident safety, including whether requested room variances meet health, safety, and quality of life needs for the affected residents.

2. Extended Survey

The extended survey is conducted after a serious issue of non-compliance is determined during a standard survey. Conduct an extended survey within 14 days after completion of the standard survey

3. Abbreviated Standard Survey

This survey focuses on particular tasks that relate, for example, to complaints received or a change of ownership or management. The abbreviated standard survey does not cover all aspects covered in the standard survey, but rather concentrates on a particular area of concern(s). For example, an abbreviated standard survey may be conducted to investigate a complaint. The survey team can expand the abbreviated standard survey to cover additional areas, or to a standard survey if, during the abbreviated standard survey, evidence is found that warrants a more extensive review.

4. Partial Extended Survey

A partial extended survey is always conducted after a significant issue of non-compliance is found during an abbreviated standard survey or during a revisit.

5. Post-Survey Revisit (Follow-Up)

The post-survey revisit may be conducted by an on-site visit, or by mail or telephone to verify correction of deficiencies cited in a prior survey.

B. Initial Licensing Survey

In a survey for initial licensing of a basic care facility, perform the tasks of both the standard and extended surveys. During the initial survey, focus both on residents and the structural requirements that relate to qualification standards and resident rights

notification, whether or not problems are identified during the information gathering tasks. Gather additional information to verify compliance with every tag number. For example, during an initial survey, verify the qualifications of the social worker, dietitian, and activities professional if the facility utilizes these professionals. Verify if the facility has a referral agency available for social services needs, if residents require these services. Verify a professional has reviewed the menus, for the prescribed diets. Also, review the rights notification statements on admissions contracts.

C. Specialty Surveyors

If a team is utilized, all members of a survey team need not be onsite for the entire survey. Surveyors may be onsite only during that portion of the survey dealing with their area of expertise (e.g. dietitian). However, they must conduct that portion while the rest of the team is present. The specialty surveyor should share any information he/she obtained that may be useful to other team members.

D. Team Communication

Throughout the survey process, the team, if a team is utilized, (including specialty surveyors) should discuss amongst themselves, on a daily basis, observations made and information obtained in order to focus on the concerns of each team member, to facilitate information gathering and to facilitate decision making at the completion of the standard survey.

II. The Survey Tasks

Task 1 - Offsite Survey Preparation

A. General Objectives

The objectives of offsite survey preparation are to analyze various sources of information available about the facility:

- Review the facility file for any complaints or concerns relating to the facility.
- Determine if the areas of potential concerns or special features of the facility require the addition of a team member or a specialty surveyor.

B. Information Sources for Offsite Survey Preparation

The following sources of information are used during the offsite preparation to focus the survey.

1. **Survey Reports:**

Statements of findings from the previous survey should be reviewed. Review the specific information under each citation and note any special areas of concern.

2. **Results of Complaint Investigations**

Review information from both complaints investigated since the previous standard survey and complaints filed with the survey agency, but not yet investigated. Note resident and staff names related to the complaints and note patterns of problems relating to specific wings or shifts.

3. **Information about Waivers or Variances**

If the facility has, or has requested any staffing waiver or room variances, note these for onsite review. Determine onsite if these should be granted, continued, or revoked.

4. **Information from the State Ombudsman Office**

Note any potential areas of concern reported by the ombudsman office and note resident names reported as potential sample residents, residents for closed record review, or family members for family interviews and the reasons for their recommendation by the ombudsman.

5. **Other Pertinent Information**

At times, the survey agency may be aware of special potential areas of concern that were reported in the news media or through other sources. Evaluate this information to determine if there are potential areas of concern that should be investigated onsite.

Offsite Survey Preparation - Surveyor Responsibilities

The surveyor is responsible for completing the following tasks:

1. Obtain the following information for review prior to the onsite survey.

    - A copy of the previous survey report.
    - Results of complaint investigations;
    - Information about waivers or variances;
    - Copy of the facility's floor plan.

- Review the most recent report of Evacuation Difficulty Index. If EDI was completed within the past 3 months, it will not be necessary to complete another EDI.

- Other pertinent information.

- Make copies of the information for review offsite. The surveyor must prepare for the survey offsite, so that they are ready to begin the Entrance Conference and Initial Tour immediately after they enter the facility.

Task 2 - Entrance Conference/Onsite Preparatory Activities

A. Entrance Conference

1. The surveyor informs the facility's Administrator about the survey and introduces team members, if a team is utilized. Provides the administrator with his/her letter that identified an announced or unannounced licensure survey will be taking place.

2. The surveyor should:

   - Explain the survey process and answer any questions from facility staff.

   - Ask the Administrator to describe any special features of the facility's care and treatment programs. For example, does the facility have a special care unit for residents with dementia? Are residents who require more assistance placed in certain wings/units?

   - Inform the Administrator that there will be interviews with individual residents and that these interviews are conducted privately, unless the interviewees request the presence of a staff member.

   - Inform facility staff that the surveyor will be communicating with them throughout the survey and will ask for facility assistance when needed. Advise them that they have the opportunity to provide the surveyor with any information that would clarify an issue brought to their attention.

   - Ask the administrator to provide the following information.

     1. Complete the Resident Roster (SFN 19226). To be completed within one hour;

NOTE: This is an important source of resident information, which is crucial for the team to have for their sample selection.

2. Complete the Resident Census and Conditions of Residents (SFN 19227);

3. Complete the name and address of the Chairperson of the Board;

4. Copy of the current activity calendar;

5. Schedule of meal times, dining locations, copies of all menus, including therapeutic menus, for the days of survey;

6. Copy of CLIA certificate;

7. List of key facility personnel including the names of department managers (i.e., activities, dietary, and social services), licensed personnel, and consultants;

8. Medication passes times;

9. All resident care policies and procedures (admission, discharge, infection control, medication administration, transportation, resident abuse, theft of property, etc.).

10. Personnel policies and procedures.

11. Inservice records.

12. List of residents transferred or discharged during the past six months (include destination). List of resident deaths within the past six months;

13. List of residents admitted in last six months.

NOTE: If the survey is commencing at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or on a Saturday or Sunday, once onsite, announce the survey, ascertain who is in charge, ask the person to notify the Administrator that a survey has begun. Modify the entrance conference in accordance with staff available.

Task 3 - Initial Tour

A. General Objectives

The Initial Tour is designed to:

- Provide an initial review of the facility, the residents, and the staff;
- Obtain an initial evaluation of the environment of the facility, including the facility kitchen;

B. General Procedures

The initial tour is used to gather information. In addition, attempt to meet and talk with as many residents as possible during the tour in order to identify candidates for the sample, to get an initial overview of facility care and services, to observe staff/resident interactions; and to evaluate the impact of the facility environment on the residents. The tour also includes a first brief look at the facility's kitchen.

Document tour information, on either the Resident Roster or the Surveyor Notes Worksheet. Document any concerns regarding the general environment on the Surveyor Notes Worksheets. Document any concerns noted in the brief tour of the facility kitchen on the Surveyor Notes Worksheet.

C. Protocol

It is desirable for team members to have a facility staff person who is familiar with the residents accompany them during the tour to answer questions and provide introductions to residents or family. However, do not delay the beginning of the Initial Tour if facility staff are not available. Begin the tour as soon as possible after entering the facility.

NOTE: When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the initial tour will need to be modified in recognition of the residents' activity, (e.g., sleep, religious services) and types and numbers of staff available upon entry. The tour may focus on specific care and quality of life issues (e.g., restraint use); meal service (use of foam or paper meal service products rather than regular dinnerware); adherence to the planned menu; sufficiency of staff (whether incontinent residents are being toileted, changed; etc., as appropriate). The tour should not be delayed for lack of staff to accompany the surveyor.

Pre-selected Concerns and Potential Residents:

During the tour, identify residents who can be selected to participate in a Resident Interview. This can be accomplished by talking with residents and asking questions. An example of a question that can be asked is: What are you planning to do today?
Observations of All Residents during the Tour

During the tour focus on the following:

- Quality of Life

    1. Resident grooming and dress, including appropriate footwear;

2. Staff - resident interaction related to residents' dignity; privacy and care needs, including staff availability and responsiveness to residents' requests for assistance;

3. The way staff talk to residents, the nature and manner of interactions, and whether residents are spoken to when care is given; and

4. Scheduled activities taking place and appropriateness to the residents.

- Emotional and behavioral conduct of the residents, and the reactions and interventions by the staff

    1. Resident behaviors such as disrobing, agitation, rocking, pacing; and

    2. The manner in which these behaviors are being addressed by staff, including nature and manner of staff interactions, response time, staff availability, and staff means of dealing with residents who are experiencing catastrophic reactions.

- Care issues, how care is provided, and prevalence of special care needs

    1. Skin conditions, e.g., excessive dryness, wetness;

    2. Skin tears, bruising, or evidence of fractures that warrant investigation;

    3. Dehydration risk factors including availability of water for most residents, and other indicators or factors, e.g., the presence of strong urinary odors, and resident complaints of dry mouth and lips;

    4. Clinical signs such as edema, emaciation and contractures;

    5. Functional risk factors such as poor positioning and use of physical restraints;

    6. Side effects of antipsychotic drug use such as tardive dyskinesia, (e.g., lip, tongue or other involuntary abnormal movements);

    7. Presence or prevalence (numbers) of infections including antibiotic resistant strains of bacteria (e.g., Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium Difficile (C-Diff) or other infections: urinary tract infections, draining wounds, eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, etc.

8. Excessive unplanned weight loss;

- Impact of the facility environment and safety issues

1. Infection control practices, (e.g., handwashing, glove use, and isolation procedures);

2. Functional and clean equipment, including kitchen equipment;

3. Presentation and maintenance of a homelike and clean environment; and

4. Availability, use, and maintenance of assistive devices.

NOTE: If the initial tour is being conducted during a mealtime, include an initial brief observation of the dining areas. Note if there are any concerns with meal service, quality of life, positioning, sufficient space, etc.

Task 4 - Sample Selection

A. General Objective

The objective of this task is to select a sample of facility residents to assess compliance with the resident-centered requirements.

B. General Procedures

- Each surveyor is assigned a certain number of residents, completing all facets of review.

NOTE: If sample selection occurs during meal time, delay or interrupt this task to conduct brief observations of the dining areas. Note if there are any concerns with meal service, quality of life, positioning, sufficient space, etc.

C. Definitions

- **Resident Review** -- This includes observations, interviews, and record reviews for all care areas for the sampled residents, as applicable.
- **Closed Record Review** -- This includes a record review of resident care issues, appropriate treatment and services, transfer and discharge, etc.

D. Protocol

1. Sample Selection

Sample selection occurs after the tour is completed and the facility has provided the completed Resident Roster or provided this information in some other format, e.g., computer-generated list. However, do not delay sample selection if the facility's Resident Roster has not arrived. The surveyor will complete the sample selection by performing the following tasks:

- Review the Resident Roster provided by the facility and compare it to the findings from the tour to determine a sample.
    - Include residents who need assistance with Activities of Daily living, use wheelchairs, are incontinent and/or have catheters;
    - Include residents who have physical restraints or are on psychoactive medication;
    - Include residents who have conditions of weight loss, hydration risk and/or pressure sores;
    - Each resident the surveyor selects is entered on the worksheet. Note the following about each resident:
        - Resident number and room number;

Special Factors to Consider in Sample Selection

If during sample selection, many more residents are identified than can be selected to represent the concerns of interest, consider the factors below in determining which residents to select:

- New admissions, admitted during the past 6 months.
- Residents in rooms in which variances have been granted for room size or number of beds in room;
- Residents receiving hospice services;
- Residents with end-stage renal disease;
- Residents under the age of 55;
- Residents with mental illness or mental retardation; and

- Residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominant language of the facility.

Other Tasks

- If concerns have been identified in the area of infection control, review policies and procedures including a focus on what preventative infection control practices the facility has in place.

- If the team has identified quality of care problems during the survey determine if problems with staffing have been discovered.

Resident Sample Selection

Survey Procedures for Basic Care Facilities
Resident Sample Selection

Resident Census	Sample size	Resident Reviews	Closed Rec. Reviews	Resident Interviews
1 - 30	5	5	1	3 - 5
31 - 60	10	10	2	6 - 10
61 - 90	15	15	3	11 - 15
91 - 115	20	20	3	16 - 20

NOTE: For facilities with individuals, who are incompetent or have a Power of Attorney such as residents in a Dementia unit, complete at least one family interview.

Task 5 - Information Gathering

Task 5 provides an organized, systematic, and consistent method of gathering information necessary to make decisions concerning whether the facility has met the requirements reviewed during the Standard Survey.

Task 5 includes the following sub-tasks:

5A General Observations of the Facility: Assessment of the environment of the facility affecting the resident's life, health and safety;

5B Kitchen/Food Service Observations: Assessment of the facility's food storage, preparation and service;

5C Resident Review: An integrated, holistic assessment of the sampled residents which includes the assessment of: drug therapies, the quality of life of the resident as affected by his/her room environment and daily interactions with staff, and assessment of those pertinent care concerns identified for each sampled resident by the surveyor or survey team. Closed record reviews and dining observations are integrated into the resident review;

5D Quality of Life Assessment: Assessment of residents' quality of life through individual interviews.

5E Medication Pass Observation: Observation of the Medication Pass.

Use survey worksheets and Basic Care Facility Interpretive Guidelines for each of the sub-tasks and requirements reviewed in Task 5. While these sub-tasks are discrete information gathering activities, there are a number of things to take into consideration during Task 5.

A. General Procedures

As appropriate, use the interpretations, definitions, probes, and procedures provided in the Basic Care Facility Interpretive Guidelines to guide the investigation and to help determine whether, based on the investigation and findings, the facility has met the requirements.

Worksheet documentation should be resident-centered, as appropriate. For example, if the lack of a reading light near the resident's bedroom chair is being documented, also note that this resident has said he/she prefers to read in his/her chair, and that the light over the chair is inadequate.

Relate to the requirements and provide clear evidence, as appropriate, of the facility's failure to meet a requirement. As information is collected, keep in mind that the information written on the worksheet will be used to determine if there are any deficiencies. Make documentation specific enough so that these decisions can be made. Include information about how the faulty facility practice affected residents, the number of residents affected, and the number of residents at risk. The Basic Care Facility Interpretive Guidelines assists in gathering information in order to determine whether the facility has met the requirements. For example, the facility has care plan objectives which are measurable. If the resident does not meet her/his goals, does the documentation reflect how the lack of implementation of the care plan and/or lack of quarterly assessments prevents the resident from reaching her/his goals?

Devote as much time as possible during the survey to performing observations and conducting formal and informal interviews. Limit record reviews to obtaining specific information, i.e., look at what is needed, not the whole record.

The information gathering tasks are interrelated. Information acquired while doing observations and interviews will direct the record review. Likewise, information obtained while doing the record review may help direct what observations or interviews are needed.

Regardless of the task, be alert at all times to the surrounding care environment and activities. For example, while conducting the dining observations of sampled residents and the medication pass observation, observe the environment and residents, e.g., care being given, staff interactions with residents, and infection control practices.

Throughout the survey, discuss observations, as appropriate, with team members, if applicable, facility staff, residents, family members, and the ombudsman. Maintain an open and ongoing dialogue with the facility throughout the survey process. This gives the facility the opportunity to provide additional information in considering any alternative explanations before making compliance decisions. This, however, does not mean that every negative observation is reported on a daily basis, e.g., at a nightly conference. Moreover, if the negative observation relates to a routine that needs to be monitored over time to determine whether non-compliance exists, wait until a trend has been established before notifying the facility of the problem.

In conducting the tasks of the Standard Survey, situations may be identified to indicate that the facility may not be meeting a requirement not routinely reviewed in the Standard Survey.

Verify information and observations in terms of credibility and reliability. If the credibility or reliability of information is doubted, validate that information or gather additional information before using it to make a compliance decision.

B. Observations

The objectives of the observational portion of information gathering are to gather resident-specific information for the residents included in the sample, and also, to be alert to the provision of care, staff-resident interactions, and quality of life for all residents.

C. Informal and Formal Interviews

The objectives of interviews are to:

- Collect information;
- Verify and validate information obtained from other survey procedures; and

- Provide the opportunity for all interested parties to provide what they believe is pertinent information.

Interview residents, staff, family, ombudsman, and other appropriate persons, as applicable. Informal interviews are conducted throughout the duration of the information gathering tasks of the survey. Use the information obtained from interviews to assist in deciding what additional observations and record review information is necessary. Avoid asking leading questions, but use the Basic Care Facility Interpretive Guidelines for specific requirements to focus questions and determine the significance of the answers.

In general, the individual who provides information during an interview will not be identified as providing that information. However, it is possible that their identity may be revealed if non-compliance is cited based in whole or part on their information.

If residents appear reserved in providing information or express concern about retaliation:

- Verify that residents have information on whom to contact in the event they become the objects of retaliation by the facility; and

- With the resident's permission, notify the ombudsman of the resident's concerns.

D. Record Review

The objectives of the record review are to:

- Acquire information to direct initial and/or additional observations and interviews;

- Provide a picture of the current status of the resident as assessed by the facility; and

- Evaluate assessments, plans of care, and outcomes of care interventions for residents included in the sample.

NOTE: *Do not spend excessive time gathering and recording information from the record. Use the record review to obtain information necessary to validate and/or clarify information obtained through observation and interviews. Ask facility staff to assist in finding any information that has not been found or that requires validation.*

Sub-Task 5A - General Observations of the Facility

A. General Objective

The general objective of this task is to observe physical features in the facility's environment that affect residents' quality of life, health, and safety.

B. General Procedures

During the Initial Tour, each surveyor should note and document any concerns in resident rooms and the general environment. These concerns should be followed up and investigated as well as any additional concerns regarding the environment, which are identified throughout the survey. Begin observations as soon as possible after entering the facility, normally after introductions at the entrance conference.

During Task 5A, review the condition of the environment, (e.g., cleanliness, sanitation, presence or absence of pests, accident hazards, functioning of equipment, and the proper and safe storage of drugs, biologicals, housekeeping compounds and equipment).

C. Making Observations

The focus in Task 5A is on quality of life and environmental health and safety indicators in areas of the facility that would be visited or used by residents. However, some non-resident areas should also be reviewed due to their potential negative effect on residents, e.g., utility rooms.

Plan to observe the facility's environment at different times during the survey, e.g., first and second shift, common areas when in use by residents.

Determine if additional information needs to be gathered.

Sub-Task 5B - Kitchen/Food Service Observation

A. General Objective

The general objective of the Kitchen/Food Service Observation is to determine if the facility is storing, preparing, distributing, and serving food to prevent food borne illness.

B. General Procedures

The surveyor conducts the Kitchen/Food service observation.

NOTE: The surveyor should begin the task with a brief visit to the kitchen as part of the initial tour, in order to observe the sanitation practices and cleanliness of the kitchen. Observe whether potentially hazardous foods have been left on counter tops or steam

table and/or being prepared, the manner in which foods are being thawed, the cleanliness, sanitary practices, and appearance of kitchen staff, e.g., appropriate attire, hair restraints.

In addition evaluate:

- The availability of food in relation to the number of residents;
- During the observation of the meal preparation determine whether the food being prepared is consistent with the written, planned menu.

NOTE: During the Dining Observation portion of the Resident Review, if concerns are identified, such as the provision of meals that are not consistent in quality (such as color and texture of vegetables or meats, the preparation and presentation of mechanically altered foods); complaints regarding taste or texture of food and foods with an "off" or bad odor; or residents being at nutritional risk, including high prevalence of residents with unintended weight loss.

Direct observations to the kitchen to determine:

- If recipes are available and consistent with the menu and followed by employees;
- If appropriate equipment is available and used to prepare and serve foods;
- If the food is being held for more than 30 minutes prior to food service, e.g., in the steam table, oven, refrigerator rather than freezer for frozen foods, etc.; and
- If cooked leftovers used during food preparation were stored and used within the appropriate time frames, and reheated to at least 165 degrees F.

Sub-Task 5C - Resident Review

A. General Objectives

The general objectives of the Resident Review are to determine:

- How resident outcomes and the resident's quality of life are related to the provision of care by the facility;
- If the care provided by the facility has enabled residents to reach or maintain their highest practicable physical, mental, and psychosocial well-being;
- If residents are assisted to have the best quality of life that is possible. The review will include aspects of the environment, staff interactions, and provision of services that affect sampled residents in their daily lives;

- If there are additional areas of concern that need to be investigated.

B. General Procedures

One surveyor should conduct the entire Resident Review for an assigned resident.

To facilitate the Resident Review, ask a staff member for schedules of the following, as appropriate:

1. Meals;
2. Medications;
3. Activities; and
4. Special treatments.

C. Resident Care Review

A Resident Care Review includes observations, interviews, and a record review. After observing and talking with the resident, the surveyor conducts a comprehensive review which includes the following:

- An overall review of the facility's assessment and care planning process including their:
  - Evaluation of assessment information;
  - Development of a care plan that meets the identified needs of the resident;
- A review of the implementation of the care plan and resident response;
- A review of the relationship of the resident's drug regimen to the resident's condition;
- An evaluation of the resident's dining experience.
- Each resident admitted to the basic care must receive a fire drill walk through within 5 days after admission to orientate the resident to the fire drill procedures, exits, and evacuation routes. This is not applicable to basic care residents located in a health care occupancy (hospital or nursing facility).

E. Closed Record Review

This includes a record review of the resident's care issues, appropriate treatment and services, and transfer and discharge requirements.

Assess quality of care and quality of life requirements that relate to the identified care areas for the sampled resident. While assessing these, note and investigate concerns with any other requirements.

F. Conducting the Resident Review

The Resident Review consists of 3 main sections: Resident Room Review, Daily Life and Care Review, and Assessment of Drug Therapies.

1. The Resident Room Review assesses aspects of accommodation of needs, environmental quality, and quality of life in the resident's room. Through observations and interviews, evaluate how the resident's environment affects his/her quality of life.

2. The Daily Life and Care Review is a review of the resident's daily quality of life, especially in the areas of staff responsiveness to resident grooming and other needs, staff interactions, choices, and activities. Through ongoing observations and interviews, evaluate the resident's daily life routines and interactions with staff.

3. The Assessment of Drug Therapies is a review of the medications the resident is receiving to evaluate whether the effectiveness of the therapeutic regimen, including all drugs that may play a significant role in the resident's everyday life, is being monitored and assessed.

General Procedures

Conduct an assessment of drug therapies for residents selected for review. In addition, if a concern has been identified that relates to the medication regimen; include a review of medication regimen in closed record reviews.

- Record the information as pertinent, all non-prescription and prescription medications taken by the resident during the past 7 days.

- Evaluate for the presence of any unnecessary drugs. The surveyor is to review the medication regimen for the following:

    - Indications/reason for use;

    - Effectiveness of therapeutic goal;

    - Dose;

- Presence of monitoring, including drug regimen review and response to identified irregularities;
- Presence of duplicative therapy; and
- Presence of possible Adverse Drug Reactions (ADR) or side effects.

NOTE: "Side Affect" is secondary effect of a drug that is usually undesirable and different from the therapeutic and helpful effects of the drug.

- Correlate the review of the drugs with the resident's clinical condition and any extenuating circumstances, such as recent admission, a change in the resident's environment, and hospitalization, etc.

- Evaluate how the drugs the resident receives affect his/her quality of care and quality of life through the following methods:
  - A review of the clinical record, i.e., any section that has useful information pertaining to the resident;
  - Observations of the resident; and
  - Interviews with the resident or interested parties.

G. Care Observations and Interviews -- Make resident observations and conduct interviews which include those factors or care areas as determined by the Resident Roster. For example, if the resident was chosen because he/she has had weight loss, observe the care and the outcomes of the interventions, facility monitoring and assessment, and nutritional needs/adequacy.

Complete the following tasks:

- Observe the resident and caregivers during care and treatments, at meals, and various times of the day, including early morning and evening, over the entire survey period. Observe residents in both informal and structured settings, e.g., participating in formal and informal activities. Also, observe staff-resident interactions;

- Gather resident-specific information, including information on the resident's functional ability, potential for increasing ability, and any complications concerning special care needs;

- Evaluate implementation of the care plan. Determine if the care plan is consistently implemented by all personnel at all times of the day, and if the care plan is working for the resident. If the care plan is not working, look for evidence

that the facility has identified this and acted on it even if the care plan has not formally been revised; and

- Determine if there is a significant difference between the facility's assessment of the resident and your observations.

Do not continue to follow residents once enough information has been accrued to determine whether the resident has received care in accordance with the regulatory requirements.

When observing residents, respect their right to privacy, including the privacy of their bodies.

Obtain verbal permission/consent from the resident to observe as the personal care is provided.

H. Record Review

Conduct a record review to provide a picture of the current status of the resident as assessed by the facility; information on changes in the resident's status over the last 12 months for those areas identified for review; and information on planned care, resident goals, and expected outcomes.

Use the record review to help determine whether the assessments accurately reflect the resident's status and are internally consistent.

For sampled residents selected for review, conduct a review of the assessment information including:

- Background information including customary routines and demographic information to provide an understanding of the resident prior to admission. This assists in assessing the quality of life of the resident.

- The facility's assessment of the resident's health status, psychosocial status, functional status, nutritional status, activities, and capability to evacuate the facility.

- The care plan to identify whether the facility used professional consultation to make sound care planning decisions. Determine whether the facility identified resident strengths, needs, and problems which needed to be addressed to assist the resident to maintain or improve his/her current functional status. Determine whether the facility identified resident-centered, measurable goals and specific interventions to achieve those goals. With observations, interviews, and record review, determine if the facility implemented the interventions defined; and

- It is not necessary to review the entire resident record. Review only those sections that are necessary to verify and clarify the information necessary to make compliance decisions. These sections may include, for example, laboratory reports, progress notes, and drug regimen review reports.

- Determine if a reassessment based on the resident's change should have been conducted. Assess if the change was avoidable or unavoidable.

- Verify the information needed has been obtained to determine if the facility fulfilled its obligation to provide care that allowed the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

- Determine if the care plan is consistently implemented, evaluated, and revised based on the response, outcomes, and needs of the resident.

Investigative Protocol
Hydration

Objectives:

- To determine if the facility identified residents at risk for dehydration and developed an appropriate preventative care plan; and

- To determine if the facility provided the resident with access to fluids, to maintain proper hydration and health.

Task 5C: Use:

Utilize this protocol for a sampled resident who has any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious process, dependence on staff for provision of fluid intake (due to physical or mental limitations), use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphasia, a history of limited fluid intake or lack of thirst sensation.

Procedures:

NOTE: A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

  - Are the resident's beverage preferences identified and honored at meals?

  - Does staff encourage the resident to drink? Are they aware of the resident's fluid needs?

Investigative Protocol
Unintended Weight Loss

Objectives:

- To determine if the identified weight loss is avoidable or unavoidable; and
- To determine the adequacy of the facility's response to the weight loss.

Task 5C: Use:

Utilize this protocol for a sampled resident with unintended weight loss.

Procedures:

- Determine if the resident was assessed for conditions that may have put the resident at risk for unintended weight loss:

  NOTE: Body Mass Index (BMI) estimates total body mass and is highly correlated with the amount of body fat. It provides important information about body composition, making it a useful indicator of nutritional status. BMI is easy to calculate because only information about height and weight are needed.

  BMI = weight (Kg)/height (M^2) or

  BMI = weight (lbs.)/height ($inches^2$) X 705

- Determine if the facility has assessed the resident's nutritive and fluid requirements, dining assistance needs, such as assistive devices, food cultural/religious preferences, food allergies, and frequency of meals.
- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident should know of, or be able to provide information about the causes of a resident's condition or problem.
- Determine if the care plan was evaluated and revised based on the response, outcomes, and needs of the resident.
- Observe the delivery of care as described in the care plan, (e.g., staff providing assistance and/or encouragement during dining; serving food as planned with attention to portion sizes, preferences, nutritional supplements, and/or between-

meal snacks) , to determine if the interventions identified in the care plan have been implemented.

Investigative Protocol
Dining and Food Service

Objectives:

- To determine if each resident is provided with nourishing, palatable, attractive meals that meet the resident's daily nutritional and special dietary needs;
- To determine if each resident is provided services to maintain or improve eating skills; and
- To determine if the dining experience enhances the resident's quality of life and is supportive of the resident's needs, including food service and staff support during dining.

Task 5C: Use

This protocol will be used for:

- All sampled residents identified with malnutrition, unintended weight loss, mechanically altered diet, pressure sores/ulcers, and hydration concerns; and
- Food complaints received from residents, families and others.

General Considerations:

- Use this protocol at two meals during the survey, preferably the noon and evening meals.
- Discretely observe all residents, including sampled residents, during meals keeping questions to a minimum to prevent disruption in the meal service.
- For each sampled resident being observed, identify any special needs and the interventions planned to meet their needs. Using the facility's menu, record what is planned in writing to be served to the resident at the meal observed.
- Conduct observations of food preparation and quality of meals.

Procedures:

1. During the meal service, observe the dining room and/or resident's room for the following:

    - Comfortable sound levels;
    - Adequate illumination, furnishings, ventilation; absence of odors; and sufficient space;
    - Tables adjusted to accommodate wheelchairs, etc.; and
    - Appropriate hygiene provided prior to meals.

2. Observe whether each resident is properly prepared for meals. For example:

    - Resident's eyeglasses, dentures, and/or hearing aids are in place;
    - Proper positioning in chair, wheelchair, etc., at an appropriate distance from the table; and
    - Assistive devices/utensils identified in care plans provided and used as planned.

3. Observe the food service for:

    - Appropriateness of dishes and flatware for each resident. Each resident has an appropriate place setting. Availability of water. Single use disposable dining ware is not used except in an emergency and, other appropriate dining activities.
    - Whether meals are attractive, palatable, served at appropriate temperatures and are delivered to residents in a timely fashion.
        - Did the meals arrive 30 minutes or more past the scheduled meal time?
        - If a substitute was needed, did it arrive more than 15 minutes after the request for a substitute?
    - Are diet cards, portion sizes, preferences, and condiment requests being honored?

4. Determine whether residents are being promptly assisted to eat or provided necessary assistance/cueing in a timely manner after their meal is served.

    - Note whether residents at the same table are being served and assisted concurrently.

5. Determine if the meals served were palatable, attractive, and nutritious and meet the needs of the resident. Note the following:

    - Whether the resident voiced concerns regarding the taste, temperature, quality, quantity and appearance of the meal served;

    - Whether attempts to provide a substitute of equal nutritive value was provided, if the resident refused/rejected food served; and

    - Whether food placement, colors, and textures were in keeping with the resident's needs or deficits, e.g., residents with vision or swallowing deficits.

6. Observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does not prohibit the administration of medications during meal service for medications that are necessary to be given at a meal, nor does this prohibit a medication to be given during a meal upon request of a resident who is accustomed to taking the medication with the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

    - Has the facility attempted to provide medications at times and in a manner to support the dining experience of the resident, such as:

        - Pain medications being given prior to meals so that meals could be eaten in comfort;

        - Foods served are not routinely or unnecessarily used as a vehicle to administer medications (mixing the medications with potatoes or other entrees).

7. Determine if the sampled resident consumed adequate amounts of food.

    - Determine if the facility is monitoring the foods/fluids consumed for residents who need monitoring. Procedures used by the facility may be used to determine percentage of food consumed, if available; otherwise, determine the percentage of food consumed using the following point system:

        - Each food item served except for water, coffee, tea, or condiments equals one point. Example: Breakfast: juice, cereal, milk, bread and

butter, coffee (no points) equals four points. If the resident consumes all four items in the amount served, the resident consumes 100% of breakfast. If the resident consumes two of the four food items served, then 50% of the breakfast would have been consumed. If three-quarters of a food item is consumed, give one point; for one-half consumed, give .5 points; for one- fourth or less, give no points. Total the points consumed x 100 and divide by the number of points given for that meal to give the percentage of meal consumed. Use these measurements when determining the amount of liquids consumed: Liquid measurements: 8 oz. cup = 240 cc, 6 oz. cup = 180 cc, 4 oz. cup = 120 cc, 1 oz. cup = 30 cc.

- Ask the staff if your observation of food intake reflects what the resident usually eats.

- Note whether plates are being returned to the kitchen with 75% or more of food not eaten.

8. If concerns are noted with meal service, preparation, quality of meals, etc., interview the person(s) responsible for dietary services to determine how the staff are assigned and monitored to assure meals are prepared according to the menu, that the meals are delivered to residents in a timely fashion, and at proper temperature, both in the dining rooms/areas and in resident rooms.

Investigative Protocol
Sufficient Staffing

Objectives:

- To determine if the facility has sufficient staff available to meet the residents' needs.

Task 5C:

NOTE: This protocol is not required during the standard survey, unless it is triggered in the event of care concerns/problems which may be associated with sufficiency of staff. It is required to be completed for an extended survey.

This protocol is to be used when:

- Quality of care problems have been identified, e.g., residents not receiving the care and services to prevent declines in their condition as described in their plans of care, such as bathing, dressing, grooming, transferring, ambulation, toileting, and eating; and

- Complaints have been received from residents, families or other resident representatives concerning services, e.g., care not being provided.

Procedures:

- Determine if staff are available to:
    - Assess resident condition changes;
    - Monitor dining activities to identify concerns or changes in residents' needs;
    - Identify training needs for the nursing assistants.
- Determine if nursing assistants and other staff are knowledgeable regarding the residents' care needs, e.g., the provision of fluids and foods for residents who are unable to provide these services for themselves; the provision of incontinence care as needed;
- If necessary, review nursing assistant assignments in relation to the care and or services the resident requires to meet his/her needs;
- In interviews with residents, families and/or other resident representatives, inquire about the staff's response to requests for assistance; and
- Determine if the problems are facility-wide, cover all shifts or if they are limited to certain units or shifts, or days of the week. This can be based on information already gathered by the team with additional interviews of residents, families, and staff, as necessary.

I. Closed Record Reviews

Try to select closed records of residents who had the same care needs, as identified as concern area during the survey, before death, discharge, or transfer.

Look for information to determine compliance with quality of care and other requirements such as:

- Assessment and care of infections;
- Significant weight loss;
- Restraints;
- Multiple falls or injuries;

- Discharge planning; and

- Transfer and discharge requirements.

Unless there is a reason to review the entire record, focus the review on the appropriateness of care and treatment surrounding the resident's discharge or transfer, and the events leading up to that discharge or transfer.

- Look for documentation related to transfer, discharge, and bed-hold, including facility's discharge planning, notices, and reasons for facility-initiated moves, e.g., proper planning and transferring subsequent to a change in payor or care needs.

Sub-Task 5D - Quality of Life Assessment

B. General Objectives

The general objectives of the quality of life assessment are:

- To determine if the facility protects and promotes the rights of residents;

- To assess the impact of the facility's environment, facility schedules and policies, and staff interactions with residents on the quality of residents' lives;

- To determine if the facility is assisting residents to achieve and maintain their highest practicable well-being; and

- To determine if the facility provides equal access to quality care for all residents, regardless of payment source.

5C. Quality of Life Protocols

Task 5D includes the following sub-tasks: Interviews with residents and family members or friends of residents.

1. Resident Interview

These interviews are conducted with a sample of interviewable residents.

It is helpful to divide the interview into two or more short segments. Seeing the resident more than once helps to establish rapport and also gives the resident a chance to think over the questions and provide more information later. Surveyors are encouraged to have several short conversations with interviewable residents during the course of the survey.

Locate a private place for the interview, and arrange interview times at the resident's convenience. Resident interviews should be conducted privately unless the resident expresses a preference to have a family member, staff member or the ombudsman present.

At the beginning of the first interview segment, explain to the resident the purpose of the interview. Discuss with the resident that some of his/her answers may be written down, and ask if that is all right. Then take a few minutes to establish rapport by letting the resident direct the conversation. For residents who are uncommunicative at first, use cues from their surroundings or from what is known about this resident to begin the conversation. Try to seek some commonality that will allow the resident to develop some ease in talking. For example, remark on family pictures and other personal items seen in the resident's room, or bring up a past occupation or hobby or a current activity preference of the resident that is of mutual interest. Share a little about yourself, as appropriate.

During the resident interview bring up topics in an order that is sensible to the conversation. Probe for further information if the answer the resident is giving is incomplete or unclear. After the interview, follow-up on the concerns the resident has raised. Include in the documentation both the facility practice in question and its effect on the resident. Share these concerns with team members, if applicable, so that they can pursue them during the remainder of the survey.

NOTE: There are some problems that a resident will express that are not within the scope of the Basic Care requirements. For example, a resident is complaining during an interview that he/she is displeased that he/she does not have a private room. This facility does not have private rooms, nor do the requirements mandate private rooms. If there is no issue related to one of the requirements, further investigation is not needed.

2. Interview with Family Member or Friend of a Resident

The purpose of this interview is to obtain information about the prior and current preferences to help assess whether the facility is individualizing daily life activities, care and services to the highest practicable level. Follow-up on any concerns raised by the family member about the resident's treatment by the facility.

Prior to the interview, review the relevant past activities and preferences, and the resident's social history and activities assessment, if any.

The interview may be conducted in person with a family member who was met on tour or by telephone, if necessary.

Combine the information gained during the interview with what has been learned about the resident during the Resident Review. What special needs and preferences does this resident have that the Basic Care Facility should be taking into account? For example, a

resident is ambulatory with Alzheimer 's disease. Her prior life included meeting the school bus at 3 p.m. every day to pick up her children. Now she attempts to leave the facility around that time. What is the facility doing to accommodate this agenda of the resident? Another resident enjoyed being outdoors, and the family member stated she believes this resident would still like the opportunity to go outdoors. Is the facility responding to this preference? Another resident preferred tea to coffee. Is this preference taken into account? A resident preferred to be addressed as Mrs. Hernandez. How do staff address this resident? A resident liked to ski, but can no longer do so due to her condition. However, she may like to see a movie on skiing, have a skiing picture in her room, or go outside in the snow. Has the facility noted this preference? A resident always watched a certain soap opera every day. The family member says that even though she is now confused, this show may still attract her interest. Is this show being made available to the resident?

For each concern, be specific in noting time, location, and exact observations. Record what is seen and heard, rather than a judgment of the situation. Instead of writing that the resident's dignity was violated by some interaction, simply record the interaction.

NOTE: During the individual and family interviews, ask questions regarding their awareness of to whom and how to report allegations, incidents and/or complaints. Follow-up on areas of concern observed.

D. Follow-Up on Concerns Raised Through Interviews

Whenever information is obtained about areas of concern through resident interviews, attempt to investigate these areas through whatever means are appropriate. These might include interviews with other residents, staff, and families, and reviews of written facility information such as policies and procedures, and the admission rights information given to residents.

Sometimes these other sources will provide no other corroborating information. Determine during decision-making if the requirement is met or not met through the information obtained in resident interviews.

E. Confidentiality

If residents or family members have stated during interviews that they do not want certain information they have shared in confidence to be shared with the facility, respect their wishes. However, the issue can still be investigated. During the survey, make the topic the subject of other interviews and observations. For example, a resident has said that certain staff "make fun" of him/her, but he/she asks you to keep that in confidence. The resident's comment may not be referred to in the survey report. However, decide how best to pursue the matter while respecting the resident's wishes. The surveyor may want to address this topic with other residents or family members. When aware of which staff are involved, attempt to observe these staff interacting with residents.

If other residents have complained about the same problem, their comments may be referred to generally as a group. For example, "Three out of five residents interviewed reported that..." Use judgment to determine if the statement would compromise the resident's confidentiality

Sub-Task 5E - Medication Pass

A. General Objective

The general objective of the medication pass is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice.

B. General Procedures

Record observations. Record the physician's actual order. Do this only if the physician's order differs from the observation of the administration of the drug. When observing the medication pass, do the following:

- Be as neutral and unobtrusive as possible during the medication pass observation.

- Observe a minimum of 10 opportunities for errors (opportunities are both the drugs being administered and the doses ordered but not administered). Strive to observe as least two individuals administering medications if possible. This provides a better overall picture of the accuracy of the facility's entire drug distribution system Ask the person administering the medication if they know what the medication is and what it does. Ask how the person was trained to administer medication. Ideally, the medication observation could include residents representative of the care needs in the sample. This would provide additional information on these residents, and provide a more complete picture of the care they actually receive. For example, if blood sugars are a problem, insulin administration may be observed. If eye infections are a problem, antibiotic eye drops may be observed, if residents are in pain, as needed pain medications may be observed, etc. Observe different routes of administration, i.e., eye drops, injections, inhalation. The opportunities should equal 50% of the resident census, not to exceed 40 opportunities.

- Verify the training and competency of the person who administered the medications.

Task 6 - Information Analysis for Compliance Determination

A. General Objectives

The objectives of information analysis for deficiency determination are:

- To review and analyze all information collected and to determine whether or not the facility has failed to meet one or more of the regulatory requirements; and

- To determine whether to conduct an extended survey.

B. Overview

The worksheets and procedures are designed to assist the surveyor in gathering, investigating, organizing, and analyzing information about the quality of services provided by the facility in order to determine whether the facility has failed to meet basic care requirements.

The information gathering portions of the survey have focused on the resident and the delivery of services by the facility using observation, interview and record review as sources of information. The information analysis and decision-making portion of the survey focuses on making determinations about whether the facility meets requirements.

For initial surveys, a determination must be made regarding whether the facility meets every basic care requirement.

C. Decision-Making Process

The surveyor should review his/her worksheets to identify concerns and specific evidence relating to requirements that the facility has potentially failed to meet. In order to identify the facility's deficient practices and to enable collating and evaluating the evidence, worksheets should reflect the source of the evidence and should summarize the concerns on relevant data tags.

- Begin the decision-making task by taking into account the daily discussions, the findings documented on the worksheets, discussions with the facility, and observations over the course of the survey, and the discussions regarding definitions of non-compliance. Gather information from all worksheets pertinent to the particular requirements being reviewed. In general, what is the facility's performance in meeting these requirements? Does the facility protect and promote resident rights? Discuss results of the information-gathering phase in the context of facility conformance with these resident-centered requirements and the examples of resident-facility interactions that cause you to believe may be non-compliance.

- Evaluate the specifics of the regulatory language and the specific data collected (e.g., observation, resident, family and staff interview information) with respect to the facility's performance in each requirement. Review the worksheets on an individual tag-by-tag

basis. If data indicates the facility has not met a specific requirement, document the finding of non-compliance.

• In order to ensure that no requirements are missed, proceed through the requirements sequentially as they appear in the interpretive guidelines, preferably section by section. Findings/evidence within each section should be shared by each team member during this discussion. Consider all aspects of the requirements within the tag/section being discussed and evaluate how the information gathered relates to the specifics of the regulatory language and to the facility's performance in each requirement. The team should come to consensus on each requirement for which problems have been raised by any member. If no problems are identified for a particular tag number during the information gathering process, then no deficiency exists for that tag number.

• The surveyor collates all information and records the substance of the decision-making.

D. Compliance Criteria

To determine if non-compliance exists, use the following definitions and guidance:

- Non-compliance is defined as a facility's failure to meet a participation requirement specified in NDAC 33-03-24.1.1. Throughout NDAC 33-03-24.1 the terms "deficiency" and deficient practice" will mean non-compliance.

- To help determine if non-compliance exists, look at the language of the requirement. Some requirements need to be met for each resident. Any violation of these requirements, even for one resident, is non-compliance.

- Other requirements focus on facility systems.

- During a standard health or complaint survey, the surveyor may determine there is Tier I finding(s) of non-compliance that will not result in a citation.

E. Evidence Evaluation

The surveyor must evaluate the evidence documented during the survey to determine if non-compliance exists due to a failure to meet a requirement and if there are any negative resident outcomes due to the failure. Failure to meet requirements related to quality of care, resident rights, and quality of life generally falls into two Tiers:

Tier I

Tier I findings are:

- **Isolated** findings that do not have more than a minimal potential for causing a negative impact on the resident(s); **and**

- Must be verified as corrected while the surveyor is on-site and prior to the exit conference.

Examples of Tier I findings of non-compliance include the following:

- The face sheet of one resident record in the sample lacked the admission date. This finding resulted in no potential harm to the resident.
- The care plan of one resident in the sample had not been reviewed and/or revised to reflect a recent change in bathing times, however the appropriate services were provided.
- A facility has two copies of the facility policy and procedure manuals. A signature was missing on one set of the facility's manuals.
- One food service worker's hair net was not completely covering a portion of the worker's hair.
- Crumbs were noted on the counter in the kitchen.
- A resident's care plan was not updated with assessment information for self-administration of medication. No potential for a negative impact resulted to the resident.
- Snack items were documented on the menu used by the kitchen staff; however, the menu posted for the residents did not list/document the daily snack. Resident's received the correct diet.

Prior to concluding the on-site survey, the surveyor will meet with the Administrator regarding any identified Tier I finding(s) of non-compliance. Verification of correction of Tier I finding(s) must occur prior to the exit conference. Any Tier I finding(s) that are not resolved prior to the exit conference will be cited as a Tier II finding(s) and require a written plan of correction.
Any Tier I finding(s) that did not remain corrected at the time of a revisit demonstrates a pattern of non-compliance and will be cited as a Tier II deficiency.

Tier II

Tier II findings of non-compliance include the following:

- A **pattern** of finding(s) of non-compliance that has the potential for causing a negative impact or harm to the resident(s);

- Any finding(s) of non-compliance having the potential for or result in minimal harm to the resident(s); and/or has the potential to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well being;

- Any finding(s) of non-compliance with potential or actual physical, mental or psychological injury or deterioration to a resident including violation of Residents Rights;

- Any finding(s) of non-compliance where the lack of (or the potential lack of) services/treatment resulted in the resident not reaching their highest practicable level of physical, mental or psychosocial well-being;

- Any finding(s) that reflect a system failure or widespread pattern of findings; or

- Tier I finding(s) that did not remain corrected at the time of the revisit demonstrating a pattern of non-compliance.

Examples of Tier II findings of non-compliance include the following:

- Loss of dignity due to lying in a urine-saturated bed for a prolonged period.
- Social isolation caused by staff failure to assist the resident in participating in scheduled activities.
- Inadequate staff to care for the residents.
- Abuse and neglect including resident to resident altercations.
- ADL cares were not provided or not completed as indicated by professional standards.
- Medications were not administered within the prescribed time frame resulting in or potential for a negative impact to the residents.
- Proper diets were not provided for residents who required prescribed diets i.e. renal or diabetic diets.
- After a recent hospitalization, a resident was assessed not able to self-administer mediation, however, the care plan was not updated to reflect this change and the resident was allowed to self-administer medication resulting in several missed medications.
- Five residents were assessed for self-administration of medication and determined unable to self-administer medication. The care plan was not updated for 2 of the 5 residents resulting in potential harm.
- The facility identified the resident's desire to reach a higher level of ability, e.g., improvement in ambulation, and care was planned accordingly. However, the facility failed to implement, or failed to consistently implement the plan of care, and the resident failed to improve, i.e., did not reach his/her highest practicable well-being.
- The facility failed to identify the resident's need/problem/ability to improve e.g., the ability to eat independently if given assistive devices, and, therefore, did not plan care appropriately. As a result, the resident failed to reach his/her highest practicable well-being, i.e., eat independently.
- Nurse aides in a facility that failed to wash their hands between caring for residents.

If the resident is the primary source of information, the surveyor should conduct further information gathering and analysis. This may include additional interviews with family and staff or record reviews to supplement or corroborate the resident's report. If additional sources of information are not available, determine if the interviewees are reliable sources of information and if the information received is accurate. If so, citation of non-compliance may be based on resident information alone.

In cases where residents are unable to speak for themselves, the surveyor should assess how most people would react to the situation in question. For example, a female resident who is unable to express herself is wheeled down the hall in a wheelchair on the way to her shower with only a towel partially covering her body. The surveyor will decide if this incident is inappropriate because the resident is unable to express herself. Quality of life and Residents' Rights requirements are most often evaluated using this type of analysis.

Task 7 - Exit Conference

A. General Objective

The general objective of the exit conference is to inform the facility of the surveyor's observations and preliminary findings.

B. Conduct of Exit Conference

Conduct the exit conference with facility personnel.

Do not discuss survey results in a manner that reveals the identity of an individual resident. Provide information in a manner that is understandable to those present.

Tier I Findings:

The surveyor determines the facility has a Tier I finding(s) which is an isolated finding(s) that does not have more than a minimal potential for causing a negative impact on the resident(s). The Tier I finding(s) must be corrected while the surveyor is on-site and verified as corrected prior to the exit conference. The Tier I finding(s) will be discussed with the Administrator and facility staff throughout the survey and during the exit conference.

At the conclusion of the exit conference, the Administrator or other authorized official will receive a form documenting any Tier I findings(s) that have been corrected and will be asked to sign and date the Tier I Findings Form attesting to the facility's correction of the Tier I finding(s). A signed copy of the Tier I Finding(s) will be provided the Administrator or other authorized official of the facility and a copy will be retained in the department's files. A written plan of correction is not required when a Tier I finding is

identified, however the facility is required to correct and maintain correction of all Tier I findings.

Tier II Findings:

Describe preliminary Tier II deficiency findings to the facility and let them know they will receive a report of the survey which will contain any Tier II findings of non-compliance that have been cited.

If an extended survey is required and the surveyor cannot complete all or part of the extended survey prior to the exit conference, inform the Administrator that the findings of non-compliance, as discussed in the conference, may be amended upon completion of the extended survey.

During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.

Other:

At the exit conference, surveyors may provide additional comments related to the operation of the facility and/or resident care that does not relate to the findings of non-compliance.

III. The Extended Survey and Partial Extended Survey

A. Extended and/or Partial Extended Survey

Conduct an extended survey subsequent to a standard survey and conduct a partial extended survey subsequent to an abbreviated survey when you have determined that there is a significant issue of non compliance.

When conducting the extended/partial extended survey, focus on the facility's policies and procedures that may have produced the issue of non compliance. As appropriate, include a review of staffing, training and supervision. An extended/partial extended survey explores the extent to which structure and process factors such as written policies and procedure, staff qualifications and functional responsibilities, and specific agreements and contracts of the facility may have contributed to the outcomes.

Document the observations from the extended or partial extended survey.

B. Timing for Conducting the Extended Survey and Partial Extended Survey

Conduct the extended or partial survey:

- Prior to the exit conference, in which case the facility will be provided with information from the standard, abbreviated standard, partial extended or extended surveys; or,

- Not later than 2 weeks after the standard/abbreviated survey is completed, if the surveyor is unable to conduct the extended survey or partial extended survey concurrent with the standard survey or the abbreviated survey. Advise the facility's Administrator that there will be an extended or partial extended survey conducted and that an exit conference will be held at the completion of the survey.

IV. Writing the Statement of Deficiencies

A. General Objective

The general objective of this section is to write the statement of deficiencies for all Tier II findings of non-compliance in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. Indicate the data prefix tag and regulatory citation, followed by a summary of the evidence and supporting observations using resident identifiers. If information was identified during confidential resident interviews, do not include a resident identifier when recording the source of the evidence.

The survey report should:

• Specifically reflect the content of each requirement that is not met;

• Clearly identify the specific finding(s) of non-compliance, and the objective evidence concerning these practices;

• Identify the extent of the non-compliance practice, including systemic practices, where appropriate; and

• Identify the source(s) of the evidence, e.g., interview, observation, or record review.

B. General Procedures

After the surveyor makes a decision to cite non-compliance, evaluate the impact on the resident(s) and the prevalence of the practice. Review statements and worksheets for evidence on which to base these determinations. The surveyor may base evidence of the

impact or prevalence for residents on record reviews, interviews and/or observations. Whatever the source, the evidence must be credible.

V. Post Survey Revisit (Follow-Up)

The State agency conducts a revisit, as applicable, to confirm the facility is in compliance and has the ability to remain in compliance for all Tier I and Tier II findings of non-compliance. The purpose of the post-survey revisit (follow-up) is to re-evaluate the specific care and services that were cited as noncompliant during the original standard, abbreviated standard, extended or partial extended survey(s).

Verify continued correction of Tier I findings which were corrected while the surveyor was originally on-site for the standard survey. Failure to maintain correction of Tier I finding(s) of non-compliance will result in a Tier II deficiency citation and the facility will be required to provide a written plan of correction.

Ascertain the status of corrective actions being taken on all requirements not in substantial compliance. The facility must develop an acceptable plan of correction for all Tier II citations which included the element of monitoring its performance for the deficient practice/care and assuring that it does not recur.

Conduct as many survey tasks as needed to determine compliance status. However, the surveyor is not prohibited from gathering information related to any requirement during a post-survey revisit.

When selecting the resident sample for the revisit survey, determine the sample size using 60% of the sample size for a standard survey.

Focus on selecting residents who are most likely to have those conditions/needs/problems cited in the original survey. If possible, include some residents identified as receiving substandard quality of care during the prior survey. If, after completing the revisit activities, you determine that the cited incidence(s) of noncompliance was not corrected, recite the findings of non-compliance.

VI. Abbreviated Standard Survey

A. Complaint Investigations

Refer to the North Dakota Department of Health, Division of Health Facilities complaint investigation policy and procedure.

B. Substantial Changes in a Facility's Organization and Management

If a facility notifies the survey agency of a change in organization or management, review the change to ensure compliance with the regulations. Request copies of the appropriate documents, e.g., written policies and procedures, personnel qualifications and

agreements. If changes in a facility's organization and management are significant and raise questions of its continued compliance, determine, through a survey, whether certain changes have caused a decline in quality of care furnished by the facility.

VII. Confidentiality and Respect for Resident Privacy

Conduct the survey in a manner that allows for the greatest degree of confidentiality for residents, particularly regarding the information gathered during the in-depth interviews. Use the resident identifier (e.g., a code number the survey team has assigned to each resident in the sample) in place of the resident's name, which should never be used on the survey report form.

Notes and worksheets contain pre-decisional information and are, therefore, not required to be disclosed to the facility at the time of the survey. Information on the worksheets that was not subsequently used as a basis for writing a deficiency remains pre-decisional and is exempt from disclosure.

VIII. Information Transfer

In conjunction with conducting surveys, the State should provide information to the facility about care and regulatory topics that would be useful to the facility for understanding and applying best practices in the care and treatment of long term care residents.

This information exchange is not a consultation with the facility, but is a means of disseminating information that may be of assistance to the facility in meeting long term care requirements. States are not liable, nor are they to be held accountable if training which occurs during information transfer does not "correct" problems at the facility.

Performance of the function is at the discretion of the State and can be performed at various times, including during the standard survey, during follow-up or complaint surveys, during other conferences or workshops or at another time mutually agreeable to the survey agency and the facility. The time allotted for this information transfer should not usually exceed one hour. In no instance should the information transfer delay the survey process.

Basic Care Facility Interpretive Guidelines

ND Department of Health
Division of Health Facilities
Revised May 2018

B900
33-03-24.1-09. Governing Body.

B910

1. **The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws.**

Interpretive Guidelines

The basic care must have a designated governing body that demonstrates its oversight for the overall operation of the facility.

Survey Procedures and Probes

- Is there evidence the governing body is responsible for the quality of resident services?
- Is there evidence the governing body is responsible for the resident health, safety, and security?
- Is there evidence the facility is in compliance with federal, state, and local laws?

B920

2. **The governing body is responsible for approval and implementation of effective resident care and administrative policies and procedures for the operation of the facility. These policies and procedures must be in writing, signed, dated, reviewed annually, and revised as necessary, and shall address:**

Interpretive Guidelines

- Policies and procedures must be reviewed annually by appropriate staff identified by the governing body.
- Policies and procedures must be revised as needed.
- The annual review and the revisions must be signed and dated.
- Policies and procedures must be implemented to ensure effective resident care.

Survey Procedures and Probes

- Have the resident care and administrative policies and revisions been approved by appropriate staff identified by the governing body?
- Are the policies and procedures for resident care issues available to staff?

B921

a. All services provided by the facility to meet the needs of the resident, including admission, transfer, discharge, discharge planning and referral services.

Interpretive Guidelines

- The facility must develop policies and procedures to address resident care issues.
- Policy/Procedures must include services provided to the residents and the way in which they are provided, i.e. directly, through arrangement, or agreement, etc.
- The facility must develop policies and procedures for admission, transfer, discharge, discharge planning and referral services.

Survey Procedures and Probes

- Review the policy and procedure manuals to ensure there are policies and procedures for required topics.
- Review resident records for sampled residents. Are there policies and procedures to address the needs of the residents?
- Review records to determine if discharge planning is being done.
- Review records to determine if referral services are available and utilized if needed.

B922

b. Protocols developed by appropriately licensed professionals for use in the event of serious health threatening conditions, emergencies, or temporary illnesses. These protocols must include provisions for:

(1) Designation of a licensed health care practitioner for each resident and arrangements to secure the services of another licensed health care practitioner if the resident's designated licensed health care practitioner is not available.
(2) Notification of an appropriately licensed professional in the event of an illness or injury of a resident.

Interpretive Guidelines

The facility must develop policies and procedures to address what protocols are to be followed in the event of serious health threatening condition, emergencies, or temporary

illnesses. These policies and procedures must be developed by appropriate licensed professionals. The facility must develop policies and procedures to address how the facility will obtain the service of another physician or licensed health care practitioner if the resident's health care practitioner in not available. Each resident must have a designated health care practitioner. The facility must have a policy and procedure regarding the notification of an appropriately licensed professional (RN consultant or health care practitioner) in the event of an illness or injury of a resident.

Survey Procedures and Probes

- Has a licensed professional developed protocols for serious health threatening conditions, emergencies, or temporary illnesses?
- Review resident records to determine:
    1. Does each resident have a licensed health care practitioner?
    2. Who is notified if that person is not available?
    3. When a resident is ill or has an injury is a licensed professional notified?

B 923

c. Provisions for pharmacy and medication services developed in consultation with a registered pharmacist, including:
(1) Assisting residents in obtaining individually prescribed medications from a pharmacist of the resident's choice.
(2) Disposing of medications that are no longer used or are outdated, consistent with applicable federal and state laws.
(3) Allowing the resident to be totally responsible for the resident's own medication upon resident request and based on the assessment of the resident's capabilities with respect to this function by an appropriately licensed professional.

Interpretive Guidelines

The pharmacy and medication services policies and procedures must be developed in consultation with a registered pharmacist.

Survey Procedures and Probes

- Are pharmacy and medication services policies and procedures developed with a registered pharmacist?
- Interview residents to determine if they chose the pharmacy from which they want to receive their medications. Choices may be limited depending on the availability of services in the community.
- Interview staff to determine how the facility destroys medications that are outdated.
- Interview staff and residents to determine if residents are allowed to self administer medication.

- Review resident records to determine if a licensed professional has assessed the resident's capabilities to self administer medications.

B924

d. Infection control practices, including provision of a sanitary environment and an active program for the prevention, investigation, management, and control of infections and communicable diseases in residents and staff members.

Interpretive Guidelines

The facility must have an ongoing infection control program. The facility policies and procedures must include prevention, investigation, management, and control of infections.

Survey Procedures and Probes

- Observe resident care, interview staff, observe the environment and review records to determine:
  (1) *If* hand *hygiene and the use of gloves (when indicated) is in accordance with current standards of practice?*
  (2) *Are linens handled, processed, transported, and stored to prevent contamination and the transmission of infection?*
  (3) Is the environment sanitary?
  (4) Are there policies and procedures written regarding the infection control program?
  (5) Does the facility have an infection control program?
  (6) Does the facility prevent, investigate, and control infections and communicable diseases?

B925

e. Prohibition of resident abuse, neglect, and misappropriation of resident property, including investigation, reporting, and follow-up action.

Interpretive Guidelines

The facility must have policies and procedures to prevent abuse, neglect, and misappropriation of resident property. The policies and procedures must include investigation, reporting, and follow-up action.

Survey Procedures and Probes

- Review records, interview staff and residents to determine:
  (1) Does the facility investigate, report, and take follow-up action for alleged violations?

B926

f. Reporting to the department significant medication administration errors by a facility staff member which results in a negative outcome to a resident or a pattern of medication errors.

Interpretive Guidelines

The facility must have a system for reporting to the department when a significant medication error results in a negative outcome to a resident. A significant medication error is one that requires medical attention (emergency room or hospitalization) and/or harms a resident. If a medication assistant I or II (staff member) makes three medication errors within a rolling 12 month period, the third error requires a report to the department.

Survey Procedures and Probes

- Does the facility have policies and procedures for reporting to the department when a significant medication error results in a negative outcome for a resident?
- Does the facility have policies and procedures for reporting to the department a staff member who makes a third medication error within 12 months?

B927

g. A process for handling complaints made by residents or on behalf of residents.

Interpretive Guidelines

The facility must have a system for handling complaints made by residents or on behalf of residents.

Survey Procedures and Probes

- Does the facility have policies and procedures for handling complaints/grievances?
- Interview residents and staff to determine if the facility has a process for handling complaints by residents or complaints made on behalf of a resident.
- Are resident's familiar with the process, and have complaints been resolved to the resident's satisfaction.

B928

h. Resident Rights which comply with North Dakota Century Code chapter 50-10.2

Interpretive Guidelines

- The facility must have policies and procedures to comply with resident rights requirements identified in the North Dakota Century Code chapter 50-10.2.

Survey Procedures and Probes

- Are residents treated with dignity and respect? Provided privacy?
- Are residents provided with Resident Rights information upon admission and annually?
- Interview residents and staff regarding resident rights.
- Do the facility policies and procedures include the resident rights requirements?

B929

i. Personnel policies to include checking state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination.

Interpretive Guidelines

- The facility must have policies and procedures which include checking state registries and licensure boards prior to employment.

Survey Procedures and Probes

- Check employee records to determine if the facility checks with the appropriate licensure board (example: North Dakota Board of Nursing or another licensure board) prior to employment.
- Does the facility check the state registry for certified nursing assistants?

B930

j. Personnel records to include job descriptions, verification of credentials where applicable, and records of training and education.

Interpretive Guidelines

The facility personnel records must include a copy of the job description, verification of the employees credentials, and a record of the employees training and education.

Survey Procedures and Probes

- Review employee records to determine if the record includes:
  (1) Job description
  (2) Verification of credentials when applicable

(3) Training and education

B940

3. **If the facility provides any clinical laboratory testing services to an individual, regardless of the frequency or the complexity of the testing the governing body is responsible to obtain and maintain compliance with the applicable parts of the clinical laboratory improvement amendments of 1988, 42 CFR part 493.**

Interpretive Guidelines

The facility must obtain and maintain a CLIA certificate, if laboratory tests are performed by facility staff (example: blood glucose testing or fecal occult blood).

Survey Procedures and Probes

- Interview staff to determine if the facility does any laboratory testing.
- Obtain a copy of the CLIA waiver if laboratory testing is done.

B950

4. **The governing body shall appoint an administrator to be in charge of the general administration of the facility. Provisions must be made for a staff member to be identified in writing to be responsible for the onsite operation of the facility in the absence of the administrator.**

Interpretive Guidelines

The governing body must appoint an administrator to be in charge of the facility. In the absence of the administrator, a staff member must be identified, in writing, as the person responsible for the operation of the facility.

Survey Procedures and Probes

- Determine who is in charge of the general administration of the facility.
- Interview the administrator to determine who is responsible for the operation of the facility when the administrator is absent.
- Review the policy regarding administration and who is responsible for the operation of the facility when the administrator is absent. The policy must reflect accountability 24 hours a day- seven days per week. May be addressed by on-call schedule/designation.

B960

5. **The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility awake, and prepared to assist residents twenty-four hours a day.**

Interpretive Guidelines

There must be sufficient trained and competent staff available to meet the needs of the residents 24 hours a day.

Survey Procedures and Probes

- Review staffing schedule.
- Interview residents to determine if their needs are met twenty-four hours per day. Ask if trained staff are prepared to assist them day or night.

33-03-24.1-10. Fire Safety.

The fire safety provisions located in section 33-03-24.2-08 apply to this chapter.

History: Effective January 1, 1995; amended effective July 1, 1996; October 1, 1998; July1, 2015.
General Authority: NDCC 23-09.3-19
Law Implemented: NDCC 18-01-03.2, 23-09.3-09

B1100
33-03.24.1-11 Education Programs

1. **The facility shall design, implement, and document educational programs to orient new employees and develop and improve employees' skills to carry out their job responsibilities.**

Interpretive Guidelines

A staff orientation program must exist. Each department should have an orientation program for job responsibilities in that department and facility wide policies and procedures. The facility is responsible to maintain a record of staff orientation. If the facility provides special care services (tube feeding, pressure sore care, oxygen, etc…), staff need to be trained to meet resident needs.

Survey Procedures and Probes

- Observe staff as they provide care for the sampled residents. Are staff trained and knowledgeable when providing care?
- Interview staff about their orientation/training. Did the orientation/training include sufficient information to adequately perform their job?
- Review files for training/orientation if concerns are identified.

B1120

2. **On an annual basis, all employees shall receive in-service training in at least the following:**
   a.) Fire and accident prevention and safety.
   b.) Mental and physical health needs of the residents, including behavior problems.
   c.) Prevention and control of infections, including universal precautions.
   d.) Resident Rights.

Interpretive Guidelines

Annual is defined as12 months from the previous in-service of the same topic. Records of in-service training should be kept for all staff members. The record should include: a.) date of training and b.) agenda or synopsis of training and the name of the presenter.

Survey Procedures and Probes

- Review in-service training records.
- Do the in-services relate to the four required categories?
- Do the in-services relate to the special care services required to meet the residents needs?

B1130

3. **The administrator shall attend at least twelve continuing education hours per year relating to care and services for residents.**

Survey Procedures and Probes

- Review the administrator's continuing education records if concerns are identified.
- Is the continuing education pertinent to resident care and services?

B1140

4. **The staff responsible for food preparation shall attend a minimum of two dietary educational programs per year.**

Interpretive Guidelines

Staff responsible for food preparation is defined as anyone who prepares food, serves food, or plans food preparation. Educational programs should incorporate topics such as food safety, food preparation, therapeutic diets, etc.

Survey Procedures and Probes

- Review dietary staff education records if concerns are identified.
- One staff member who has attended dietary related educational programs can train other staff members.

B1150

5. **The staff responsible for activities shall attend a minimum of two activity-related educational programs per year.**

Interpretive Guidelines

Staff responsible for activities includes staff who plan activities as well as staff that assist with activities. Educational programs should incorporate topics relevant to meeting the activity needs of the residents.

Survey Procedures and Probes

- Review activity staff education records if concerns are identified.
- One staff member who has attended activity related educational programs can train other staff members.

B1200
33-03-24.1-12 Resident Assessments and Care Plans

B1210

1. **An assessment is required for each resident within fourteen days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly.**

Interpretive Guidelines

A licensed professional can be anyone who is licensed, if their practice act indicates the licensed professional can complete assessments. An assessment must be completed on each resident within fourteen days of admission and at least quarterly.

Survey Procedures and Probes

- Review the assessments of sampled residents to ensure the assessment are completed within the required time frames by a licensed professional.

B1220

2. **The assessment must be completed in writing by an appropriately licensed professional. The assessment must include:**

    a. **A review of health, psychosocial, functional, nutritional, and activity status.**
    b. **Personal care and other needs.**
    c. **Health needs.**
    d. **The capability of self-preservation.**
    e. **Specific social and activity interests.**

Interpretive Guidelines

The assessment must include a review of the health status (diagnoses, special care needs, overall well being etc…) The assessment must include a review of the psychosocial status (psychological, emotional, and social needs etc…) The assessment must include a review of the functional status (how the resident is able to care for herself/himself/move about the facility.) The assessment must include a summary of activities the resident attended for the quarter. Nutritional status means dietary needs such as therapeutic diet, hydration, weight concerns, etc. The assessment must include the personal care needed by the resident to meet his/her needs. The assessment must include how the health needs of the resident were met by the facility staff or professional staff in the community. The assessment must include the resident's capability to evacuate the facility in the event of a fire, disaster, or other emergency without staff intervention. The assessment must include the resident's social and activity interests; such as family in the community, organizations where the resident was a member, church affiliation, hobbies, etc.

Survey Procedures and Probes

- Review the initial and quarterly assessments for the sampled residents to ensure all required areas are addressed.
- Does the assessment address all aspects of the resident?

B1230

3. **A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty one days of the admission date and consistently implemented in response to individual resident needs and strengths.**

Interpretive Guidelines

A plan of care must be developed for each resident within twenty-one days of admission. The care plan must be developed based on the information gathered from the assessment and with input from the resident or the person with the legal responsibility to act on behalf of the resident. The care plan should identify the strengths and needs of the resident and how the staff should meet those needs. Staff must consistently follow the care plan.

Survey Procedures and Probes

- Review care plans for sampled residents.
- Does the care plan accurately reflect the resident's problems/needs/strengths?
- Is the care plan consistent with the assessment and documented resident observations?
- Does the care plan identify staff interventions for resident problems/needs?
- Do staff follow the care plan?

B1240

4. **The care plan must be updated as needed, but no less than quarterly.**

Interpretive Guidelines

The resident's care plan must be updated with new interventions when there is a need to change the care provided to the resident. Care plans must be updated at least quarterly. Care plan changes must be dated, and discontinued problems and interventions on the care plan should be clearly identified.

Survey Procedures and Probes

- Has the care plan been updated to reflect the current status of the resident?
- Are care plan changes/updates clearly identified and dated.

B1300
33-03-24.1-13 Resident Records

B1310

1. **The facility shall provide secure maintenance and storage of all resident records.**

Interpretive Guidelines

Resident records need to be kept in a secure area away from public access. Resident records need to be kept safe from loss and destruction.

Survey Procedures and Probes

- Observe the location of the resident records.
- Are the resident records stored to maintain resident's confidentiality?
- Are the resident's records stored to prevent loss and destruction?

B1320

2. Resident records must include:

a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, designated representative or other responsible person.

Interpretive Guidelines (a)

- The resident record must be updated as needed to reflect the current information.

b. The licensed health care practitioner's orders and report of an examination of the resident's current health status.

Interpretive Guidelines (b)

- "Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care.
- The resident record must contain licensed health care practitioner orders. This includes telephone orders.
- Reports of examinations by a licensed health care practitioner which addresses the resident's current health status must be included in the resident's record.

c. An admission note.

Interpretive Guidelines (c)

- Resident records must include an admission note with pertinent information. This information should include the date and time of admission, where the resident was admitted from, and the resident's status at the time of admission.

d. A copy of an initial and current assessment and care plan.

Interpretive Guidelines (d)

Resident records must include the initial resident assessment and care plan; and the most current resident assessment and care plan.

e. Documentation of resident observations by authorized staff.

Interpretive Guidelines (e)

Documentation of resident observations must accurately reflect the status of the resident. This would include observations related to health, social service, activity, etc… The frequency of documentation of resident observations is determined by the status of the resident's condition. Examples include: Changes in a resident's medical condition must be documented; observation of treatment area (improvement or lack of improvement) must be documented.

Survey Procedures and Probes (e)

- Do resident observations describe the current status of the resident?
- Does documentation clearly explain significant events in a resident's life? For example: accidents, hospitalizations, traumatic events, behavior, etc.

f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility.

Interpretive Guidelines (f)

The facility must document the cause of the resident's death. The facility must document how the personal belongings of the resident were disposed of.

g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs.

Interpretive Guidelines (g)

Resident records must include quarterly progress notes which include the resident's current health condition, functional ability, involvement in activities, nutritional status, psychosocial interactions, and needs.

h. Documentation of review of prescribed diets.

Interpretive Guidelines (h)

- Resident records must document a review of the resident's prescribed diet by a qualified health professional.

i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility.

Interpretive Guidelines (i)

- Resident records must include copies of completed transfer forms. This includes transfers to the emergency room, hospital, and to other health care facilities.
- Transfer forms must be signed and sent with the resident.

j. A medication administration record documenting medication administration consistent with applicable state laws, rules and practice acts.

Interpretive Guidelines (j)

The facility must have a system/method for recording medications when they are administered. The medication record must include the name of the medication, dosage, route of administration, time given and the initials of the person administering the medication. The full signature of the staff administering the medications must appear on the medication administration record or on another form in the resident record which identifies the initials of staff. Medications must be administered consistent with all applicable state laws, rules, and practice acts.

Survey Procedures and Probes (j)

- Review sampled residents' medication administration records.
- The medication record should accurately reflect the physician order.

k. Documentation of an annual medication regiment review.

Interpretive Guidelines (k)

Resident records must include an annual medication regimen review completed by a licensed healthcare practitioner or a pharmacist.

Survey Procedures and Probes (k)

- Review the resident record for documentation of annual medication regimen review.

l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund.

Interpretive Guidelines (l)

Reports of funds must include deposit to and withdrawals from the fund.

Survey Procedures and Probes (l)

- Does the resident record indicate if funds are kept for the resident?
- During resident interviews, determine if funds are kept for the resident.

m. Documentation of a fire drill walk-through within five days of admission.

Interpretive Guidelines (m)

Resident records must include evidence of a fire drill walk-through within five days of admission.

Survey Procedures and Probes (m)

- Interview sampled residents, who have been admitted to the facility during the past year, regarding what they have been told to do in case of a fire.
- Review records of sampled residents admitted during the past year to determine if a fire drill walk-through was done within 5 days of admission.

n. All agreements or contracts entered into between the facility and the resident or legal representative.

Interpretive Guidelines (n)

Resident records must include an admission agreement.

Survey Procedures and Probes (n)

- Review sampled resident's records to determine if an admission agreement is signed and in the record.
- Copies of other agreements or contracts should be in the record.

o. A discharge note.

Interpretive Guidelines (o)

Resident records must include a discharge note when a resident is discharged from the facility.

Survey Procedures and Probes (o)

- Review closed records to determine if a discharge note is in the record.

B1330

3. **The facility shall maintain resident records for a period of not less than five years from the date of discharge or death.**

Survey Procedures and Probes

- Does the facility maintain resident records at least five years after a resident is discharged or expires?

B1400
33-03-24. 1-14 Personal Care Services

The facility shall provide personal care services to assist the resident to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. These services must include assistance with:

Interpretive Guidelines

"Personal care" means assistance with activities of daily living and instrumental activities of daily living and general supervision of physical or mental well-being.

B1410

1. **Activities of daily living and instrumental activities of daily living and observation and documentation of changes in physical, mental, and emotional functioning as needed.**

Interpretive Guidelines

"Activities of daily living" means those personal, functional activities required by an individual for continued well-being, mobility, toileting, and behavior management. "Instrumental activities of daily living" includes preparing meals, shopping, managing money, housework, laundry, transportation, use of telephone, and mobility outside the basic care facility.

Survey Procedures and Probes

- Review resident records for residents who receive assistance with activities of daily living (ADL's).
- Make observations of resident care for residents who need assistance with ADLs.
- Interview residents to determine if ADL and IADL needs are met.

B1420

2. Arrangements to seek health care when the resident shows signs or describes symptoms of an illness or abnormality for which treatment may be indicated.

Interpretive Guidelines

The RN consultant or licensed healthcare professional must be consulted when the resident experiences signs or symptoms of an illness or abnormality (i.e.: fall in which an injury occurs, fracture, persistent diarrhea, abnormal symptoms, etc.) for which treatment may be indicated.

Survey Procedures and Probes

- Review the medical records of sampled residents
- Does the documentation indicate residents received treatment for their illness or abnormality?

B1430

3. Arrangements for appropriate transfer and transport as needed.

Interpretive Guidelines

Facility staff is responsible to make arrangements for appropriate transfer and transportation as needed for necessary appointments.

Survey Procedures and Probes

- Is the facility providing transportation or arranging for transportation?

B1440

4. Functional aids or equipment, such as glasses, or hearing aids, canes, crutches, walkers, or wheelchairs.

Interpretive Guidelines

The facility must assist residents to assure that functional aids or equipment are accessible when needed by the resident.

Survey Procedures and Probes

- If the resident needs functional aids/equipment, does the facility provide for the need or do they refer the resident to an agency that can provide the needed equipment?
- If the resident has functional aids/equipment, does the facility maintain or arrange outside services to assist with the maintenance of the functional aids/equipment?

B1450

5. Clothing and other personal effects as well as maintenance of personal living quarters.

Survey Procedures and Probes

- Does the facility provide assistance with clothing and other personal effects of the resident or does it arrange for an outside agency to provide assistance with these items if the resident is unable?
- Maintenance of personal living quarters: Does the facility have policies and procedures to identify how they will maintain the resident's personal space? For example, if a resident has a refrigerator, microwave, humidifier, etc. who will clean these items?

B1500
33-03-24.1-15. Pharmacy and medication administrative programs.

B1510

1. The facility shall provide assistance to the resident in obtaining necessary medication and medical supplies.

Survey Procedures and Probes

- Interview staff to determine how medications and medical supplies are obtained.

B1520

2. **The facility shall provide a secure area for medication storage consistent with Chapter 61-03-02.**

Interpretive Guidelines

Chapter 61-03-02. is the consulting pharmacist regulations for long term care facilities (skilled, intermediate, and basic care). Medications must be stored to prevent access by unauthorized individuals.

Survey Procedures and Probes

- Where do residents store their medications? Is the medication stored securely?

B1530

3. **Medication administration services must be available for residents.**

Interpretive Guidelines

The facility is responsible to develop a system to provide medication administration for residents.

Survey Procedures and Probes

- Review facility policies and procedures to determine if medication administration services are available.

B1540

4. **All medications used by residents which are administered or supervised by staff must be:**
   a. **Properly recorded by staff at the time of administration.**
   b. **Kept and stored in original containers labeled consistently with state laws.**
   c. **Properly administered.**

Interpretive Guidelines

When staff administer medications or supervise medication administration, the staff person must document the medication and dose given at the time it is administered. Medication must be stored in the original container. The label on the container must meet North Dakota Board of Pharmacy requirements (Chapter 61-03-02). Medications must be administered as ordered by the licensed health practitioner?

Survey Procedures and Probes

- Observe medication administration.
- Do staff properly record the medication at the time of administration?

- Are the medications stored in original containers?
- Are medications properly administered?
    a. In accordance with the licensed health practitioner order?
    b. Manufacturers specifications?
    c. Acceptable professional standards?
    d. Medications must be administered to the right resident, with the right medications, in the right dose, at the right time, and in the right route (oral, injection, inhaler, etc.).

B1550

5. The resident's licensed health care practitioner, another licensed health care professional consistent with applicable state practice acts, or a consulting pharmacist shall review the medication regimen of each resident as needed, but at least annually.

Interpretive Guidelines

"Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care.

Survey Procedures and Probes

- Review the resident record.
- Has the resident's medication regimen been reviewed at least annually by a licensed health care practitioner or a pharmacist?

B1560

6. A medication record need not be kept for those residents for whom authorization has been given by a licensed health care professional to keep their medication in their rooms and to be fully responsible for taking the medication in the correct dosage and at the proper times.

Interpretive Guidelines

"Licensed health care practitioner" means an individual who is licensed or certified to provide medical, medically related, or advanced registered nursing care. The facility is not required to keep a medication administration record for a resident who has an order from a licensed health care professional to self administer medication and the facility has determined the resident is capable of safely doing so.

Survey Procedures and Probes

- Review the resident record.
- Has a licensed health care professional authorized self-administration of medication by the resident?
- Has the facility assessed the capabilities of the resident to self administer the medication in the correct dose at the proper time?

B1600
33-03-24. 1-16. Social Services

Social Services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate agency offering social services.

Interpretive Guidelines

"Social Services" means services provided to assist residents in maintaining or improving their ability to deal with physical, mental, and psychosocial issues. It is the responsibility of the facility to identify the social service needs of the residents and assure that the needs are met. The following are examples of social service responsibilities, however this does not include all social service needs:

- Making arrangements for obtaining needed equipment/clothing.
- Maintaining contact with family.
- Assisting residents with financial and legal matters.
- Discharge planning services.
- Provision of counseling services.
- Assisting residents to determine how they would like to make decisions about their health care, or involving others in the decision process.
- Meeting the needs of residents who are grieving.
- Finding options that meet their physical and emotional needs.

Referral agencies should be identified and available to address social service needs the facility is unable to meet.

Survey Procedures and Probes

- Interview residents to determine if their social service needs are met.
- Review resident records to determine if social service issues are identified and services are provided.

B1700
33-03-24.1-17. Nursing services.

Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services.

Interpretive Guidelines

Nursing services are services to assist the resident with health needs. If the facility admits residents with medical/health needs, the facility must meet those needs. Nursing services must be provided either directly by the facility or arranged by the facility. If the facility makes arrangements for nursing services to be provided by another agency, the basic care facility retains primary responsibility for the resident.

Survey Procedures and Probes

- Review the resident records for sampled residents.
- Are the medical/health needs of the resident met in accordance with acceptable professional standards?

B1800
33-03-24.1-18 Dietary Services

The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include:

Interpretive Guidelines

The facility must follow the "North Dakota Requirements for Food and Beverage Establishments" (Chapter 33-33-04).

Survey Procedures and Probes

- Conduct a tour of the dietary department to determine compliance with "North Dakota Requirements for Food and Beverage Establishments".
- Observe food storage, preparation and serving of a meal(s) to determine compliance.

B1810

1. **A minimum of three meals each day. Meals must be nutritious and well balanced in accordance with the recommended dietary allowances of the food**

and nutrition board of the national research council, national academy of sciences.

Survey Procedures and Probes

- Review menus for the week of survey.
- Who writes/approves the menus?
- Determine if menus meet the recommended dietary allowances of the food and nutrition board of the national research council.

B1820

2. **No more than a 14 hour span may exist between an evening meal and breakfast.**

Interpretive Guidelines

Example: If the evening meal is served at 5:30 p.m., breakfast cannot be served later than 7:30 a.m.

Survey Procedures and Probes

- Obtain a schedule of meals served.
- Observe meals to determine that no longer than a fourteen hour span exists between the evening meal and breakfast.
- Is a substantial snack provided in the evening/hs if the meal span exceeds 14 hrs.

B1830

3. **Snacks between meals and in the evening. These snacks must be listed on the daily menu. Vending machines may not be the only source of snacks.**

Interpretive Guidelines

Snacks must be listed on the daily menu. Snacks must be served between meals and in the evening.

Survey Procedures and Probes

- Obtain a schedule of meals and snacks served.
- Are snacks served between meals and in the evening?
- Are the snacks included on the daily menu? Is there a specific food item listed as the snack?

B1840

4. **Provisions for prescribed diets, if the facility accepts or retains individuals in need of such diets.**
    a. **The facility shall provide for preparation and serving of prescribed diets.**
    b. **Menus for prescribed diets must be planned and reviewed as needed by a professional consistent with North Dakota Century Code chapter 43-44.**

Survey Procedure and Probes

- Observe if meals are consistent with the planned menu and resident care plan in the amounts, types, and consistency of foods served.
- Are there planned menus for all diets ordered by the licensed health practitioner?
- Is there an order by a licensed health practitioner for the prescribed diet?
- Are there recipes for all diets? Does the facility follow recipes while cooking?
- Review records for sampled residents to determine diet ordered.
- Observe meal(s) to determine if the facility is serving foods, in the required amounts as identified on the menus.
- Is food being served as planned? Does the facility provide a substitute of similar nutritive value if the planned menu is changed or if the resident does not like the food served?

B1850

5. **Menus of food served must be kept for at least three months.**

Interpretive Guidelines

The facility must keep menus of food served for at least three months.

Survey Procedures and Probes

- Interview the dietary manager to determine how long the facility keeps the menus of food served. Are the menus kept at least three months?
- Review substitutions made/served in lieu of planned menu. Were substitutions comparable in nutritional value and were RDA's met?

B1860

6. **Preparation of food by methods that will conserve nutritive value and enhance flavor and appearance, and be served at the proper temperatures and in a form to meet individual needs.**

Interpretive Guidelines

The nutritive value of food should not be compromised because of prolonged food storage, light, air exposure, prolonged cooking in a large volume of water, prolonged holding on a steam table. Methods of storage and preparation should cause minimum loss of nutrients. Foods must be served at the proper temperature. Cold foods must be served cold, and hot foods must be served hot. Foods must be served in a form to meet individual needs. Examples include pureed diet, mechanical soft diet, ground meat, etc. Refer to ND Requirements for Food Beverage Establishments.

Survey Procedures and Probes

- Observe meal(s) preparation and the serving of a meal(s).
- Interview residents to determine if food is served at the correct temperature (hot foods are served hot and cold foods are served cold).
- If a resident complains of food taste or temperature, the surveyor should request a test tray.
- The surveyor may take temperatures at the point of service as needed.
- Interview residents to determine if foods are served in a form which meets the residents' needs, such as mechanically altered diets.
- If mechanically altered diets are served, observe the preparation of such foods to ensure the nutritional value of the food is not compromised, and adequate amounts are served.

B1870

7. **Meals must be served to all residents in a dining room, except for residents with a temporary illness.**

Survey Procedures and Probes

- Observe meals(s) to determine if all residents are served in a dining room.
- Interview residents and staff to determine if meal trays are served outside of the dining room for residents with a temporary illness.

B1900
33-03-24.1-19 Activity Services

There must be a planned and meaningful activity program to meet the needs and interests of the residents and encourage self-care and continuity of normal activities. This program must:

B1910

1. **Be developed based on the activity needs and interests of each resident identified through the initial and ongoing assessments.**

Interpretive Guidelines

Activities may include in room and out of room activities based on the individual needs and interests of each resident. Activities may include individual and group activities based on the residents' interests.

Survey Procedures and Probes

- During individual interviews, ask residents if they are able to give input regarding what activities are conducted in the facility.
- Does the facility address the needs of special populations: dementia residents, developmentally disabled, the young resident etc.
- Does the facility assist the resident in obtaining individual activity/hobby supplies.
- Are the residents given the opportunity to participate in community social religious etc. functions/activities.

B1920

2. **Develop and post a monthly group activity calendar, based on the individual interests identified, which lists social, recreational, and other events available to residents.**

Survey Procedures and Probes

- Is the monthly group activity calendar posted?
- Does the activity calendar include a variety of activities?
- During resident interview ask the resident if the activities are of interest.

B1930

3. **Activities must be available and provided to meet the needs of all residents during the day, in the evening, and on the weekend.**

Survey Procedures and Probes

- Review the activity calendar for activities during day, night, and weekend hours.
- During individual interviews, ask residents if they are satisfied with the frequency of activities.
- During individual interviews, ask residents if they have an opportunity to give input to the type, time and frequency of activities.

B1940

4. **Assist residents with arrangements to participate in social, recreational, religious, or other activities within the facility and the community in accordance with individual interests and capabilities.**

Survey Procedures and Probes

- Does the facility provide assistance to residents to attend activities, if needed. (remind, direct, or provide physical assistance)?
- Does the facility provide transportation or arrange transportation for residents to attend activities outside of the facility?

B2000
33-03-24.1-20. Housekeeping and Laundry Services

The facility shall maintain the interior and exterior of the facility in a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents.

Interpretive Guidelines

The facility must provide laundry services including personal laundry services directly or through a contract with an outside agency. The facility can charge for laundry services for private pay individuals, provided this is a part of the facility policy. The resident must be informed of the charge for this service. If the resident is Medicaid eligible, the resident cannot be charged for personal laundry services.

Survey Procedures and Probes

- Is the facility safe? Is there anything that could cause an accident or would potentially harm a resident?
- Is the facility clean?
- Is the facility uncluttered and well maintained?
- Interview residents to determine if laundry services are available and if there is a charge for the service.

B2100
33-03-24.1-20. Adult day care services.

B2110

1. **A facility must obtain approval from the department to provide adult day care services.**

Survey Procedures and Probes

- Does the facility provide adult day services?
- Review the facility file prior to the survey to determine if the facility has approval to provide adult day services.

B2120

2. **Use of existing space and equipment to deliver adult day care services is acceptable if this does not diminish the services provided to the residents of the facility and their needs being met.**

Interpretive Guideline

A facility can provide adult day care services if the services do not result in the needs of the residents of the facility not being met.

Survey Procedures and Probes

- Do the adult day care services affect the services of the residents who live at the facility?

B2130

3. **Medications and treatments must be administered only by order of a licensed physician.**

Survey Procedures and Probes

- Does the facility have physician orders for medications and treatments?

B2140

4. **Records must be maintained of services provided to individuals participating in adult day care services.**

Survey Procedures and Probes

- Does the facility maintain a record for the adult day care individuals?

B2150

5. **An area allowing privacy for adult day care individuals must be developed to allow for rest periods.**

Survey Procedures and Probes

- Does the facility provide a private area for adult day care individuals to rest?

History: Effective January 1, 1995.
General Authority: NDCC 23-09.3-09, 28-32-02(1)
Law Implemented: NDCC 23-09.3-04

33-03-24.1-22 General building requirements.

Repealed effective July 1, 2015.

B2300
33-03-24.1-23. Optional end-of-life services.

B2301

A facility that intends to retain residents who require end-of-life care must comply with the requirements of this section, apply on an application specified by the department, and receive written approval from the department prior to providing the services. The facility must meet the following requirements:

1. **A facility may not retain residents who require more than intermittent nursing care unless the resident requires and elects to receive end-of-life care from a licensed and Medicare-certified hospice agency and the facility is licensed to provide end-of-life care.**

Survey Procedures and Probes

- Ask for the name of all residents requiring more than intermittent nursing care.
- Review the medical record for proof of the resident's election of end-of-life care.
- Is the hospice agency providing the care licensed and Medicare certified?
- Is the facility licensed to provide end-of-life care?

B2302

2. **A facility providing end-of-life care must employ or contract with a registered nurse to supervise resident care to meet the needs of the residents at all times, either directly or indirectly. The facility must employ a licensed nurse who is on the premises at least forty hours per week to identify and respond to resident needs, care plan accordingly, provide oversight related to care, and review and document the resident's individual needs and care provided.**

Survey Procedures and Probes

- Is a registered nurse available at all times, either directly or indirectly when the facility has a resident on end-of-life care?
- Request the schedule to verify a licensed nurse is on the premises at least forty hours per week.
- Ask what services the licensed nurse provides for the resident on end-of-life care.

B2303

3. **Individuals in need of end-of-life care who require skilled nursing care or are not capable of self-preservation may not be admitted.**

Survey Procedures and Probes

- How does the facility screen prospective residents, who are in need of end-of-life care, to determine they do not require skilled nursing care or are capable of self-preservation before accepting the resident for admission to the facility?
- Determine when residents were started on end-of-life care. Review their needs/self-preservation capability at the time of admission.

B2304

4. **The facility and the licensed and Medicare-certified hospice agency shall enter into an agreement that delineates responsibilities, with the licensed and Medicare-certified hospice agency retaining the professional management responsibility for the hospice service.**

Survey Procedures and Probes

- Request the agreement/contract between the facility and the hospice agency for review.
- Does the agreement list the responsibilities of both the facility and the hospice agency?
- Does the hospice agency retain the professional management for the hospice service?

B2305

5. **The facility and licensed and Medicare-certified hospice agency in consultation with the resident shall develop and implement an interdisciplinary care plan that identifies how the resident's needs are met and includes the following:**
    a. **What service are to be provided;**

b. **Who will provide the services, the facility or hospice agency;**
c. **How the services will be provided;**
d. **Delineation of the care and services that are provided with the signature of the person who provided the care and services; and**
e. **A list of the current medications or biologicals the resident receives and now is authorized to administer the medications.**

Survey Procedures and Probes

- Review the resident's interdisciplinary care plan.
- Does it identify how the resident's needs are met and what service are provided?
- Who provides the services, and how are they provided?
- Does it specify the role of facility staff and hospice agency staff in the care plan process?
- Are care and services provided by staff documented and signed by the person providing the care?
- Is there a list of current medications and who is authorized to administer them?

B2306

6. **The facility shall notify the department within forty-eight hours of election that the resident has elected hospice, the date the hospice was elected, and the name of the hospice agency serving the resident.**

Survey Procedures and Probes

- Ask for proof the department was notified of a resident's hospice election within 48 hours of election. Does the notice also contain the name of the hospice agency?

B2307

7. **The facility shall notify the department within forty-eight hours of the hospice resident's discharge, transfer, death, or when the resident is no longer capable of self-preservation.**

Survey Procedures and Probes

- Ask for proof the department was notified of a hospice resident's discharge, transfer, death, or is no longer capable of self-preservation within 48 hours of change.

B2308

8. **A facility that retains a resident requiring end-of-life care that is not capable of self-preservation shall be equipped with an approved automatic sprinkler system designed to comply with the national fire protection association standard 13 or 13R, or shall meet the national fire protection association 101 Life Safety Code, 2012 edition, health care occupancy requirements.**

Survey Procedures and Probes

- Check the recent Life Safety Code survey to ensure the facility has an approved automatic sprinkler system or meets the NFPA 101 health care occupancy requirements.

B2309

9. **Facility evacuation or E scores shall be completed at a minimum of weekly and when there is a significant change in the resident's capability for self evacuation when a resident is receiving end-of -life care. Facility staffing must be adjusted consistent with the E scores to maintain a slow evacuation capability. Hospice staff, family members, volunteers, or other nonfacility staff cannot replace required facility staff.**

Survey Procedures and Probes

- Verify the facility completes E scores at least weekly and with a significant change in the hospice resident's capability for self-evacuation.
- Has the facility adjusted staffing to maintain a slow evacuation capability?

B2310

10. **A facility approved to provide end-of-life care shall ensure training and competency evaluation is completed for all nursing and personal care staff members specific to the care and services necessary to meet the needs of the terminally ill resident, and the hospice philosophy and services. The training and competency evaluation may be completed, and documented, by the facility registered nurse, a registered nurse consultant, or a hospice agency nurse. Nursing and personal care staff members shall complete the above training and competency evaluation:**
    a. **Prior to facility approval from the department to provide end-of-life care;**
    b. **Within thirty days of employment; and**
    c. **Annually.**

Survey Procedures and Probes

- Review the personnel records of nursing and personal care staff for proof of training and competency evaluation prior to approval to provide end-of-life care, within 30 days of employment, and annually.
- Verify a facility registered nurse, registered nurse consultant, or hospice agency nurse provided the training and evaluation.
- Verify the training included care and services specific to the needs of the terminally ill resident, and the hospice philosophy and services.

B2311

11. **A facility that intends to retain residents who require end-of-life care shall comply with the additional requirements in this section and request and receive approval on a printed new license from the department, prior to providing end-of-life care to residents.**

Survey Procedures and Probes

- Request to see the facility's license from the department to provide end-of-life care.
- Verify the facility received the license prior to providing services.

B2312

12. **The facility approved and licensed to retain residents in need of end-of-life care remains responsible for the appropriate delivery of end-of-life care in coordination with the licensed and Medicare-certified hospice agency. If the facility is unable, or becomes unable, to meet the needs of the resident requiring end-of-life care, the resident rescinds election of the hospice benefit, or the facility is unable to comply with these requirements, the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement consistent with the level of care required to meet the resident's needs.**

Survey Procedures and Probes

- Review records of residents on hospice services (current or closed record) to ensure the facility discharges or transfers the resident promptly to a facility able to meet the level of care required, when the facility can no longer meet the needs for end-of-life care.

EVACUATION DIFFICULTY INDEX

2013 EDITION

6.1 General.

6.1.1
This chapter is part of an NFPA guide and, therefore, is not mandatory. The term *shall* in this chapter is used to indicate that if the provisions of the chapter are applied, the procedures mandated are to be followed to ensure the effectiveness of the system. For ease of reading, only the masculine pronoun is used; however, the contents of this chapter apply equally to females and males.

6.1.2
Chapter 33 (NFPA *101*) specifies three sets of requirements for an existing facility based on its evacuation capability. The three levels of evacuation capability defined are *prompt*, *slow*, and *impractical*.

6.1.3
The evacuation capability shall be determined for the residents of a given facility who are living as a group and are provided with staff assistance prior to application of the fire protection requirements. This chapter describes one method for determining evacuation capability.

6.1.4
The evacuation capability for specific facilities, with residents living as a group with staff assistance, is determined by a mathematical method that includes the following:

1. (1)

   Determining the evacuation assistance scores of the individual residents

2. (2)

   Computing a relative level of evacuation difficulty faced by the resident of a specific facility based on the response capabilities of the staff

3. (3)

   Adjusting for vertical egress travel

4. (4)

   Calculating an evacuation capability score

6.1.5
Chapter 33 (NFPA *101*) defines the three evacuation capability levels in terms of residents' performance in a timely response to an emergency evacuation with assistance from staff members or other residents. Utilization of this chapter provides a numerical score that can be translated into one of the three levels of evacuation capability.

6.1.6
The evacuation capability shall be permitted to be used with either Chapter 7 of this guide or Chapter 33 (NFPA *101*).

6.2 Procedure for Determining Evacuation Capability.

6.2.1 Methodology.
Evacuation capability shall be determined via the worksheets included in Figure 6.8.

6.2.2 Evacuation Capability by Zones.

6.2.2.1
Small facilities (those with no more than 16 residents) shall have their evacuation capability scores based on all the residents and the available staff measured in accordance with the criteria for evaluating residents and staff in this chapter.

6.2.2.2
Large facilities (those with more than 16 residents) shall be permitted to have their evacuation capability score calculated on the basis of the entire building, as with small facilities, or on the basis of separate fire or smoke zones. The procedure providing the better (i.e., lower) evacuation capability score shall be permitted to be used. A fire or smoke zone is a portion of the building separated from all other portions of the building by one of the following:

1. (1)

   Construction having at least 1-hour fire resistance

2. (2)

   A smoke barrier conforming to the requirements of Section 8.5 (NFPA *101*), with the smoke barriers constructed with at least a ½-hour fire resistance rating

3. (3)

   In buildings protected throughout with an automatic sprinkler system, construction that is sound and smoke-resistant

6.2.3
If a building is zoned, each zone shall be evaluated separately. The evacuation capability score is based on the residents of that zone and the staff available to that zone in accordance with the staff rating criteria in this chapter.

6.2.4
Where using zones, a separate evacuation capability score shall be determined for zones that include common use spaces where the residents of more than one zone congregate for meals, recreation, or other purposes. In such cases, adjust the resident evacuation assistance scores as appropriate to reflect the different needs that residents might have under such conditions.

6.3 Rating Residents.

6.3.1
Worksheets 6.8.1 through 6.8.4 of Figure 6.8 are used for rating individual residents and also for recordkeeping purposes.

6.3.2
This method of determining evacuation capability has been designed to minimize speculation about how a resident might perform in an actual fire emergency by using ratings based on observed performance. Instead of speculating, raters who are not familiar enough with a resident to provide ratings confidently should consult with an individual who has observed the resident on a daily basis.

6.3.3
Due to the stress of an actual fire emergency, it is likely that some residents will not perform at full capacity. Therefore, ratings based on commonly observed examples of poor performance provide the best readily available indication of behavior that could be reduced by the unusually stressful conditions of an actual fire. All persons are less capable on some occasions, and the ratings should be based on examples of resident performance on a typical "bad" day. Ratings should not be based on rare instances of poor performance.

6.4 Rating Residents Using Worksheets 6.8.1 through 6.8.4.

6.4.1 Risk of Resistance (Line I of Worksheet 6.8.2).

6.4.1.1 General.

6.4.1.1.1

Line I rates the risk that the resident might resist leaving the facility during an emergency evacuation. Unless there is specific evidence that resistance might occur, the resident should be rated as "minimal risk." If more than one rating applies, use the rating with the highest numerical score.

6.4.1.1.2
Specific evidence of resistance means that staff have had to use some physical force in the past. However, an episode of resistance should not be counted if it was the result of a situation that was different enough from an actual fire emergency that it probably does not predict behavior in such an emergency. For example, an incident in which a resident refuses to visit with parents probably does not predict behavior in an actual fire emergency and should not be counted as specific evidence. Resistance can be active (the resident might have struck a staff member or attempted to run away) or passive (the resident might have "gone limp" or hidden from staff members). Simply complaining or arguing is not considered resistance.

6.4.1.2 Minimal Risk.
This rating indicates that there is no specific evidence to suggest that the resident might resist an evacuation.

6.4.1.3 Risk of Mild Resistance.
This rating indicates that there is specific evidence that the resident might resist leaving the facility. Examples of specific evidence are as follows:

1. (1)

   The resident has mildly resisted instructions from staff. Further, the resistance was brief or easily overcome by one staff member and occurred in a situation similar enough to a fire emergency to predict that the behavior could recur during an actual fire emergency.

2. (2)

   The resident has hidden from the staff in a situation similar enough to a fire emergency to predict that the behavior could recur during an actual fire emergency. However, once found, the resident offered no further resistance.

6.4.1.4 Risk of Strong Resistance.
The resident might offer resistance that necessitates the full attention of one or more staff members. Examples of specific evidence of such risk include the following:

1. (1)

   The resident has struggled vigorously in a situation similar enough to a fire emergency to predict that the behavior could recur during an actual fire emergency.

2. (2)

   The resident has totally refused to cooperate in a situation that is similar enough to a fire emergency to predict that the behavior could recur during an actual fire emergency.

3. (3)

   The resident has hidden in a situation that is similar enough to a fire emergency to predict that the behavior could recur during an actual fire emergency. Moreover, once found, the resident continued to offer resistance.

6.4.2 Impaired Mobility (Line II of Worksheet 6.8.2).

6.4.2.1 General.

6.4.2.1.1

Line II rates the physical ability of the resident to leave the facility. This rating should reflect the current physical environment in the building where the resident lives and should be based on the resident's lying awake on his bed. The resident is rated according to how easily he can leave, given the presence of factors such as physical barriers that hinder movement (e.g., stairs), his ability to get out of bed, or the chairs normally used. The resident should be given credit for being able to use devices that aid movement (e.g., wheelchairs, walkers, crutches, and leg braces). However, the rater shall be permitted to give credit for such devices only if the devices are always available for an emergency evacuation.

6.4.2.1.2
The resident should be rated on his ability to use the most accessible route out of the facility. For example, a resident who is "self-starting" when using the back door but who "needs limited assistance" to get out the front door would be rated as "self-starting."

6.4.2.1.3
The resident should be rated for performance while under the influence of any routinely administered medication that slows movement.

6.4.2.1.4
Where the resident needs physical assistance to make a timely evacuation, the rating of assistance needed is based on the degree of strength used by the staff member to assist the resident. Guiding or directing the resident by giving gentle pushes or leading by the hand is not considered physical assistance. If more than one rating applies, use the rating with the highest numerical score.

6.4.2.2 Self-Starting.
The resident is physically able to start and complete an evacuation without physical assistance.

6.4.2.3 Slow.
The resident prepares to leave and travels to the exit (or an area of refuge) at a speed significantly slower than normal. Specifically, the resident is rated "slow" if not able to prepare to leave and then travel from his sleeping room to the exit (or area of refuge) within 90 seconds.

6.4.2.4 Needs Limited Assistance.
The resident might need some initial or brief intermittent assistance but can accomplish most of the evacuation without assistance. An example of specific evidence of such mobility is that the resident is physically able to start and complete an evacuation, except that the resident needs help to accomplish the following:

1. (1)

   Get into a wheelchair

2. (2)

   Descend stairs

3. (3)

   Get out of bed

4. (4)

   Open a door

6.4.2.5 Needs Full Assistance or Very Slow.
The resident "needs full assistance" or is "very slow" as defined in 6.4.2.5.1 and 6.4.2.5.2.

6.4.2.5.1 Needs Full Assistance.

The resident either needs physical assistance from a staff member during most of the evacuation or must be assisted by staff in one of the following ways:

1. (1)

   Carried from the facility

2. (2)

   Helped into a wheelchair and wheeled out of the facility

3. (3)

   Helped into leg braces and to descend the stairs

6.4.2.5.2 Very Slow.

The resident is very slow if the time necessary to prepare to leave and then travel from his sleeping room to the exit is so long that the staff usually assists the resident to evacuate. Specifically, the resident is rated very slow if unable to prepare to leave and then travel to the exit (or area of refuge) within 150 seconds.

6.4.3 Impaired Consciousness (Line III of Worksheet 6.8.2).

6.4.3.1 General.

6.4.3.1.1

Line III rates the risk that a resident could experience a partial or total loss of consciousness in a fire emergency. Unless there is specific evidence that loss of consciousness might occur during a fire emergency, the resident should be rated as "no significant risk."

6.4.3.1.2

Specific evidence is an indication that the resident has experienced some temporary impairment of consciousness of short duration (seconds or minutes) six or more times during the three months preceding the rating of the resident. Regardless of frequency, if there is specific evidence that loss of consciousness might be caused by the stress of a fire emergency, the resident should be rated as having impaired consciousness. An episode of partial loss of consciousness should be counted only if the impairment was severe enough to significantly interfere with the resident's ability to leave the facility. Do not count episodes where the loss of consciousness was the result of a temporary medical problem (e.g., a severe infection). If more than one rating applies, use the rating with the highest numerical score.

6.4.3.2 No Significant Risk.

The resident is not subject to loss of consciousness, or the resident has had fewer than six episodes of losing consciousness (partial and total) during the three months preceding the rating.

6.4.3.3 Partially Impaired.

The resident has had at least six episodes of losing consciousness in the preceding three months, of which the most severe episode was only a partial loss of consciousness; that is, the resident still is able to participate in an evacuation to some degree. Specific evidence that a resident should be rated in this category includes loss of consciousness resulting from mild (partial or petit mal) seizures, dizzy spells, intoxication, or any other partially incapacitating impairment of consciousness.

6.4.3.4 Totally Impaired.

The resident has had at least six episodes of losing consciousness in the preceding three months, the most severe episode involving total or severely incapacitating loss of consciousness; that is, the resident needs the full assistance of at least one staff member to get out of the building. Specific evidence that a resident should be rated in this category includes losses of consciousness resulting from severe (generalized or grand mal) seizures, fainting spells, intoxication, or other total or severely incapacitating loss of consciousness.

6.4.4 Need for Extra Help (Line IV of Worksheet 6.8.2).

6.4.4.1 General.

6.4.4.1.1
Line IV rates the possibility that more than one staff member might be needed to evacuate the resident. Specific evidence is a previous need for two or more persons to assist the resident and an indication that the resident could need assistance from two persons in a fire emergency.

6.4.4.1.2
Where determining the need for additional assistance, the evaluator should disregard the physical strength or weakness of staff members. (For example, a large staff member who is exceptionally strong might be able to assist a resident alone, while a smaller staff member might be unable to assist the resident fully. However, there is no assurance that a staff member who is able to assist alone always will be able to respond to a resident requiring extra assistance.)

6.4.4.2 Needs at Most One Staff Member.
There is no specific evidence that the resident might need help from two or more persons in a fire emergency.

6.4.4.3 Needs Limited Assistance from Two Staff Members.
The resident might need some initial or brief intermittent assistance from two staff members, but otherwise needs help from no more than one. Specific evidence supporting this rating is that a resident needs assistance from no more than one person except to accomplish the following:

1. (1)

   Getting into a wheelchair

2. (2)

   Descending stairs

6.4.4.4 Needs Full Assistance from Two Staff Members.
The resident might need assistance from two staff members during most of an evacuation. Specific evidence of the need for assistance from two staff members follows:

1. (1)

   Two persons are needed to carry the resident from the facility.

2. (2)

   Two persons are needed to get the resident into a wheelchair and to get the wheelchair down a flight of stairs.

3. (3)

   The resident might resist an evacuation vigorously, and two persons are needed to get the resident out of the facility.

6.4.5 Response to Instructions (Line V of Worksheet 6.8.2).

6.4.5.1 General.
Line V rates the resident's ability to receive, comprehend, and follow through with simple instructions during a staff-directed evacuation. Residents often do not respond equally well to all staff members; therefore, a resident should be rated on his responses to staff members whose directions he is least likely to follow. If more than one rating applies, use the rating with the highest numerical score.

6.4.5.2 Follows Instructions.
The resident usually can be depended on to receive, comprehend, remember, and follow simple instructions.

6.4.5.3 Requires Supervision.
The resident generally is capable of following instruction but is not dependable. Therefore, the resident might need to be guided, reminded, reassured, or otherwise accompanied during evacuation but does not require the exclusive attention of a staff member (e.g., a staff member can lead two or more residents who fit this classification simultaneously).

6.4.5.3.1
This category includes elderly persons who sometimes show early signs of senile dementia or Alzheimer's disease (e.g., confusion, disorientation, frequent "misplacement" of possessions) and young children who cannot be depended on to follow through with instructions.

6.4.5.3.2
Residents in this category generally are capable of following instructions except in one of the following situations:

1. (1)

   The resident is deaf or hearing impaired and sometimes misinterprets communications from staff using sign language.

2. (2)

   The resident sometimes forgets instructions after a brief period of time.

3. (3)

   The resident is sometimes distracted or confused and fails to follow through with instructions.

4. (4)

   The resident is sometimes groggy and might fail to listen carefully or follow through with instructions.

5. (5)

   The resident is sometimes uncooperative without apparent good reason.

6. (6)

   The resident is elderly and sometimes becomes "lost" in a familiar place.

7. (7)

   The resident is a young child who might become frightened and not follow through with instructions.

6.4.5.4 Requires Considerable Attention or Might Not Respond.

6.4.5.4.1
The resident might fail to receive, understand, or follow through with instructions; that is, the resident might not respond to instructions or general guidance. Therefore, the resident might require most of the attention of a staff member during an evacuation.

6.4.5.4.2

This category includes elderly persons who have the symptoms of senile dementia or Alzheimer's disease (e.g., severe confusion, disorientation, very limited short-term memory).

6.4.5.4.3
Residents in this category might display one or more of the following characteristics:

1. (1)

   The resident sometimes does not understand simple instructions.

2. (2)

   The resident might not respond to instructions from a particular staff member.

3. (3)

   The resident is sometimes emotionally upset and is therefore unwilling to follow instructions.

4. (4)

   The resident is deaf or hearing impaired and the staff cannot communicate reliably with the resident.

5. (5)

   The resident is very forgetful, easily confused, or easily distracted.

6.4.6 Waking Response to Alarm (Line VI of Worksheet 6.8.2).

6.4.6.1 General.

6.4.6.1.1
Line VI rates the risk that the fire alarm might fail to awaken the resident.

6.4.6.1.2
Residents should be rated as "response probable" unless any of the following conditions exists:

1. (1)

   The building does not have an alarm system meeting the requirements of Chapter 33 (NFPA *101*), or the alarm is not sufficiently loud where the resident sleeps (doors should be closed and barriers kept in place where determining the audibility of the fire alarm).

2. (2)

   Medication taken by the resident before retiring differs in type or amount (i.e., medication is increased) from the medication taken during waking hours.

3. (3)

   The resident has a readily apparent hearing impairment, or the resident's hearing aid is removed before sleeping.

4. (4)

There is specific evidence that the resident is an exceptionally sound sleeper. For example, the resident previously failed to be awakened by a particularly loud noise, and staff members have had to shake the resident vigorously to awaken him.

6.4.6.1.3

Where any of the conditions in 6.4.6.1.2 exist, the resident should be rated as "response not probable" unless the resident's ability to wake up has been demonstrated. The demonstration of the resident's ability to wake up in response to the fire alarm should be conducted after the first half hour of sleep and during the first three hours of sleep. In addition, the resident's ability to wake up in response to the alarm should be demonstrated on two different nights under normal conditions (e.g., without hearing aid, under usual medications). Also, the resident should be alert enough to follow simple instructions within 1 minute after waking. To avoid waking other residents during the demonstrations of the capability of a particular resident, a device that makes a sound that is similar to, but not louder than, the fire alarm shall be permitted to be used (e.g., an alarm clock or clock radio with a sound similar to the fire alarm). Listed and approved tactile alarms shall be permitted as alternative devices used to demonstrate a hearing-impaired resident's response probability.

6.4.6.2 Response Probable.

Either none of the conditions in 6.4.6.1.2 affect the resident, or, if any of the conditions exist, the resident's ability to be awakened has been demonstrated.

6.4.6.3 Response Not Probable.

One or more of the conditions in 6.4.6.1.2 affect the resident, and either the resident has not been tested for the ability to be awakened by the fire alarm or the resident has failed to demonstrate the ability to be awakened by the fire alarm.

6.4.7 Response to Fire Drills (Line VII of Worksheet 6.8.2).

6.4.7.1 General.

6.4.7.1.1

Line VII rates the resident's ability to leave the facility during fire drills, as demonstrated by the resident's performance, without guidance or advice from the staff. A resident must demonstrate three separate responses reliably and without instructions or supervision to be rated "yes" in each case. The resident is rated "yes" only where he has been specifically trained or instructed in the desired reaction and has demonstrated the desired response in at least three of the last four fire drills in which a response was demonstrated. If the resident has not been involved in four fire drills, the rating shall be permitted to be "yes" only if the resident has demonstrated the desired response during the last two opportunities to demonstrate the response. Ratings are based on demonstrated performance, and any resident who has not been trained to participate in fire drills must be rated "no."

6.4.7.1.2

This rating covers the ability of the resident to make decisions but does not relate to mobility, which is covered separately. For example, a resident might need assistance only in transferring from a bed to a wheelchair but otherwise can initiate and complete an evacuation promptly. Such a resident would be rated "yes" for "Initiates and Completes Evacuation Promptly" but would be rated "Needs Limited Assistance," in Line II, Impaired Mobility.

6.4.7.1.3

Residents should be rated assuming that an emergency could occur when they are least likely to respond well. For most residents, this is after being awakened. Determining the rating should not include difficulties in actually awakening the resident, since there are great differences in how easily the same individual awakens at various times.

6.4.7.2 Initiates and Completes Evacuation Promptly.

The resident has demonstrated a proper response to an alarm or warning of a fire by starting and completing the evacuation without unnecessary delay. Specific evidence leading to a rating of "no" includes the following responses:

1. (1)

   The resident might not react to the alarm until alerted by a staff member.

2. (2)

   The resident spends an excessive amount of time preparing to leave (e.g., getting dressed, observing others).

3. (3)

   The resident has a hearing impairment and, therefore, needs to be alerted by a staff member.

4. (4)

   The resident is sometimes upset or confused and, therefore, might seek out a staff member before evacuating.

5. (5)

   The resident consistently begins an evacuation but is easily distracted and needs some supervision.

6.4.7.3 Chooses and Completes Backup Strategy.

The resident has demonstrated the ability to select an alternative means of escape or has taken other appropriate action if the primary escape route is blocked. Specific evidence leading to a rating of "no" is where the resident is unlikely to select a good course of action if the primary escape route cannot be used; that is, the resident has not been trained to find alternative escape routes, find an area of refuge, or perform other appropriate action(s). Where the resident lacks the conceptual ability to understand fire hazards and blocked escape routes, and, therefore, requires supervision, the rating should be "no."

6.4.7.4 Remains at Designated Location.

The resident must have demonstrated willingness to remain at a designated safe location during fire drills. (The whereabouts of already evacuated residents needs to be confirmed to avoid dangerous return trips to look for residents who might have returned to buildings.)

6.4.7.4.1

Specific evidence leading to a "yes" for this rating includes the following:

1. (1)

   The resident has been specifically trained to remain at a designated location in a safe area and has demonstrated this ability without the presence of staff members in three of the previous four fire drills.

2. (2)

   The resident is physically immobile and, therefore, cannot leave the designated location.

3. (3)

   The facility uses a motor vehicle (e.g., a van or bus) or a building that is detached and remote from the facility (i.e., another building or a remote garage) as the designated location, and the resident has demonstrated in three of the previous four fire drills the ability to remain there without the presence of a staff member.

4. (4)

   The resident might tend to wander, but a reliable resident has been assigned to keep the wandering resident at the designated location without using any force or coercion. Furthermore, this arrangement has been demonstrated as effective in at least three of the previous four fire drills.

6.4.7.4.2
Specific evidence leading to a "no" for this rating includes the following:

1. (1)

   The resident has not been trained to remain at a designated location without any staff supervision.

2. (2)

   The resident has been trained to remain without staff supervision at a designated location but has failed to demonstrate this capability in three of the previous four fire drills.

6.5 Rating the Staff Shift (Worksheets 6.8.5 through 6.8.11).

6.5.1
This rating is intended to predict the promptness of response of a staff member who is present in the facility, at a given time (shift), and who is capable of assisting residents in an evacuation.

6.5.2
Before rating the staff shift, there are five basic requirements relative to the staff response capability, protection plans, and fire drills that shall be met. The determination of whether or not these requirements are met is recorded on Worksheet 6.8.8, Staff Shift Scores. If the corresponding requirements of 6.5.2.1 through 6.5.2.5 have been met, a "yes" rating should be given.

6.5.2.1
A protection plan shall have been promulgated, and all staff members considered in this rating shall have been trained in its implementation. Regardless of the staff's everyday competencies, they cannot be relied upon to innovate effective life safety actions under the extreme stress and time limitation of an actual fire emergency. Notwithstanding the facility's fire protection features, the staff must have a valid and practiced plan of action that can be put into effect immediately in an emergency. The protection plan should include the following features:

1. (1)

   A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes

2. (2)

   A fundamental knowledge of fire growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes

6.5.2.2
Staff shall be provided in accordance with 6.5.2.2.1 or 6.5.2.2.2.

6.5.2.2.1
The total available staff at any given time is able to handle the individual evacuation needs of each resident who might be in the facility. In calculating evacuation capability, it might be possible to have a ratio of staff to residents that appears to be favorable but that still is unacceptable under this system. This would be the case when a resident needs assistance from two staff members but only one staff member is present. Thus, the situation should be such that all residents can be evacuated by the available staff.

6.5.2.2.2
The facility meets the criteria for an evacuation capability level of "impractical," the resident whose evacuation needs cannot be handled is in a sleeping room or other room that provides adequate refuge from fire outside the room, and there is at least one staff member present who can close the door to the room. For example, a very heavy resident is in a facility, meeting the criteria for impractical level of evacuation capability, with one available staff member who cannot transfer the resident from a bed to a wheelchair. Although the staff member is unable to meet all the resident's evacuation assistance needs, the sleeping room provides adequate refuge.

6.5.2.3
Every staff member considered in this rating shall be able to participate meaningfully in the evacuation of every resident. For example, a staff member who, due to his own disability, might be unable to assist one or more physically disabled residents shall not be included in the rating. However, if a staff member's disability does not limit his ability to assist the residents, then the staff member shall be permitted to be included in the rating.

6.5.2.4
All staff members considered in this rating shall be in the facility when on duty, except as otherwise permitted by 6.5.2.4.1 through 6.5.2.4.4. This rating is based on the assumption that there are staff present when residents are in the facility.

6.5.2.4.1
Unstaffed facilities, which are not covered by this system, shall be permitted to be assigned an evacuation capability level based on the demonstrated ability of the residents to meet the criteria of Chapter 33 (NFPA *101*) without staff assistance.

6.5.2.4.2
Residents who receive only the most favorable ratings on Worksheet 6.8.3 for rating residents shall be permitted to be present in the facility without the presence of staff members.

6.5.2.4.3
A staff member shall be permitted to be at a location outside of the facility where his ability to respond to a fire emergency from the location is roughly equivalent to his response ability from within the facility. In determining equivalency, the authority having jurisdiction should consider the following:

1. (1)

   Whether the fire alarm meets the minimum loudness criteria *(see 6.5.3.2.2)* at the locations outside the facility or whether another staff member who is required to remain in the facility can immediately report a fire emergency to the staff member who is outside

2. (2)

   Travel time to the facility

3. (3)

   Detection of fire cues (e.g., smoke, noises) from locations outside the facility

4. (4)

   Whether the staff member will be notified immediately about which area of the facility has the fire emergency, if the staff member who is outside is required to report fire emergencies in more than one facility or fire zone

6.5.2.4.4
The authority having jurisdiction shall be permitted to grant partial credit (which shall not exceed the promptness of the response score that the staff member receives where required to remain in the facility) for staff members who are permitted at locations outside the facility and who have the ability to respond promptly.

6.5.2.5
Fire drills shall be conducted monthly, and at least 12 fire drills shall have been conducted during the previous year. A facility in operation for less than one year shall be permitted to have conducted a fire drill for each month of its operation.

6.5.3 Staff Shift Scores (Worksheet 6.8.8).

6.5.3.1
The purpose of this rating is to determine which staff shift is likely to be the least able to respond promptly to assist residents in an evacuation. If it is not obvious which staff shift will be the least able to respond, complete separate forms for each staff shift and use the staff shift having the lowest score.

6.5.3.2 Promptness of Response Scores (Worksheet 6.8.7).

6.5.3.2.1 Staff Availability.
This rating determines whether there are circumstances in which a staff member is less able to respond appropriately or might be delayed in his response to a fire emergency. A staff member shall be included in this rating only under the following conditions:

1. (1)

   He is required to remain within the facility while on duty.

2. (2)

   He sleeps less than 100 ft (30 m) from all locations in the portion of the facility being evaluated.

3. (3)

   His travel time to any location in the portion of the facility being evaluated does not exceed 60 seconds.

6.5.3.2.1.1 Standby or Asleep.
This rating means that the staff member does not have specific duties that ensure an immediate response to the alarm but is otherwise available to assist in a timely manner. This includes live-in staff who might be asleep, showering, or otherwise unable to respond immediately.

6.5.3.2.1.2 Immediately Available.
This rating means that the staff member is required to be on duty to provide immediate assistance but is not required to remain in proximity to the residents (e.g., the staff member is allowed to wash clothes or do bookkeeping).

6.5.3.2.1.3 Immediately Available and Close By.
This rating means that the staff member, in addition to satisfying the requirement for "immediately available," also is required to remain in proximity to the residents except for brief periods of time.

6.5.3.2.1.4
If the facility is classed as "large" and has multiple fire or smoke zones, some staff members might have responsibilities for residents outside the fire or smoke zone being evaluated. If a staff member's duties include rescue of residents in the fire zone being evaluated, the staff member shall be permitted to be assigned partial or full promptness of response scores. The authority having jurisdiction shall assign the points based on the proximity of the staff member to the zones and the nature of his duties in a fire emergency. This credit shall be given only if there is a smoke detection system that alerts the staff member and a system or procedure for promptly informing the staff member of the general location of the fire.

6.5.3.2.1.5
Individual residents shall be permitted to be assigned responsibilities similar to those of staff members to assist other residents during fire emergencies. The authority having jurisdiction shall be permitted to assign these individual residents as many as eight points for promptness of response, based on their capabilities and responsibilities.

6.5.3.2.2 Alarm Effectiveness.
This rating determines whether smoke detector–activated alarm devices are loud enough to alert the staff to a fire emergency dependably.

6.5.3.2.2.1 Assured.

To be rated "assured," the alarm shall be "easily noticeable" in all locations where the staff member is permitted, regardless of his rating on the promptness of response factor. "Easily noticeable" means the alarm shall be a minimum of 55 dBA measured at ear level. The authority having jurisdiction shall be permitted to require the alarm to be louder than 55 dBA where background noises could interfere with alarm audibility. For example, the alarm might need to be more than 55 dBA to be heard over noise such as from a washing machine in the laundry or a television in the day room. If there are staff who are permitted to sleep, the alarm shall be a minimum of 70 dBA measured at "pillow" level in any area where the staff might be asleep. The alarm shall be activated by smoke detectors, an automatic sprinkler system, or both. If the facility has smoke detectors meeting the requirements of Chapter 33 (NFPA *101*), the smoke detectors shall activate the alarm. If the facility has an automatic sprinkler system whose fire protection properties are considered in the evaluation of the facility, activation of the sprinkler system shall activate the alarm.

6.5.3.2.2.2 Not Assured.

The alarm does not satisfy the conditions specified under "assured." Doors that normally are closed during the staff shift being rated should be closed when determining the loudness of the fire alarm. Any other barriers that could reduce the loudness of the fire alarm also shall be in place.

6.6 Rating the Facility (Worksheet 6.8.9).

6.6.1

The vertical distance from sleeping rooms to a floor level with exits might affect the risk because of the time and difficulty in moving on the stairs.

6.6.2 Special Terminology.

6.6.2.1 Direct Exit.

Direct exit shall mean that there is no more than one step between the inside of the facility and either (1) ground level outside or (2) a level area outside the facility that is at least 32 ft^2 (3 m^2). This level area might be a porch or a stairway landing. Where the vertical distance is greater than one step, a ramp shall be permitted to be used to comply with this definition.

6.6.2.2 Vertical Distance.

Vertical distance shall refer to the greatest number of floors that separate any resident sleeping room from its nearest direct exit.

6.6.3 All Sleeping Rooms on Floors with Direct Exit.

Every room where residents sleep is on a floor with at least one direct exit. Examples of facilities that fall within this category include the following:

1. (1)

   A one-story building without sleeping rooms in the basement

2. (2)

   A two-story building without sleeping rooms on the second floor

3. (3)

   A split-level building with direct exits at each level

4. (4)

   A two-story building with sleeping rooms on the second floor that has an exterior stairway from the second floor, with a landing at the second floor that is greater than 32 ft^2 (3 m^2)

6.6.4 Any Sleeping Room One Floor from Exit.

There is at least one room where residents sleep in which the shortest vertical distance to a direct exit is one floor. Examples of facilities that fall within this category include the following:

1. (1)

   A two-story building with sleeping rooms on the second floor, in the basement, or both

2. (2)

   A one-story building where all the exits have stairs that lead to grade without a landing or porch of, at minimum, 32 ft^2 (3 m^2)

6.6.5 Any Sleeping Room Two or More Floors from Exit.

There is at least one room where residents sleep in which the shortest vertical distance to a direct exit is two or more floors. Buildings that fall within this category include the following:

1. (1)

   A three-story building with sleeping rooms on the third floor and no exterior fire escape

2. (2)

   A three-story building with sleeping rooms on the third floor that has an exterior stairway from the third floor, but where the landing at the third floor is less than 32 ft^2 (3 m^2)

6.6.6 Facilities in an Apartment House.

If the facility is located in an apartment house and the unit containing the facility requires ascending or descending stairs to move from any sleeping room to the door to the corridor, a score of 1.2 for "vertical distance from sleeping rooms to exit" should be assigned. In all other apartments, the score for vertical distance from sleeping rooms to exits is 1.0.

6.7 Determining Evacuation Capability (Worksheet 6.8.10).

6.7.1

When the scores for the residents, the staff, and the vertical travel distances have been determined, the scores are entered on Worksheet 6.8.10 and the calculation made to obtain a numerical result.

6.7.2

The numerical evacuation capability score then is translated into a level of evacuation capability of either "prompt," "slow," or "impractical" and recorded on Worksheet 6.8.11. This evacuation capability is a valid assessment that shall be permitted to be used in Chapter 7 of this guide or in Chapter 33 (NFPA *101*).

6.8 Worksheets for Rating Residents.

The worksheets for rating residents use a seven-step process found in Figure 6.8.

Figure 6.8 Worksheets for Rating Residents.

WORKSHEET 6.8.1 COVER SHEET

Worksheet for Rating Residents

Resident's name _____ Evaluator _____

Facility _____ Zone _____ Date _____

Write any explanatory remarks here:

WORKSHEET 6.8.2 RATING THE RESIDENT ON THE RISK FACTORS

Rate the resident on each of the factors below by checking the one circle for each risk factor that best describes the resident. For the first six factors, write the scores for the circles checked in the appropriate score boxes in the far right column. For "Response to Fire Drills," write the three checked scores in the large circles. Write the sum of the three scores in the large box on the right.

					Score Boxes
I. Risk of Resistance (Check only one)	Minimal Risk ○ score=0	Risk of Mild Resistance ○ score=6	Risk of Strong Resistance ○ score=20		
II. Impaired Mobility (Check only one)	Self-Starting ○ score=0	Slow ○ score=3	Needs Limited Assistance ○ score=6	Needs Full Assistance or Very Slow ○ score=20	
III. Impaired Consciousness (Check only one)	No Significant Risk ○ score=0	Partially Impaired ○ score=6	Totally Impaired ○ score=20		
IV. Need for Extra Help (Check only one)	Needs at Most One Staff ○ score=0	Needs Limited Assistance from 2 Staff ○ score=30	Needs Full Assistance from 2 Staff ○ score=40		
V. Response to Instructions (Check only one)	Follows Instructions ○ score=1	Requires Supervision ○ score=3	Requires Considerable Attention/Might Not Respond ○ score=10		
VI. Waking Response to Alarm (Check only one)	Response Probable ○ score=0	Response Not Probable ○ score=6			

VII. Response to Fire Drills (Without guidance or advice from staff)	Initiates and Completes Evacuation Promptly	Yes ○ score=0	No ○ score=8	○ +	
	Chooses and Completes Back-up Strategy	Yes ○ score=0	No ○ score=4	○ +	
	Remains at Designated Location	Yes ○ score=0	No ○ score=6	○	Sum of These Three Scores

(For use with NFPA 101A-2013/NFPA *101*-2012)

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Figure 6.8 *Continued*

WORKSHEET 6.8.3 DETERMINING THE RESIDENT'S OVERALL NEED FOR ASSISTANCE

Compare the numbers in the seven score boxes filled in on Worksheet 6.8.2. Take the highest score from the score boxes and write it in the box at the right.

Evacuation Assistance Score: ____

Notes:

WORKSHEET 6.8.4 RESIDENT SCORES

Resident Name	Evac. Assistance Score	Resident Name	Evac. Assistance Score
Evacuation Assistance Score Total		**Evacuation Assistance Score Total**	

Figure 6.8 *Continued*

WORKSHEET 6.8.5 COVER SHEET

Staff Shift Score

Facility _____ Zone _____

Evaluator _____ Date _____

Staff Shift: From _____ To _____

WORKSHEET 6.8.6 STAFF RESPONSE AND TRAINING

	Yes	No
A protection plan has been promulgated and all staff members considered in this rating have been trained in its implementation. *(See 6.5.2.1.)*		
The total available staff at any given time is able to handle the individual evacuation needs of each resident who is in the facility. *(See 6.5.2.2.)*		
Every staff member considered in this rating can meaningfully participate in the evacuation of every resident. *(See 6.5.2.3.)*		
All staff members considered in this rating are required to be in the facility when on duty, except as permitted. *(See 6.5.2.4.)*		
At least 12 fire drills were conducted during the previous year. *(See 6.5.2.5.)*		

All items must score "Yes" before proceeding.

WORKSHEET 6.8.7 PROMPTNESS OF RESPONSE SCORES

Staff Availability	Alarm Effectiveness	
	Assured	Not Assured
Standby or asleep	16	2
Immediately available	20	2
Immediately available and close by	20	10

WORKSHEET 6.8.8 STAFF SHIFT SCORES

Staff Name	Promptness of Response Score	Staff Name	Promptness of Response Score
Staff Shift Score Total		Staff Shift Score Total	

Figure 6.8 *Continued*

WORKSHEET 6.8.9 RATING THE FACILITY

	Vertical Distance from Sleeping Rooms to Exits		
	All SR on Floors with Direct Exit	Any SR One Floor from Exit	Any SR Two or More Floors from Exit
Small Facility[a]	◯ Score 0.8	◯ Score 1.0	◯ Score 1.2
Large Facility or Apartment[b]		◯ Score 1.0	

[a] Small facilities have 16 or fewer residents.
[b] See 6.6.6 for apartments.

WORKSHEET 6.8.10 CALCULATION OF EVACUATION CAPABILITY SCORE

Total Resident Evacuation Assistance Score (Worksheet 6.8.4) ☐ **X** Vertical Distance from Sleeping Room to Exit (Worksheet 6.8.9) ☐

☐ Staff Shift Score (Worksheet 6.8.8)

= Evacuation Capability Score ☐

(go to Worksheet 6.8.11)

WORKSHEET 6.8.11 EVACUATION CAPABILITY SCORE

Evacuation Capability Score	Level of Evacuation Capability	Evacuation Capability for this Facility or Zone
≤1.5	Prompt	
>1.5 to ≤5.0	Slow	
>5.0	Impractical	

6.8.1 Step 1 — Complete the Cover Sheet Using Worksheet 6.8.1.
See Figure 6.8.

6.8.2 Step 2 — Read Section 6.3 and Section 6.4, then Fill out Worksheets 6.8.2 and 6.8.3.
Complete both forms for each resident, basing the ratings on commonly observed examples of poor performance.

6.8.3 Step 3 — Compute the Total Resident Evacuation Assistance Score.
The following steps should be taken:

1. (1)

   List each resident's name on Worksheet 6.8.4. Use a separate scoresheet for each zone being rated. Use additional scoresheets for a large number of residents.

2. (2)

   Enter the score for each resident from Worksheet 6.8.3 that was completed for him.

3. (3)

   Total the scores for all residents in the facility or zone being rated, as appropriate.

6.8.4 Step 4 — Consider Prequalifications Related to Computing.
The following steps should be taken:

1. (1)

   Complete the cover sheet in Worksheet 6.8.5.

2. (2)

   Complete Worksheet 6.8.6 for the time of day, week, and so on when the combined ratings for staff and residents yield the highest score. This usually is late at night. Where it is not obvious which staff shift will score highest, complete separate forms for each staff shift and utilize the highest score. Read Section 6.5 before filling out this form.

6.8.5 Step 5 — Determine the Staff Shift Score.
Note that in large facilities, staff members might be responsible for assisting residents in a fire or smoke zone but also might have responsibilities for residents in other zones. *(See Section 6.5.)* The following steps should be taken:

1. (1)

   On Worksheet 6.8.8, list the names of staff members who are required to be on duty in the facility during the shift being rated.

2. (2)

   Determine whether the effectiveness of the alarm is "assured" or "not assured." *(See 6.5.3.2.2.)*

3. (3)

   Using the values from Worksheet 6.8.7, determine each staff member's "promptness of response score" for the shift being rated. Enter each staff member's name and score in the appropriate spaces on Worksheet 6.8.8.

4. (4)

Total the "promptness of response scores" for the shift rated.

6.8.6 Step 6 — Rate the Facility Using Worksheet 6.8.9.

Rate the facility by checking the circle that indicates the vertical distance a resident must travel from a sleeping room (SR) to an exit.

6.8.7 Step 7 — Determine Evacuation Capability.

Determine the facility's evacuation capability, using Worksheet 6.8.10. Calculate the score by multiplying the Total Resident Evacuation Assistance Score (Worksheet 6.8.4) by the Vertical Distance from Sleeping Room to Exit (Worksheet 6.8.9) and then dividing by the Staff Shift Score (Worksheet 6.8.8). The evacuation capability is determined and recorded in Worksheet 6.8.11.

Section 7
Basic Care Assistance Program

CHAPTER 50-24.5
AID TO AGED, BLIND, AND DISABLED PERSONS

50-24.5-01. Definitions. (Effective through December 31, 2019)
In this chapter, unless the context otherwise requires:

1. "Aged" means at least sixty-five years of age.
2. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.].
3. "Congregate housing" means housing shared by two or more individuals not related to each other which is not provided in an institution.
4. "County agency" means the county social service board.
5. "Department" means the department of human services.
6. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.].
7. "Eligible beneficiary" means a resident of this state who:
   a. (1) Is aged; or
      (2) Is at least eighteen years of age and is disabled or blind;
   b. (1) Has applied for and is eligible to receive and receives benefits under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and who has applied for and is receiving benefits, if the individual is eligible to receive benefits, under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.]; or
      (2) Has applied for and is eligible to receive and receives benefits under section 50-24.1-37 for long-term services and supports pursuant to an asset test established under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and section 50-24.1-02;
   c. Meets the requirements of section 23-09.3-08.1;
   d. Based on a functional assessment, is not severely impaired in any of the activities of daily living of toileting, transferring to or from a bed or chair, or eating and:
      (1) Has health, welfare, or safety needs, including a need for supervision or a structured environment; or
      (2) Is impaired in three of the following four instrumental activities of daily living: preparing meals, doing housework, taking medicine, and doing laundry; and
   e. Is determined to be eligible pursuant to rules adopted by the department.
8. "Institution" means a facility licensed under chapter 23-09.3.
9. "Living independently" includes living in congregate housing. The term does not include living in an institution.
10. "Personal needs allowance" means an amount retained by the eligible beneficiary to cover the costs of clothing and other personal needs.
11. "Proprietor" means an individual responsible for day-to-day administration and management of a facility.
12. "Remedial care" means services that produce the maximum reduction of an eligible beneficiary's physical or mental disability and the restoration of an eligible beneficiary to the beneficiary's best possible functional level.
13. "Would be eligible to receive the cash benefits except for income" refers to an individual whose countable income, less the cost of necessary remedial care that may be provided under this chapter, does not exceed an amount equal to the cash benefit under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.] which the individual would receive if the individual had no income, plus the amount allowed as the personal needs allowance.

Definitions. (Effective after December 31, 2019) In this chapter, unless the context otherwise requires:

1. "Aged" means at least sixty-five years of age.

2. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.].
3. "Congregate housing" means housing shared by two or more individuals not related to each other which is not provided in an institution.
4. "Department" means the department of human services.
5. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.].
6. "Eligible beneficiary" means a resident of this state who:
   a. (1) Is aged; or
      (2) Is at least eighteen years of age and is disabled or blind;
   b. (1) Has applied for and is eligible to receive and receives benefits under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], and who has applied for and is receiving benefits, if the individual is eligible to receive benefits, under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.]; or
      (2) Has applied for and is eligible to receive and receives benefits under section 50-24.1-37 for long-term services and supports pursuant to an asset test established under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and section 50-24.1-02;
   c. Meets the requirements of section 23-09.3-08.1;
   d. Based on a functional assessment, is not severely impaired in any of the activities of daily living of toileting, transferring to or from a bed or chair, or eating and:
      (1) Has health, welfare, or safety needs, including a need for supervision or a structured environment; or
      (2) Is impaired in three of the following four instrumental activities of daily living: preparing meals, doing housework, taking medicine, and doing laundry; and
   e. Is determined to be eligible pursuant to rules adopted by the department.
7. "Human service zone" means a county or consolidated group of counties administering human services within a designated area in accordance with an agreement or plan approved by the department.
8. "Institution" means a facility licensed under chapter 23-09.3.
9. "Living independently" includes living in congregate housing. The term does not include living in an institution.
10. "Personal needs allowance" means an amount retained by the eligible beneficiary to cover the costs of clothing and other personal needs.
11. "Proprietor" means an individual responsible for day-to-day administration and management of a facility.
12. "Remedial care" means services that produce the maximum reduction of an eligible beneficiary's physical or mental disability and the restoration of an eligible beneficiary to the beneficiary's best possible functional level.
13. "Would be eligible to receive the cash benefits except for income" refers to an individual whose countable income, less the cost of necessary remedial care that may be provided under this chapter, does not exceed an amount equal to the cash benefit under titles II and XVI of the Social Security Act [42 U.S.C. 401-434 and 42 U.S.C. 1381 et seq.] which the individual would receive if the individual had no income, plus the amount allowed as the personal needs allowance.

50-24.5-02. Powers and duties of the department. (Effective through December 31, 2019)

The department shall:

1. Administer aid to vulnerable aged, blind, and disabled persons and supervise and direct county agencies in the administration of aid to vulnerable aged, blind, and disabled persons.

2. Supplement, within the limits of legislative appropriation, the income of an eligible beneficiary receiving necessary basic care services to the extent that the eligible beneficiary lacks income sufficient to meet the cost of that care, provided at rates determined by the department adjusted by the inflation rate for basic care services used to develop the legislative appropriation for the department.
3. Pay qualified basic care providers at rates determined by the department, within the limits of legislative appropriation.
4. Issue payment to basic care facilities for services provided to an eligible beneficiary.
5. Take action and give directions necessary to implement this chapter.

Powers and duties of the department. (Effective after December 31, 2019) The department shall:

1. Administer aid to vulnerable aged, blind, and disabled persons and supervise and direct human service zones in the administration of aid to vulnerable aged, blind, and disabled persons.
2. Supplement, within the limits of legislative appropriation, the income of an eligible beneficiary receiving necessary basic care services to the extent that the eligible beneficiary lacks income sufficient to meet the cost of that care, provided at rates determined by the department adjusted by the inflation rate for basic care services used to develop the legislative appropriation for the department.
3. Pay qualified basic care providers at rates determined by the department, within the limits of legislative appropriation.
4. Issue payment to basic care facilities for services provided to an eligible beneficiary.
5. Take action and give directions necessary to implement this chapter.

50-24.5-02.1. Registration of assisted living facilities.

Repealed by S.L. 2003, ch. 429, § 5.

50-24.5-02.2. Basic care facility private room rates.

The department of human services shall allow a basic care facility to charge a higher rate for a private room used by a recipient of benefits under this chapter if the private room is not necessary to meet the resident's care needs; the resident, or a person acting on behalf of the resident, has requested the private room and the facility informs the person making the request, at the time of the request, of the amount of payment and that the payment must come from sources other than a resident's monthly income; and the payment does not exceed the amount charged to private pay residents.

50-24.5-02.3. Basic care payment rates.

1. The department shall establish, by rule, procedures for determining rates for the care of residents of basic care facilities that qualify as vendors of an aged, blind, and disabled persons program and for implementing provisions of this chapter. The procedures must be based on methods and standards that the department finds are adequate to recognize the costs that must be incurred for the care of residents in efficiently and economically operated basic care facilities.
2. The department shall identify costs that are recognized for establishing payment rates.
3. For the rate year beginning July 1, 2016, the department shall establish the limits by using the average of the highest and lowest rates from the 2014 rate year. The direct care limit must be ninety-five percent of the average and the indirect care limit must be ninety percent of the average. Beginning with the July 1, 2017, rate year, the department shall adjust the limits by using the cost percentage change from the prior two rate years, within the limits of legislative appropriations.
4. The department shall provide, by rule, within the limits of legislative appropriations, for payment of rates paid by the aged, blind, and disabled persons program for a maximum of thirty days per occurrence for leave days for a resident who is in a licensed health care facility when the resident is expected to return to the facility.

5. Within the limits of legislative appropriations, the department shall establish an uncompensated care expense of one hundred eighty days.

50-24.5-03. Powers and duties of county agency. (Effective through December 31, 2019)

Each county agency shall:

1. Administer aid to aged, blind, and disabled persons at the county level under the direction and supervision of the department, pursuant to state requirements.
2. Provide the services described in this chapter.
3. Determine eligibility for benefits under this chapter and periodically redetermine eligibility of persons receiving benefits pursuant to this chapter.
4. Provide case management services to eligible beneficiaries.
5. Conduct initial and ongoing functional assessments of applicants in cooperation with basic care facilities.
6. Cooperate with any other county agency to assure the conduct of initial and ongoing functional assessments and determinations of eligibility with respect to any applicant or eligible beneficiary who is physically present in a county other than the county in which the applicant or eligible beneficiary is a resident for purposes of chapter 50-01.

Powers and duties of human service zone. (Effective after December 31, 2019) Each human service zone, unless otherwise directed or determined by the department, shall:

1. Administer aid to aged, blind, and disabled persons at the human service zone level under the direction and supervision of the department, pursuant to state requirements.
2. Provide the services described in this chapter.
3. Determine eligibility for benefits under this chapter and periodically redetermine eligibility of persons receiving benefits pursuant to this chapter.
4. Provide case management services to eligible beneficiaries.
5. Conduct initial and ongoing functional assessments of applicants in cooperation with basic care facilities.
6. Cooperate with any other human service zone to assure the conduct of initial and ongoing functional assessments and determinations of eligibility with respect to any applicant or eligible beneficiary who is physically present in a human service zone other than the human service zone in which the applicant or eligible beneficiary is a resident for purposes of chapter 50-01.

50-24.5-04. Services provided - Limit on cost.

Services provided under this chapter must be treated as necessary remedial care to the extent those services are not covered under the medical assistance program. The cost of the services provided under this chapter to a person residing in a basic care facility for which the rate charged includes room and board is limited to the rate set for services in that facility, plus the amount allowed as the personal needs allowance, less that person's total income.

50-24.5-05. Applicant's or guardian's duty to establish eligibility.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, and financial eligibility for each month for which benefits are sought.

50-24.5-06. Appropriation of county funds - Reimbursement by department - Reimbursement by county agency.

Repealed by S.L. 1997, ch. 403, § 13.

50-24.5-07. Residency. (Effective through December 31, 2019)

For purposes of this chapter:

1. A person is a resident of this state if:
   a. The person is not living in an institution and is living in this state:

(1) With intent to remain in this state permanently or for an indefinite period; or
(2) Without intent if the person is incapable of stating intent.

b. The person is living in an institution outside this state and was receiving a benefit under chapter 50-01 on January 1, 1995.

c. The person was placed in an out-of-state institution by a county agency or the department while the person was incapable of indicating intent.

d. The person is living in an in-state institution, has lived in that institution for at least thirty days, and was not placed in that institution by another state. A person placed in an institution by another state is a resident of the state making the placement. Any action beyond providing information to the person and the person's family constitutes arranging or making a state placement. However, the following actions do not constitute state placement:
(1) Providing basic information about this chapter and information about the availability of this chapter; or
(2) Assisting a person in locating an institution in this state, if the person is capable of indicating intent and independently decides to move.

2. A person who is a resident of this state is a resident of the county in which the person is a resident for purposes of chapter 50-01.

Residency. (Effective after December 31, 2019) For purposes of this chapter:

1. A person is a resident of this state if:
   a. The person is not living in an institution and is living in this state:
      (1) With intent to remain in this state permanently or for an indefinite period; or
      (2) Without intent if the person is incapable of stating intent.
   b. The person is living in an institution outside this state and was receiving a benefit under chapter 50-01 on January 1, 1995.
   c. The person was placed in an out-of-state institution by a human service zone or the department while the person was incapable of indicating intent.
   d. The person is living in an in-state institution, has lived in that institution for at least thirty days, and was not placed in that institution by another state. A person placed in an institution by another state is a resident of the state making the placement. Any action beyond providing information to the person and the person's family constitutes arranging or making a state placement. However, the following actions do not constitute state placement:
      (1) Providing basic information about this chapter and information about the availability of this chapter; or
      (2) Assisting a person in locating an institution in this state, if the person is capable of indicating intent and independently decides to move.
2. A person who is a resident of this state is a resident of the human service zone in which the person is a resident for purposes of chapter 50-01.

50-24.5-08. Department has preferred claim against estate.

Funds used to provide services to an eligible beneficiary may not be considered as gifts. The department has a preferred claim against the estate of any person for recovery of funds expended under this chapter for that person or that person's spouse or minor children. No statute of limitations or similar statute nor the doctrine of laches bars a claim under this chapter.

50-24.5-09. Responsibility for expenditures. (Effective through December 31, 2019)

Except as otherwise specifically provided in section 50-03-08, expenditures required under this chapter are the responsibility of the state of North Dakota.

Responsibility for expenditures. (Effective after December 31, 2019) Expenditures required under this chapter are the responsibility of the state of North Dakota.

50-24.5-10. Compensation for top management personnel - Department to adopt emergency rules.

Notwithstanding the requirements of subsection 2 of section 28-32-03, the department of human services has the authority to create emergency rules related to the compensation for top management personnel of a basic care facility combined with a hospital.

Basic Care Assistance Program Frequently Asked Questions

Q. What is the Basic Care Assistance Program (BCAP)?

A. BCAP helps aged, blind or disabled people, who need services in a licensed, basic care facility, to pay for their care.

Q. Who can apply for programs or services?

A. Generally speaking, anyone may apply for assistance. Eligible applicants will ordinarily reside in North Dakota. For additional information, please refer to the Basic Care Brochure (1.081Mb pdf).

Q. Will there be any cost to a recipient for programs or services?

A. Basic Care Assistance Program (BCAP) recipients are allowed to keep $100 for personal needs and, in some cases, additional amounts to cover health insurance and medical costs. Generally, all other income the individual receives goes toward the cost of care. BCAP pays the difference for those who cannot pay the full cost of their care.

Q. Who is eligible for the Basic Care Assistance Program (BCAP)?

A. There are three main requirements for BCAP eligibility. First, you must be at least age 18 and aged (65 or over), blind or disabled. Second, you must apply and qualify for Medical Assistance (Medicaid). Third, you must have a functional assessment. That means a social worker will make a visit and determine what level of care is appropriate based on a person's ability to handle activities of daily living.

Q. What is a functional assessment for the Basic Care Assistance Program (BCAP)?

A. A functional assessment is an evaluation by a social worker of a person's ability to live independently. A Home and Community Based Service (HCBS) case manager does the assessment. Basic Care is appropriate for those who are not severely impaired in activities of daily living, transferring to or from a bed or chair, or eating. But those who have health, welfare, or safety

needs or who are impaired in three of the four following instrumental activities of daily living:

- preparing meals,
- doing housework,
- taking medications, or
- doing laundry

may need services of a licensed, basic care facility.

Q. How much income does a Basic Care Assistance Program (BCAP) recipient get to keep?

A. State law allows a BCAP recipient to keep $100 per month for personal needs. All other income must be paid toward their care or health care costs.

Q. How much income and assets can a person have and still qualify for the Basic Care Assistance Program (BCAP)?

A. An individual must qualify for Medical Assistance (Medicaid). For those income and asset amounts check the eligibility requirements of that program.

Q. How are payments determined and made?

A. After allowing a person to keep $100 per month for personal needs, any other income is paid to the basic care facility or for health insurance and medical costs. What care costs your income does not cover, the Basic Care Assistance Program pays directly to the basic care facility.

Applicant Responsibility

It is the applicant's or guardian's responsibility to provide information to establish eligibility including a Social Security Number, proof of age, identification, residence, blindness or disability, functional limitation, and financial information.

NOTE: *An individual may not qualify for benefits if he or she or the individuals spouse gave away assets or income for less than fair market value within 36 months of the date of application, in order to qualify for the program.*

Basic Care payments

The N.D. Department of Human Services sends payments directly to licensed basic care facilities.

Confidentiality

All applications, information, and records concerning any applicant or recipient of the Basic Care Program are confidential and will not be disclosed or used for any purpose not directly connected with the administration of the program.

Discrimination Prohibited

Anyone who believes they have been discriminated against because of race, color, religion, national origin, age, sex, political beliefs, disability or status with respect to marriage or public assistance, may file a written complaint of the alleged discrimination. Written complaints should be filed with the county social service board, the N.D. Department of Human Services, 600 East Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250, or the U.S. Department of Health and Human Services, Washington, D.C. 20201.

north dakota department of human services

N.D. Department of Human Services
Economic Assistance Policy Division
600 E. Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Phone: 1-800-755-2716 Fax: 701-328-1060
ND Relay TTY 1-800-366-6888

DN 519 (REV 03-15)

BASIC CARE ASSISTANCE PROGRAM

north dakota department of human services

What is Basic Care Assistance?

The Basic Care Assistance Program helps qualifying individuals pay a portion of their cost for care while living in a licensed basic care facility.

Who qualifies for the Basic Care program?

Individuals age 65 or older or an individual age 18 and older who is blind or disabled, who require services, provided by a licensed basic care facility and meet income guidelines.

How do I apply?

- **Apply at your County Social Service Office**
- **Apply online at** www.nd.gov/dhs/

Program Requirements

- ✓ **Medicaid eligible**
- ✓ **Resident of North Dakota**
- ✓ **All income, minus $100 per month for personal needs, must be paid to the basic care facility for cost of care**
- ✓ **Meets functional assessment**
- ✓ **Need a supervised environment**

- ✓ **Individuals must be UNABLE to:**
  - **Prepare meals**
  - **Do housework or laundry**
  - **Take medication**
- ✓ **Individuals must NOT be severely impaired in any activities of daily living such as:**
  - **Toileting**
  - **Transferring to or from a bed or chair**
  - **Eating.**

Section 8
Basic Care
Payment System

CHAPTER 75-02-07.1
RATESETTING FOR BASIC CARE FACILITIES

Section
75-02-07.1-01 Definitions
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75-02-07.1-26 One-Time Adjustments
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75-02-07.1-28 Notification of Rates
75-02-07.1-29 Reconsiderations and Appeals
75-02-07.1-30 Resident Personal Funds

75-02-07.1-01. Definitions.

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment factor" means the inflation rate for basic care services used to develop the legislative appropriation for the department for the applicable rate year.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Aid to vulnerable aged, blind, and disabled persons" means a program that supplements the income of an eligible beneficiary who resides in a facility.

6. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by basic care regulations.

7. "Alzheimer's and related dementia facility" means a licensed basic care facility which primarily provides services specifically for individuals with Alzheimer's disease or related dementia.

8. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's-length transaction. It does not include:

   a. A purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 4 of section 75-02-07.1-13;

   b. A sale and leaseback to the same licensee;

   c. A transfer of an interest to a trust;

   d. Gifts or other transfer for nominal or no consideration;

   e. A change in the legal form of doing business;

   f. The addition or deletion of a partner, owner, or shareholder; or

   g. A sale, merger, reorganization, or any other transfer of interest between related organizations.

9. "Building" means the physical plant, including building components and building services equipment, licensed as a facility and used directly for resident care, and auxiliary buildings including sheds, garages, and storage buildings if used directly for resident care.

10. "Capital assets" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

11. "Chain organization" means a group of two or more basic care or health care facilities owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to basic care or health care.

12. "Close relative" means an individual whose relationship by blood, marriage, or adoption to an individual who is directly or indirectly affiliated with, controls, or is controlled by a facility is within the third degree of kinship.

13. "Community contribution" means contributions to civic organizations and sponsorship of community activities. It does not include donations to charities.

14. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, determination of cost limitations, and determination of rates.

15. "Cost center" means a division, department, or subdivision thereof, group of services or employees, or both, or any unit or type of activity into which functions of a facility are decided for purposes of cost assignment and allocations.

16. "Cost report" means the department-approved form for reporting costs, statistical data, and other relevant information of the facility.

17. "Department" means the department of human services.

18. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

19. "Depreciation" means an allocation of the cost of a depreciable asset over its estimated useful life.

20. "Depreciation guidelines" means the American hospital association's depreciation guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2013 edition.

21. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

22. "Direct care costs" means the cost category for allowable resident care, activities, social services, and laundry costs.

23. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

24. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the facility premises.

25. "Eligible beneficiary" means a facility resident who is eligible for aid to vulnerable aged, blind, and disabled persons.

26. "Employment benefits" means fringe benefits and other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

27. "Facility" means a provider licensed as a basic care facility, not owned or administered by state government, which does not meet the definition of an Alzheimer's and related dementia facility, traumatic brain injury facility, or institution for mental disease, which is enrolled with the department as a basic care assistance program provider.

28. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

29. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

30. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

31. "Food and plant costs" means the cost category for allowable food, utilities, and maintenance and repair costs.

32. "Freestanding facility" means a facility that does not share basic services with a hospital-based provider or a nursing facility.

33. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits, uniform allowances, and medical services furnished at facility expense.

34. "Highest market-driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

35. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

36. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

37. "In-house resident day" for basic care, swing bed, and nursing facilities means a day that a resident was actually residing in the facility. "In-house resident day" for hospitals means an inpatient day.

38. "Institution for mental disease" means a facility with a licensed capacity of seventeen or more beds which provides treatment or services primarily to individuals with a primary diagnosis of mental disease.

39. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

40. "Limit rate" means the rate established as the maximum allowable rate for direct care and indirect care.

41. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

42. "Medical care leave day" means any day that a resident is not in the facility but is in a licensed health care facility, including a hospital, swing bed, nursing facility, or transitional care unit, and is expected to return to the facility.

43. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

44. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

45. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

46. "Personal care rate" means a per diem rate that is the sum of the rates established for direct personal care costs, indirect personal care costs, and the operating margin for personal care.

47. "Private-pay resident" means a resident on whose behalf the facility is not receiving any aid to vulnerable aged, blind, and disabled persons program payments and whose payment rate is not established by any governmental entity with ratesetting authority.

48. "Private room" means a room equipped for use by only one resident.

49. "Property costs" means the cost category for allowable real property costs and passthrough costs.

50. "Provider" means the organization or individual who has executed a provider agreement with the department.

51. "Rate year" means the year from July first through June thirtieth.

52. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into

account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

53. "Related organization" means a close relative or person or an organization which a provider is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists when an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

54. "Report year" means the provider's fiscal year ending during the calendar year immediately preceding the rate year.

55. "Resident" means a person who has been admitted to the facility but not discharged.

56. "Resident day" in a facility means any day for which service is provided or for which payment in any amount is ordinarily sought, including medical care leave and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought. The amount of remuneration has no bearing on whether a day should be counted as a resident day. "Resident day" for assisted living or any other residential services provided means a day for which payment is sought by the provider regardless of remuneration.

57. "Room and board rate" means a per diem rate that is the sum of the rates established for property costs, direct room and board costs, indirect room and board costs, the operating margin for room and board and food and plant costs.

58. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

59. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater. It does not mean an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds. It does not mean an increase in a facility's capacity resulting from converting beds formerly licensed as nursing facility beds.

60. "Specialized facility for individuals with mental disease" means a licensed basic care facility with a licensed capacity of less than seventeen which provides treatment or services primarily to individuals with mental disease.

61. "Therapeutic leave day" means any day that a resident is not in the facility or in a licensed health care facility.

62. "Top management personnel" means corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

63. "Traumatic brain injury facility" means a licensed basic care facility which primarily provides services to individuals with traumatic brain injuries.

64. "Working capital debt" means debt incurred to finance facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000; July 1, 2001; February 1, 2007; October 1, 2011; July 1, 2014; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3)

Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-02. Financial reporting requirements.

1. Records.

   a. The facility shall maintain on the premises the required census records and financial information in a manner sufficient to provide for a proper audit or review. For any cost being claimed on the cost report, sufficient data must be available as of the audit date to fully support the report item.

   b. Where several facilities are associated with a group and their accounting and reports are centrally prepared, added information must be submitted, for those items known to be lacking support at the reporting facility, with the cost report or must be provided to the local facility prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost. Home office cost reporting and cost allocation must be in conformance with applicable sections in this chapter.

   c. Each provider shall maintain, for a period of not less than five years following the date of submission of the cost report to the department, accurate financial and statistical records of the period covered by such cost report in sufficient detail to substantiate the cost data reported. Each provider shall make such records available upon reasonable demand to representatives of the department.

   d. Except for motor vehicles used exclusively for resident-related activities, the provider shall maintain a mileage log for all motor vehicles that identifies mileage and purpose of each trip. Vehicle mileage for nonresident-related activities must be documented.

2. Accounting and reporting requirements.

   a. The accrual basis of accounting, in accordance with generally accepted accounting principles, must be used for cost reporting purposes. A facility may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at yearend and when subsequently reported. Ratesetting procedures must prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles.

   b. To properly facilitate auditing, the accounting system must be maintained in a manner that allows cost accounts to be grouped by cost category and readily traceable to the cost report.

   c. No later than the last day of the third month following the facility's fiscal yearend, except as provided for in subdivision d, each facility shall provide to the department:

      (1) A cost report on forms prescribed by the department.

      (2) A copy of the facility's financial statement. For provider organizations that operate more than one facility, a consolidated financial report can be provided. The information must be reconciled to each facility's cost report.

      (3) A statement of ownership for the facility, including the name, address, and proportion of ownership of each owner.

         (a) If a privately held or closely held corporation or partnership has an ownership interest in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an

ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the facility's cost report must be identified regardless of the proportion of ownership interest.

(b) If a publicly held corporation has an ownership interest of fifteen percent or more in the facility, the facility shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of ten percent or more.

(4) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the facility or a certification that the content of any such document remains unchanged since the most recent statement given pursuant to this subsection.

(5) Supplemental information reconciling the costs on the financial statements with costs on the cost report.

(6) The following information, upon request by the department:

(a) Access to certified public accountant's workpapers that support audited, reviewed, or compiled financial statements.

(b) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs.

(c) Separate financial statements for any organization, excluding individual facilities of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

(d) Separate financial statements for any organization with which the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconcile costs on the financial statements to costs for the report year.

d. A facility may elect to file a cost report based on a December thirty-first report year or a June thirtieth report year, rather than on the facility's fiscal yearend. Once elected, the facility may not change the reporting period without written approval from the department. The due date for the information required in subdivision c will be March thirty-first if the facility elects a December thirty-first report year and September thirtieth if the facility elects a June thirtieth report year.

e. If a facility fails to file the required cost report on or before the due date, the department may reduce the current payment rate to eighty percent of the facility's most recently established rate. Reinstatement of the current payment rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

f. A facility shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any cost report when the information filed is incomplete or inaccurate. If a cost report is rejected, the department may reduce the current payment rate to eighty percent of its most recently established rate until the information is completely and accurately filed.

g. Costs reported must include total costs and be adjusted to allowable costs. Adjustments made by the department, to attain allowable cost, may, if repeated on future cost filings,

be considered as possible fraud and abuse. The department may forward all such items identified to the appropriate investigative group.

h. The department may grant an extension of the reporting deadline to a facility for good cause. To receive an extension, a facility shall submit a written request to the department. The deadline for filing may not be extended past April fifteenth of the year following the report year.

3. In order to properly validate the accuracy and reasonableness of cost information reported by the facility, the department may provide for an onsite audit.

4. Penalties for false reports.

   a. A false report is one where a facility knowingly supplies inaccurate or false information in a required report that results in an overpayment. If a false report is received, the department may:

      (1) Immediately adjust the facility's payment rate to recover the entire overpayment within the rate year;

      (2) Terminate the department's agreement with the provider;

      (3) Prosecute under applicable state or federal law; or

      (4) Use any combination of the foregoing actions.

   b. The department may determine a report is a false report if a provider claims previously adjusted costs as allowable costs. Previously adjusted costs being appealed must be identified as nonallowable costs. The provider may indicate that the costs are under appeal and not claimed under protest to perfect a claim if the appeal is successful.

History: Effective July 1, 1996; amended effective October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-03. General cost principles.

1. For ratesetting purposes, a cost must:

   a. Be ordinary, necessary, and related to resident care;

   b. Be what a prudent and cost-conscious business person would pay for the specific good or service in the open market in an arm's-length transaction; and

   c. Be for goods or services actually provided in the facility.

2. The cost effects of transactions which circumvent these rules are not allowable under the principle that the substance of the transaction prevails over form.

3. Costs incurred due to management inefficiency, unnecessary care, unnecessary facilities, agreements not to compete, or activities not commonly accepted in the basic care industry are not allowable.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-04. Participation requirement.

A facility may not receive aid to vulnerable aged, blind, and disabled persons assistance payments unless it complies with all provisions of this section.

1. A facility shall have an effective provider agreement with the department.

2. A facility may charge to hold a bed for a period in excess of the periods covered under subsection 2 or 3 of section 75-02-07.1-05 if:

   a. The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge; and

   b. For an eligible beneficiary, the payment comes from sources other than from the beneficiary's monthly income.

3. A facility may not violate any resident rights as set forth in North Dakota Century Code section 50-10.2-02. Collection and use by a facility of financial information of any applicant pursuant to a screening process does not raise an inference that the facility is using that information for any purpose prohibited by North Dakota Century Code section 50-10.2-02 or this section.

4. A facility may not require any vendor of medical care, who is paid by medical assistance under a separate fee schedule, to pay any portion of the vendor's fee to the facility except as payment for the fair market value of renting or leasing space or equipment of the facility or purchasing support services, if those agreements are disclosed to the department.

5. A facility shall file on behalf of each resident or assist each resident in filing requests for any third-party benefits to which the resident may be entitled.

6. If a facility does not comply with this section, the department, if extreme hardship to the residents would otherwise result, may continue to make medical assistance and aid to vulnerable aged, blind, and disabled persons program payments to the facility for a period not to exceed ninety days from the date of mailing a written notice of a violation of this section. The facility may seek reconsideration of or appeal the department's action.

7. A facility may charge a higher rate for a private room used by an eligible beneficiary if:

   a. The private room is not necessary to meet the eligible beneficiary's care needs;

   b. The eligible beneficiary, or a person acting on behalf of the eligible beneficiary, has requested the private room;

   c. The facility informs the individual making the request, at the time of the request, of the amount of payment and that the payment must come from sources other than the eligible beneficiary's monthly income;

   d. The payment does not exceed the amount charged to private-pay individuals for use of a private room; and

   e. Appropriate semiprivate accommodations are available at the time the first charges for a private room apply.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-05. Resident census.

1. Adequate census records must be prepared and maintained on a daily basis by the facility to allow for proper audit of the census data. The daily census records must include:

   a. Identification of the resident;

   b. Entries for all days, and not just by exception;

   c. Identification of type of day, i.e., medical care, in-house; and

   d. Monthly totals by resident and by type of day.

2. A maximum of thirty days per occurrence may be allowed for payment of the room and board rate for medical care leave. Medical care leave days in excess of thirty consecutive days not billable to the aid to vulnerable aged, blind, and disabled persons program are not resident days unless any payment is sought as provided for in subsection 2 of section 75-02-07.1-04.

3. A maximum of twenty-eight therapeutic leave days per rate year may be allowed for payment of the room and board rate. Nonbillable therapeutic leave days in excess of twenty-eight are not resident days unless any payment is sought as provided for in subsection 2 of section 75-02-07.1-04.

4. Residents admitted to the facility through a hospice program, or electing hospice benefits while in a facility, must be identified as hospice residents for census purposes.

5. Payment may not be sought for payment of the personal care rate for any day in which an eligible beneficiary is not in the facility or for the day of discharge. Payment of the personal care rate may be sought for the day of death.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-06. Direct care costs.

Direct care costs include only those costs identified in this section.

1. **Resident care.**

   a. Salary and employment benefits for the director or supervisor of resident care staff, inservice trainers for resident care staff, quality assurance personnel, resident care aides, medication aides, and ward clerks.

   b. Routine hair and personal hygiene items and services furnished routinely and relatively uniformly to all residents; items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities; and items used by individual residents that are reusable, vary by the needs of the individual, and are expected to be available in the facility.

   c. Medically necessary items, services, and durable medical equipment which could otherwise be billed directly to Medicaid if the facility chooses to provide them.

2. **Licensed health care professionals.**

   a. Salary and employment benefits for the director or supervisor of licensed health care professional staff, registered nurses, licensed practical nurses, speech, occupational, and physical therapists.

b. The cost of supplies used to provide therapy, or noncapitalized therapy and resident care equipment.

3. **Laundry.**

   a. Salary and employment benefits for a director of laundry, laundry aides, seamstresses, and other personnel who gather, transport, sort, and clean linen and clothing.

   b. The cost of laundry supplies including detergents, softeners, and linens.

   c. Contracted services for laundry.

4. **Social services.** Salary and employment benefits or consultant fees for social workers or social worker designees.

5. **Activities.**

   a. Salary and employment benefits for activities director, activities aides, and other personnel who directly provide for leisure and recreational activities.

   b. The cost of leisure and recreational activities and supplies including games, ceramics, pets, out-of-house activities, and noncapitalized exercise equipment.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-07. Indirect care costs.

Indirect care costs include all costs specifically identified in this section. Indirect care costs must be included in total, without direct or indirect allocation to other cost categories unless specifically provided for elsewhere.

1. **Administration.** Costs for administering the overall activities of the facility include:

   a. Salary and employment benefits for administrators, except that part of an administrator's salary may be allocated to other cost categories provided adequate records identifying the hours and services provided are maintained by the facility.

   b. Salary and employment benefits for assistant administrators, top management personnel, accounting personnel, clerical personnel, secretaries, receptionists, data processing personnel, purchasing, receiving and store personnel, medical director, and salary and employment benefits of all personnel not designated in other cost categories.

   c. Board of directors' fees and related travel expenses.

   d. Security personnel or services.

   e. Supplies except as specifically provided for in the direct care and other cost centers of the indirect care cost category.

   f. Insurance, except insurance included as a fringe benefit and insurance included as part of related party lease costs.

   g. Telephone.

   h. Postage and freight.

   i. Membership dues and subscriptions.

j. Professional fees for services such as legal, accounting, and data processing.

k. Central or home office costs including property costs, but not including costs that may be allocated to other cost centers under subsection 4 of section 75-02-07.1-12.

l. Advertising and personnel recruitment costs.

m. Management consultants and fees.

n. Business meetings, conventions, association meetings, and seminars.

o. Travel.

p. Training, including inservice training.

q. Business office functions.

r. Computer software costs, except costs that must be capitalized, and computer maintenance contracts.

s. Working capital interest.

t. Any costs that cannot be specifically classified to other cost categories.

2. **Chaplain.**

a. Salary and employment benefits for all personnel assigned to meet the spiritual needs of the residents.

b. Supplies and other expenses related to meeting the spiritual needs of the residents.

3. **Pharmacy.** Compensation for pharmacy consultants.

4. **Plant operations.**

a. Salary and employment benefits for a director of plant operations, engineers, carpenters, electricians, plumbers, caretakers, vehicle drivers, and all other personnel performing tasks related to maintenance or general plant operations.

b. Motor vehicle operating and resident transportation expenses.

5. **Housekeeping.**

a. Salary and employment benefits for a director of housekeeping, housekeepers, and other cleaning personnel.

b. Cost of cleaning supplies including soaps, waxes, polishes, household paper products such as hand towels and toilet paper, and noncapitalized cleaning equipment.

c. Contracted services for housekeeping.

6. **Dietary.**

a. Salary and employment benefits for a director of dietary, nutritionists, dieticians, cooks, and kitchen personnel involved in the preparation and delivery of food.

b. The cost of dietary supplies and utensils including dietary paper products, silverware, and noncapitalized kitchen and dining equipment.

7. **Medical records.** Salary and employment benefits for personnel performing medical records maintenance.

History: Effective July 1, 1996; amended effective July 1, 2001; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-08. Property costs.

Property-related costs and pass-through costs include only those costs identified in this section.

1. Depreciation.
2. Interest expense on capital debt.
3. Property taxes including special assessments as provided for in section 75-02-07.1-17.
4. Lease and rental costs.
5. Startup costs.
6. Reasonable legal and related expenses:
   a. Incurred or as a result of a successful challenge to a decision by a governmental agency, made on or after July 1, 1995, regarding a rate year beginning on or after July 1, 1995;
   b. Related to legal services furnished on or after July 1, 1995; and
   c. In the case of a partially successful challenge, not in excess of an amount determined by developing a ratio of total amounts claimed successfully to total amounts claimed in the partially successful challenge and applying that ratio to the total legal and related expenses paid.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-08.1. Food and plant costs.

Food and plant costs include only those costs identified in this section.

1. The cost of consumable food products and dietary supplements.
2. The cost of heating and cooling, electricity, water, sewer and garbage, and cable television.
3. Repairs and maintenance contracts and purchased services.
4. Supplies necessary for repairs and maintenance of the facility, including hardware, building materials and tools, other maintenance-related supplies, and noncapitalized equipment not included elsewhere.

History: Effective July 1, 2001.
General Authority: NDCC 50-06-15
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-09. Cost allocations.

1. Direct costing of allowable costs must be used whenever possible. For a facility that cannot direct cost, the following allocation methods must be used:

a. If a facility is combined with other residential or health care facilities, except for a nursing facility, the following allocation methods must be used:

(1) Resident care salaries that cannot be reported based on actual costs must be allocated using time studies. Time studies must be conducted at least semiannually for a two-week period or quarterly for a one-week period. Time studies must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibilities. Allocation percentages based on the time studies must be used starting with the next pay period following completion of the time studies or averaged for the report year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, resident care salaries must be allocated based on revenues for resident services.

(2) Salaries for a director or supervisor of resident care or licensed health care professionals that cannot be reported based on actual costs or time studies must be allocated based on resident care salaries, licensed health care professional salaries or full-time equivalents of resident care staff, or licensed health care professional staff.

(3) Salaries for cost center supervisors must be allocated based on cost center salaries or full-time equivalents of supervised staff.

(4) Other resident care costs must be allocated based on resident days.

(5) Dietary and food costs must be allocated based on the number of meals served or in-house resident days.

(6) Laundry costs must be allocated on the basis of pounds of laundry or in-house resident days.

(7) Activity costs must be allocated based on in-house resident days.

(8) Social service costs must be allocated based on resident days.

(9) Housekeeping costs must be allocated based on weighted square footage.

(10) Plant operation costs must be allocated based on weighted square footage.

(11) Medical records costs must be allocated based on the number of admissions or discharges and deaths.

(12) Pharmacy costs for consultants must be allocated based on in-house resident days.

(13) Administration costs must be allocated on the basis of the percentage of total adjusted cost, excluding property, administration, chaplain, and utility costs, in each facility.

(14) Property costs must be allocated first to a cost center based on square footage. The property costs allocated to a given cost center must be allocated using the methodologies set forth in this section for that particular cost center.

(15) Chaplain costs must be allocated based on the percentage of total adjusted costs, excluding property, administration, and chaplain.

(16) Employment benefits must be allocated based on the ratio of salaries to total salaries.

b. If any of the allocation methods in subdivision a cannot be used by a facility, a waiver request may be submitted to the department. The request must include an adequate explanation as to why the referenced allocation method cannot be used by the facility. The facility shall also provide a rationale for the proposed allocation method. Based on the information provided, the department shall determine the allocation method used to report costs.

c. Malpractice, professional liability insurance, therapy salaries, purchased therapy services, and resident care salaries and benefits costs for a facility combined with an optional Alzheimer's, dementia, special memory care or traumatic brain injury facility, or unit must be direct costed.

d. The costs of operating a pharmacy may not be included as facility costs.

e. For purposes of this subsection, "weighted square footage" means the allocation of the facility's total square footage, excluding common areas, identified first to a cost category and then allocated based on the allocation method described in this subsection for that cost category.

2. If a facility is combined with a nursing facility, the allocation methodologies, exceptions, and waivers set forth in chapter 75-02-06 must also be used for the facility.

3. If a facility cannot directly identify salaries and employment benefits to a cost category, the following cost allocation methods must be used:

a. Salaries must be allocated using time studies. Time studies must be conducted semiannually for a two-week period or quarterly for a one-week period. Time studies must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibilities. Allocation percentages based on the time studies must be used starting with the next pay period following completion of the time studies or averaged for the report year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, salaries must be allocated entirely to indirect care costs if any of the employee's job duties are included in this cost category.

b. Employment benefits must be allocated based on the ratio of salaries in the cost center to total salaries.

4. A facility that operates or is associated with nonresident-related activities, such as apartment complexes, shall allocate all costs, except administration costs, in the manner required by subsection 1, and shall allocate administration costs as follows:

a. If total costs of all nonresident-related activities, exclusive of property, administration, chaplain, and utility costs, exceed five percent of total facility costs, exclusive of property, administration, chaplain, and utility costs, administration costs must be allocated on the basis of the percentage of total costs, excluding property, administration, chaplain, and utility costs.

b. If total costs of all nonresident-related activities, exclusive of property, administration, chaplain, and utility costs, are less than five percent of total facility costs, exclusive of property, administration, chaplain, and utility costs, administration costs must be allocated to each activity based on the percent gross revenues for the activity is of total gross revenues except that the allocation may not be based on a percentage exceeding two percent for each activity.

c. If the provider can document, to the satisfaction of the department, that none of the facility resources or services are used in connection with the nonresident-related activities, no allocation need be made.

d. The provisions of this subsection do not apply to the activities of health care facilities associated with a facility.

5. All costs associated with a vehicle not exclusively used by a facility must be allocated between resident-related and nonresident-related activities based on mileage logs.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000; October 1, 2011; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-10. Nonallowable costs.

Costs not related to resident care are costs not appropriate or necessary and proper in developing and maintaining the operation of the facility and its activities. These costs are not allowed in computing the rates. Nonallowable costs include:

1. Political contributions;

2. Salaries or expenses of a lobbyist;

3. Advertising designed to encourage potential residents to select a particular facility;

4. Fines or penalties, including interest charges on the penalty, bank overdraft charges, and late payment charges;

5. Legal and related expenses for challenges to decisions made by governmental agencies except for successful challenges as provided for in section 75-02-07.1-08;

6. Costs incurred for activities directly related to influencing employees with respect to unionization;

7. Cost of memberships in sports, health, fraternal, or social clubs or organizations such as elks, YMCA, country clubs, or knights of columbus;

8. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies, including all dues unless an allocation of dues to such costs is provided;

9. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., lions, chamber of commerce, kiwanis, in excess of one thousand five hundred dollars per cost reporting period;

10. Home office costs not otherwise allowable if incurred directly by the facility;

11. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors that include annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for security exchange commission purposes, stock transfer agent fees, and stockbroker and investment analysis;

12. Corporate costs not related to resident care, including reorganization costs; costs associated with the acquisition of capital stock, except otherwise allowable interest and depreciation

expenses associated with the transaction described in subsection 4 of section 75-02-07.1-13; and costs relating to the issuance and sale of capital stock or other securities;

13. The full cost of items or services such as telephone, radio, and television, including cable hookups or satellite dishes, located in resident accommodations, excluding common areas, furnished solely for the personal comfort of the residents;

14. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

15. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates, to the satisfaction of the department, that any portion of the use of equipment was related to resident care;

16. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any health care facility or basic care facility;

17. Costs incurred by the provider's subcontractors or by the lessor of property that the provider leases, that are an element in the subcontractor's or lessor's charge to the provider, if the costs would not have been allowable had the costs been incurred by a provider directly furnishing the subcontracted services, or owning the leased property, except no facility shall have a particular item of cost disallowed under this subsection if that cost arises out of a transaction completed before July 1, 1995;

18. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises;

19. Depreciation expense for facility assets not related to resident care;

20. Nonbasic care facility operations and associated administration costs;

21. All costs for services paid directly by a government entity to an outside provider, such as prescription drugs;

22. Travel costs involving the use of vehicles not exclusively used by the facility except to the extent:

    a. The facility supports vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care;

    b. Resident-care related vehicle travel costs do not exceed a standard mileage rate established by the internal revenue service; and

    c. The facility documents all costs associated with a vehicle not exclusively used by the facility;

23. Travel costs other than vehicle-related costs unless supported, reasonable, and related to resident care;

24. Additional compensation paid to an employee, who is a member of the board of directors, for service on the board;

25. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid, per day, to a member of the legislative council, pursuant to North Dakota Century Code section 54-35-10;

26. Travel costs associated with a board of directors meeting to the extent the meeting is held in a location where the organization has no facility;

27. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion which relates to costs that benefit all eligible employees;

28. Premiums for top management personnel life insurance policies, except that the premiums must be allowed if the policy is included within a group policy provided for all employees, or if the policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the sole beneficiary;

29. Personal expenses of owners and employees, including vacations, personal travel, and entertainment;

30. Costs not adequately documented through written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities;

31. The following taxes:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes on the issuance of bonds, property transfers, or issuance or transfer of stocks, which are generally either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;

    d. Taxes, including real estate and sales tax, for which exemptions are available to the provider;

    e. Taxes on property not used in the provision of covered services;

    f. Taxes, including sales taxes, levied against the residents and collected and remitted by the provider; and

    g. Self-employment (FICA) taxes, applicable to persons such as individual proprietors, partners, or members of a joint venture;

32. The unvested portion of a facility's accrual for sick or annual leave;

33. Salaries accrued at a facility's fiscal yearend but not paid within seventy-five days of the facility's fiscal yearend;

34. Employment benefits associated with salary costs not includable in a rate set under this chapter;

35. The cost, including depreciation, of equipment or items purchased with funds received from a government agency;

36. Hair care, other than routine hair care, furnished by the facility;

37. The cost of education unless:

    a. The education was provided by an accredited academic or technical educational facility;

    b. The expenses were for materials, books, or tuition;

c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility and is in that position; and

d. The facility claims the cost of the education at a rate that does not exceed one dollar per hour of work performed by the employee in the position for which the employee received education at the facility's expense, provided the amount claimed per employee may not exceed two thousand dollars per year, or an aggregate of eight thousand dollars, and in any event may not exceed the cost to the facility of the employee's education;

38. Repealed effective July 1, 1999.

39. Increased lease costs of a provider except to the extent:

a. The lessor incurs increased costs related to the ownership of the facility or a resident-related asset;

b. The increased costs related to the ownership are charged to the lessee; and

c. The increased costs related to the ownership would be allowable had the costs been incurred directly by the lessee;

40. Bad debts expense;

41. Costs associated with or paid for the acquisition of licensed basic care capacity; and

42. Goodwill.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2000.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-11. Offsets to costs.

1. Several items of income must be considered as offsets against various costs as recorded in the books of the facility. Income received by the facility in any form must be offset up to the total of the appropriate allowable costs, with the following exceptions:

a. The established rate;

b. Income from payments made under the Job Training Partnership Act;

c. Income from charges for private rooms or special services;

d. Noncovered bed hold days; or

e. The deferred portion of patronage dividends credited to the facility and not previously offset.

2. If actual costs are not identifiable, income must be offset up to the total of costs as described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each of the cost categories. Sources of income and the related offset include:

a. Activities income. Income from the activities department and the gift shop must be offset to activity costs.

b. Bad debt recovery. Income for bad debts previously claimed must be offset to administration costs in total in the year of recovery.

c. Dietary income. Amounts received from or on behalf of employees, guests, or other nonresidents for lunches, meals, or snacks must be offset to dietary and food costs.

d. Drugs or supplies income. Amounts received from the sale of resident care supplies to employees, doctors, or others not admitted as residents must be offset to resident care supplies.

e. Insurance recoveries income. Any amount received from insurance for a loss incurred must be offset against the appropriate cost category, regardless of when or if the cost is incurred, if the facility did not adjust the basis for depreciable assets.

f. Interest or investment income. Interest received on investments, except amounts earned on funded depreciation or from earnings on gifts where the identity remains intact, must be offset to interest expense.

g. Laundry income. All amounts received for laundry services rendered to or on behalf of employees, doctors, or others must be offset to laundry costs.

h. Other cost-related income. Miscellaneous income, including amounts generated through the sale of a previously expensed or depreciated item, e.g., supplies or equipment, must be offset, in total, to the cost category where the item was expensed or depreciated.

i. Rentals of facility space income. Revenues received from outside sources for the use of facility space and equipment must be offset to property costs.

j. Telephone income. Revenues received from residents, guests, or employees for use of a telephone must be offset to administration costs. Income from emergency answering services need not be offset.

k. Therapy income. Income from all therapy services must be offset to licensed health care professional costs.

l. Vending income. Income from the sale of beverages, candy, or other items must be offset to the cost of the vending items or, if the cost is not identified, all vending income must be offset to the cost category where vending costs are recorded.

3. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased.

4. Payments to a provider by its vendor must ordinarily be treated as purchase discounts, allowances, refunds, or rebates, even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor. Payments that represent a true donation or grant need not be treated as purchase discounts, allowances, refunds, or rebates. Examples of payments that represent a true donation or grant include contributions made by a vendor in response to building or other fundraising campaigns in which communitywide contributions are solicited or when the volume or value of purchases is so nominal that no relationship to the contribution can be inferred. The provider shall provide verification, satisfactory to the department, to support a claim that a payment represents a true donation.

5. Where an owner, agent, or employee of a provider directly receives from a vendor monetary payments or goods or services for the owner's, agent's, or employee's own personal use as a result of the provider's purchases from the vendor, the value of the payments, goods, or services constitutes a type of refund or rebate and must be applied as a reduction of the provider's cost for goods or services purchased from the vendor.

6. Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to costs of the provider and may not be treated as income by the central unit or organization or used to reduce the administrative costs of the central unit or organization.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2016.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-12. Home office costs.

1. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to member facilities. Although the home office of a chain is normally not a provider in itself, it may furnish central administration or other services including centralized accounting, purchasing, personnel, or management services. To the extent the home office furnishes services related to resident care to a facility, the reasonable resident-related costs, not to exceed actual costs of the services, are includable in the facility's cost report and are includable as part of the facility's rate.

2. Where the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.

3. Home office costs incurred for expansion of a chain organization must be directly allocated to the appropriate component of the chain. The costs of abandoned plans are not allowable.

4. Central or home office costs representing services of consultants required by law in areas for social services, nursing, therapies, or activities and central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of resident care may be allocated to the appropriate cost category of a facility according to subdivisions a through e.

   a. Only the salaries and employment benefits associated with the individual performing the service may be allocated. No other costs may be allocated.

   b. The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services in the facility.

   c. The cost in subdivision a for each consultant may not be allocated to more than one cost category in the facility. If more than one facility is served by a consultant, all facilities shall allocate the consultant's cost to the same operating category.

   d. Top management personnel may not be considered consultants.

   e. An allocation may not be made unless the consultant's full-time responsibilities are to provide the services identified in this section.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-13. Related organizations.

1. Except as provided in subsection 4, costs applicable to services, facilities, and supplies furnished to a provider by a related organization may not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased

elsewhere primarily in the local market. The provider shall identify the related organizations and costs in the cost report.

2. A provider may lease a facility from a related organization within the meaning of ratesetting principles. In such case, the rent paid to the lessor by the provider is not allowable as cost. The provider may include in its cost the allowable costs of ownership of the facility. These costs are property insurance, depreciation as provided for in section 75-02-07.1-15, interest on the mortgage as provided for in section 75-02-07.1-16, and real estate taxes as provided for in section 75-02-07.1-17. Other operating expenses of the related organization, relating to the leased facility, are not includable by the provider as an allowable cost of ownership, but may be included as allowable operating expenses subject to subsection 1.

3. The relationship between a provider and a related organization at the time a transaction between the two parties occurs must govern the treatment of cost regardless of subsequent events that may change the relationship between the parties.

4. In the case of a facility acquired through purchase of shares, interest and depreciation expense are treated in the same manner as if the capital assets of the acquired corporation were acquired as an ongoing operation by the acquiring entity on the day the secretary of state issues a certificate of dissolution of the acquired corporation if organized in North Dakota, or on the day the acquired corporation is irrevocably dissolved if organized other than in North Dakota, provided the transaction has all of the following characteristics:

   a. The facility was owned and operated by the acquired corporation;

   b. The acquired corporation is irrevocably dissolved, and all of its capital assets become the property of the acquiring entity, within one year after the first day on which any ownership interest in the acquired corporation was acquired by the acquiring entity; and

   c. Neither the acquiring entity nor any related organization of the acquiring entity has had any ownership interest in the acquired corporation, or any ownership interest in any related organization of the acquired corporation, for at least ten years prior to the day the acquiring entity, or a related organization of the acquiring entity, first acquired any ownership interest in the acquired corporation.

5. For purposes of subsection 4, "acquiring entity" means the entity that, upon dissolution of the acquired corporation, owns all the capital assets formerly owned by the acquired corporation.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-14. Compensation.

1. Compensation on an annual basis for top management personnel must be limited, prior to allocation, if any, to the greatest of:

   a. The highest market-driven compensation of an administrator employed by a freestanding not-for-profit facility during the report year;

   b. Sixty thousand nine hundred seventy-four dollars;

   c. The limit set under this subsection for the previous rate year adjusted by the adjustment factor;

   d. If the facility is combined with a nursing facility or hospital, the compensation limit for top management personnel as determined by chapter 75-02-06, except the allocation of the

compensation to the basic care facility may not exceed the greatest of subdivision a, b, or c; or

e. For a facility licensed before July 1, 2016, which is located in North Dakota and shares a home office that is also located in North Dakota with no more than two nursing facilities that are located in North Dakota, but whose cost report does not include nursing facility costs, the compensation limit for top management personnel as determined by chapter 75-02-06, except the allocation of the compensation to the basic care facility may not exceed the greatest of subdivision a, b, or c.

2. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation described in subsection 1, divided by three hundred sixty-five times the number of calendar days the individual was employed.

3. Compensation includes:

   a. Salary for managerial, administrative, professional, and other services;

   b. Amounts paid for the personal benefit of the person, e.g., housing allowance, flat-rate automobile allowance;

   c. The cost of assets and services the person receives from the provider;

   d. Deferred compensation, pensions, and annuities;

   e. Supplies and services provided for the personal use of the person;

   f. The cost of a domestic or other employee who works in the home of the person; or

   g. Life and health insurance premiums paid for the person and medical services furnished at facility expense.

4. Reasonable compensation for a person with at least five percent ownership, persons on the governing board, or any person related within the third degree of kinship to top management personnel must be considered an allowable cost if services are actually performed and required to be performed. The amount to be allowed must be an amount determined by the department to be equal to the amount required to be paid for the same services if provided by a nonrelated employee to a North Dakota facility. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the facility would have to employ another person to perform them. Reasonable hourly compensation may not exceed the amount determined under subsection 1, divided by two thousand eighty.

5. Costs otherwise nonallowable under this chapter may not be included as compensation.

History: Effective July 1, 1996; amended effective July 1, 1998; October 1, 2011; July 1, 2011; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3), 50-24.5-10
Law Implemented: NDCC 50-24.5-02(3), 50-24.5-10

75-02-07.1-15. Depreciation.

1. Ratesetting principles require that payment for services include depreciation on all capital assets used to provide necessary services.

   a. Capital assets that may have been fully or partially depreciated on the books of the provider, but are in use at the time the provider enters the program, may be depreciated. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. To properly provide for costs

or the valuation of such assets, an appraisal is required if the provider has no historical cost records or has incomplete records of the capital assets.

b. A depreciation allowance is permitted on assets used in a normal standby or emergency capacity.

c. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the cost report. The facility shall use the sale price in computing the gain or loss on the disposition of assets.

2. Depreciation methods.

a. The straight-line method of depreciation must be used. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, may not be used. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different from that submitted on the cost report, a reconciliation must be prepared by the facility.

b. Except as provided in subdivision c, a provider shall apply the same methodology for determining the useful lives of all assets purchased after June 30, 1995. If a composite useful life methodology is chosen, the provider may not thereafter use the depreciation guidelines without the department's written approval. The provider shall use, at a minimum, the depreciation guidelines to determine the useful life of buildings and land improvements. The provider may use:

(1) A composite useful life of ten years for all equipment except automobiles and five years for automobiles; or

(2) The useful lives for all equipment identified in the depreciation guidelines and a useful life of ten years for all equipment not identified in the depreciation guidelines.

c. A provider acquiring assets as an ongoing operation shall use as a basis for determining depreciation:

(1) The estimated remaining life, as determined by a qualified appraiser, for land improvements, buildings, and fixed equipment; and

(2) A composite remaining useful life for movable equipment, determined from the seller's records.

3. Acquisitions.

a. If a depreciable asset has, at the time of its acquisition, a historical cost of at least one thousand dollars for each item, its cost must be capitalized and depreciated over the estimated useful life of the asset. Costs incurred during the construction of an asset, such as architectural, consulting and legal fees, and interest, must be capitalized as a part of the cost of the asset.

b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building repaired or maintained, or one-half of the original estimated useful life, whichever is greater.

4. Proper records must provide accountability for the fixed assets and provide adequate means by which depreciation can be computed and established as an allowable resident-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. Donated assets, excluding assets acquired as an ongoing operation, may be recorded and depreciated based on fair market value. In the case where the provider's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal may be made. The appraisal must be made by a recognized appraisal expert and must be accepted for depreciation purposes. The useful life of a donated asset must be determined in accordance with subsection 2. The facility may elect to forego depreciation on a donated asset thereby negating the need for a fair market value determination.

6. Basis for depreciation of assets acquired as an ongoing operation.

   a. Determination of the cost basis of a facility and its depreciable assets acquired as an ongoing operation depends on whether or not the transaction is a bona fide sale. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide.

   b. The cost basis of a facility and its depreciable assets acquired in a bona fide sale after July 1, 1995, is limited to the lowest of:

      (1) Purchase price paid by the purchaser;

      (2) Fair market value at the time of the sale; or

      (3) The seller's cost basis, increased by one-half of the increase in the consumer price index for all urban consumers, United States city average, all items, from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes.

   c. In a sale not bona fide, the cost basis of an acquired facility and its depreciable assets is the seller's cost basis, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer.

   d. The cost basis of a facility and its depreciable assets acquired through donation or for a nominal amount is the cost basis of the seller or donor, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer or donee.

   e. In order to calculate the increase over the seller's cost basis, an increase may be allowed, under paragraph 3 of subdivision b, only for assets with a historical cost basis established separately and distinctly in the seller's depreciable asset records.

   f. For purposes of this subsection, "date of acquisition" means the date when ownership of the depreciable asset transfers from the transferor to the transferee such that both are bound by the transaction. For purposes of transfers of real property, the date of acquisition is the date of delivery of the instrument transferring ownership. For purposes of titled personal property, the date of acquisition is the date the transferee receives a title acceptable for registration. For purposes of all other capital assets, the date of acquisition is the date the transferee possesses both the asset and an instrument, describing the asset, which conveys the property to the transferee.

7. An adjustment may not be allowed for any depreciable cost that exceeded the basis in effect for rate periods prior to July 1, 1995.

8. The department shall establish a cost basis limitation for construction or renovation of a facility. A per bed cost limitation must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation, or remodeling.

   a. Effective August 1, 2009, the per bed limitation basis for double occupancy is one hundred twelve thousand seven hundred thirty-two dollars.

   b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by one and one-half.

   c. The existing per bed limitations for single and double occupancy must be adjusted annually on July first, using the increase, if any, in the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May thirty-first.

   d. The per bed limitations in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.

   e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitations.

History: Effective July 1, 1996; amended effective July 1, 1998; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-16. Interest expense.

1. To be allowable, interest expense must meet all of the following criteria:

   a. Interest expense must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds is required.

   b. Interest expense must be identifiable in the facility's accounting records.

   c. Interest expense must be related to the reporting period in which the costs are incurred.

   d. Interest expense must be necessary and proper for the operation, maintenance, or acquisition of the facility.

   e. Interest expense must not relate to funds borrowed to finance costs of assets in excess of the depreciable cost basis established at the time of purchase as recognized in section 75-02-07.1-15.

   f. If associated with refinancing or refunding debt, interest expense associated with the original borrowing must have been allowable when the debt was initially incurred.

   g. If associated with borrowing for the purpose of acquiring assets as an ongoing operation in a bona fide sale, interest expense must be limited to the amount of interest associated with borrowing, occurring at the time of the sale, that does not exceed ninety percent of the cost basis as determined in subsection 6 of section 75-02-07.1-15.

   h. In a sale not bona fide, interest expense may not exceed the amount that would have been allowable had the sale not occurred.

2. In cases where it is necessary to issue bonds for financing, any bond premium or discount must be amortized over the life of the bond issue.

3. Interest paid by the provider to partners, stockholders, or related organizations of the provider is not allowable as a cost. Where the owner loans funds to a facility, the funds are considered capital, rather than borrowed funds.

4. If a facility incurs interest expense because of late payments for resident services and charges a service charge or interest for late payments, the income must be offset against interest expense. If no interest expense is incurred by the facility because of late payments for resident services, service charges or interest paid must be offset against administration expenses.

5. For refinanced or refunded debt, the total net aggregate allowable costs to be incurred for all reporting periods may not exceed the total net aggregate costs that would have been allowed had the refinancing or refunding not occurred. Annual allowable costs must be limited to the lesser of the cost that would have been allowed had the refinancing or refunding not occurred or the costs associated with the refinancing or refunding plus the portion, if any, of adjustments not recognized in prior cost reporting periods.

6. Interest on operating loans paid more than three years after the borrowing is not allowable.

7. Interest expense must be allocated between allowable and nonallowable expense based on the ratio of the principal balance of allowable debt to the principal balance of nonallowable debt at the time the debt was incurred, except that the ratio may be adjusted to reflect principal payments on nonallowable debt made in excess of scheduled repayments, provided no funded depreciation or borrowed funds are used to make the excess principal payments.

8. For purposes of this section:

   a. "Necessary" means that the interest is incurred on debt made to satisfy a financial need of the facility and for a purpose reasonably related to resident care; and

   b. "Proper" means that the interest is incurred at a rate not in excess of what a prudent borrower would be obliged to pay in an arm's-length transaction and is incurred on debt made by a lender that is not a related organization, except for funds borrowed in accordance with section 75-02-07.1-19.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-17. Taxes.

1. Taxes assessed against the provider, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense may not include fines, penalties, or those taxes identified as nonallowable costs in section 75-02-07.1-10.

2. Whenever exemptions to taxes are legally available, the provider is to take advantage of them. If the provider does not take advantage of available exemptions, the expense incurred for the taxes is not an allowable cost.

3. Special assessments in excess of one thousand dollars paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as they are billed by the taxing authority.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-18. Startup costs.

In the first stages of operation, a new facility incurs certain costs in developing its ability to care for residents prior to admission. Staff is obtained and organized, and other operating costs are incurred during this time of preparation that cannot be allocated to resident care because there are no residents receiving services. These costs are commonly referred to as startup costs. Actual allowable startup costs may be considered as deferred charges and allocated over a number of periods that benefit from the costs. Where a facility has properly capitalized startup costs as a deferred charge, the startup costs must be recognized as allowable costs amortized over sixty consecutive months starting with the month in which the first resident is admitted.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-19. Funded depreciation.

1. Funding of depreciation is the practice of placing funds, including nonborrowed bond reserve and sinking funds, in a segregated account for the acquisition of capital assets used in rendering resident care or for other capital purposes related to resident care. Other capital purposes include capital debt liquidation, such as principal payments for bonds and mortgages.

2. All provisions of this subsection must be met in order to qualify as funding of depreciation. If the provisions are not met, income earned on investments must be offset to interest expense.

   a. The action to fund depreciation must be approved by the appropriate managing body of the facility.

   b. The fund or funds must be clearly designated in the facility's records as funded depreciation.

   c. Funded depreciation (total market value of fund) must be available, unless contractually committed as provided in subsections 8 and 9, on an as-needed basis for the acquisition of the facility's capital assets used to render resident care, or for other capital purposes related to resident care. Loans made from funded depreciation do not alter the requirement that funded depreciation must be available.

   d. Income earned on investments in the fund must be deposited in and become part of the funded depreciation account.

   e. Deposits to the funded depreciation account must remain for six months or more to be considered as funded depreciation. Deposits of less than six months are not eligible for the benefits of the funded depreciation account. Investment income earned prior to elapse of the six-month period may not be offset unless the deposits are actually withdrawn and then only if the withdrawal is not for capital purposes.

   f. Funded depreciation may not be restricted for a specific or future purpose.

   g. When a provider invests or transfers the assets of the fund to a home office of a chain organization or the motherhouse or governing body of a religious order or to other related parties, the assets are considered to be the facility's funds and are subject to all provisions of this section.

3. Total funded depreciation from deposits in excess of accumulated depreciation on resident-related assets must be considered as ordinary investments and the income therefrom must be used to offset interest expense.

4. Withdrawals for the acquisition of capital assets, the payment of mortgage principal on the assets, and other capital expenditures are on a first-in, first-out basis. Withdrawals for general operating purposes or for loans to the general fund are made on a last-in, first-out basis.

5. The facility may borrow from funded depreciation to obtain working capital for normal operating expenses used for resident care. In addition, the facility may borrow from funded depreciation accounts of related health care facilities if the funded depreciation accounts of the related facilities are maintained in accordance with health care financing administration regulations. The interest incurred by the general fund is allowable provided the loans are necessary and proper, and provided the funds withdrawn have met the six-month funding requirement. If the funds withdrawn do not meet the six-month funding requirement, interest paid on the loan is not an allowable cost. Funds loaned from funded depreciation under the provisions of this subsection are treated as available funded depreciation for purposes of this section. Costs incurred to secure lines of credit to ensure availability are not allowable costs.

6. Interest paid by the general fund to the funded depreciation account is not an allowable cost if the facility borrows the funds to acquire capital assets. The facility is expected to use funded depreciation for that purpose.

7. Deposits of funds into the funded depreciation account must be first applied to reduce loans outstanding from the funded depreciation account to the general fund. Until such loans, including related-party loans, are repaid in full, funds deposited in the funded depreciation account must be considered as repayments on the loans and any subsequent interest expense of the general fund to the extent of the repaid loans is not allowable.

8. Available funded depreciation must be withdrawn and used before resorting to borrowing for the acquisition of capital assets or other capital purposes. Because it is frequently difficult to time a bond offering or other borrowing to coincide with the exhaustion of available funded depreciation, it is sufficient if available funded depreciation is contractually committed to and expended during the course of construction.

9. Funds are considered available unless committed, by virtue of contractual arrangements, to the acquisition of capital assets used to render resident care, or to other capital purposes. Borrowing for a purpose intended by funded depreciation is unnecessary to the extent funded depreciation is available. Thus, interest expense for borrowing up to the amount of available funded depreciation is not an allowable cost.

10. When funded depreciation is used by the facility for other than the acquisition of capital assets, other capital purposes related to resident care, or loans to the general fund for current operating costs, the income earned on these funds while on deposit in the funded account must be adjusted in the report year the withdrawal was made. The adjustment must include all offsets not made in prior reporting periods for earnings applicable to the funds.

11. Borrowing for a purpose for which funded depreciation account funds may have been used makes the borrowing unnecessary to the extent that funded depreciation account funds were available at the time of the borrowing. Available funds in the funded depreciation account, to the extent of the unnecessary borrowing, are tainted funds. Interest expense incurred on borrowing for a capital purpose is not an allowable cost to the extent that funded depreciation account funds were available at the time of the borrowing.

12. A provider may remove the unnecessary characterization of borrowing, and thereby cure tainted funded depreciation, by using the tainted funds for a proper purpose described in

subsection 1. Any funded depreciation that existed at the time of the unnecessary borrowing and is not classified as tainted must be used before any of the tainted funds.

13. When only a portion of the borrowing is considered unnecessary under subsection 11, subsequent repayments of the borrowing from general funds must first be applied to the allowable portion of the borrowing and then, when all of the allowable borrowing is repaid, to the unallowable portion of the borrowing. When funds from the funded depreciation account are used for the repayment of the unnecessary borrowing, an equivalent amount of tainted funds is cured without regard to the provisions of subsections 11 and 12. Where general funds are used to pay for the unallowable borrowing after the necessary borrowing has been repaid, an equivalent amount of tainted funded depreciation is cured without regard to the provisions of subsections 11 and 12.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-20. Rate calculation.

1. For each cost category, the actual rate is calculated using allowable historical operating costs plus adjustment factors provided for in section 75-02-07.1-21 for the direct care, indirect care, and food and plant cost categories, divided by in-house resident days for the direct care and indirect care cost categories and resident days for the food and plant and property cost categories. The actual rate as calculated for direct care and indirect care is compared to the limit rate for each category to determine the lesser of the actual rate or the limit rate. The lesser of the actual rates or the limit rates for the direct personal care and indirect personal care costs and the operating margin are added to establish the facility's personal care rate. The rates for property costs, food and plant costs, the operating margin for room and board, and the lesser of the actual rates or the limit rates for direct room and board and indirect room and board costs are added to establish the facility's room and board rate. The sum of the personal care rate and the room and board rate is the facility's established rate.

2. The established rate for a licensed nursing facility providing services to an eligible beneficiary is:

   a. For a nursing facility that shares basic services with a licensed basic care facility, the rate established for the licensed basic care facility as provided for in subsection 1; and

   b. For a nursing facility that does not share basic services with a licensed basic care facility, the sum of the limit rates for direct care and indirect care costs, the maximum three percent operating margin calculated in section 75-02-07.1-21, and a rate calculated using allowable food and plant and property costs and census used in establishing the nursing facility's current rate under chapter 75-02-06.

History: Effective July 1, 1996; amended effective July 1, 1999; July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-21. Adjustment factor for direct care, indirect care, and food and plant costs.

1. The adjustment factor will be applied to adjust historical costs. The adjustment factor will be used to adjust direct care, indirect care, and food and plant costs.

2. Costs reported for a period other than twelve months ended December thirty-first of a report year will be adjusted to December thirty-first using:

a. The increase, if any, in the consumer price index, urban wage earners and clerical workers, all items, United States city average, over the period ending December thirty-first of the report year, and beginning at the end of the month within which the report period ends.

b. The increase, if any, identified in subsection a of this section shall be applied prior to any application of the adjustment factor.

History: Effective July 1, 1996; amended effective July 1, 2001; July 2, 2002; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-22. Rate limitations.

Historical costs, as adjusted, for all facilities for which a rate is established excluding specialized facilities for individuals with mental disease, must be used in the establishment of a limit rate for the direct care and indirect care cost categories. The actual rate for each cost category for each facility must be determined in accordance with this chapter. When establishing a facility's rate:

1. Except for a specialized facility for individuals with mental disease, a facility with an actual rate that exceeds the limit rate for direct care cost category shall receive the limit rate for that cost category;

2. A specialized facility for individuals with mental disease with an actual rate that exceeds two times the limit rate for the direct care cost category shall receive the limit rate times two for that cost category; and

3. A facility with an actual rate that exceeds the limit rate for the indirect care cost category shall receive the limit rate for that cost category. A facility shall receive an operating margin of three percent based on the lesser of the actual direct care rate, exclusive of the adjustment factor, or the direct care limit rate, exclusive of the adjustment factor, established for the rate year. For purposes of this subsection, the adjustment factor does not include the factor necessary to adjust reported costs to December thirty-first.

4. The July 1, 2017, direct care limit rate is fifty-seven dollars and thirty-two cents.

5. The July 1, 2017, indirect care limit rate is forty-nine dollars and ninety-five cents.

6. The department may use an adjustment factor to calculate the direct care and indirect care limits for future rate years within legislative appropriation.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 1999; amendments partially voided by the Administrative Rules Committee effective June 5, 2000; amended July 1, 2001; February 1, 2007; October 1, 2011; July 1, 2014; April 1, 2018.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-23. Rates.

1. **Desk audit rate.**

   a. The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by telephone or electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment may not be made. The department shall review the information and make any appropriate adjustments.

b. The desk audit rate must be effective July first of each rate year unless the department specifically identifies an alternative effective date, and must continue in effect until a final rate is established.

c. The desk rate may be adjusted for special rates or one-time adjustments provided for in section 75-02-07.1-25 or 75-02-07.1-26.

d. The desk rate may be adjusted to reflect errors, omissions, or adjustments for the report year that results in a change of at least twenty-five cents per day.

2. **Final rate.**

a. The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective July first of each rate year unless the department specifically identifies an alternative effective date.

b. The final rate must include any adjustments for nonallowable costs, errors, or omissions found during a field audit or reported by the facility and that result in a change from the desk audit rate of at least twenty-five cents per day.

c. The final rate may be revised at any time for special rates or one-time adjustments provided for in section 75-02-07.1-25 or 75-02-07.1-26.

d. If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(1) Adjustments, errors, or omissions found within twelve months of the date of notification of the final rate not including subsequent revisions, and resulting in a change of at least twenty-five cents per day, must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(2) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate not including subsequent revisions, and that would have resulted in a change of at least twenty-five cents per day had they been included, must be included as an adjustment on the latest filed cost report.

(3) Adjustments resulting from an audit of home office costs, and that result in a change of at least twenty-five cents per day, must be included as an adjustment in the report year in which the costs were incurred.

(4) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

3. **Adjustment of the total payment rate.** The final rate as established must be retroactive to the effective date of the desk rate.

History: Effective July 1, 1996; amended effective July 1, 1998; January 1, 2002; July 1, 2014.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-24. Rate payments.

1. The established rate must be considered as payment for all accommodations and includes all items includable as allowable under this chapter for an eligible beneficiary. No payment may

be solicited or received from the eligible beneficiary or any other person to supplement the rate as established, unless otherwise provided for in this chapter.

2. The department may supplement the income of an eligible beneficiary receiving necessary basic care services only if the lowest rate charged to private-pay residents equals or exceeds the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to an eligible beneficiary for the same bed type, including medical leave or therapeutic leave days.

3. If the established rate exceeds the rate charged to a private-pay resident on any given date, the facility shall immediately report that fact to the department and charge an eligible beneficiary at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment to the department. The refund must be the difference between the established rate and the rate charged the private-pay residents times the number of resident days paid for eligible beneficiaries during the period in which the established rate exceeded the rate charged to the private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

4. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically identified in other sections of this chapter.

5. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change the peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

History: Effective July 1, 1996; amended effective July 1, 2001; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-25. Special rates.

1. For a new facility, the department shall establish an interim rate equal to the lesser of the limit rates for direct and indirect care for the rate year in which the facility begins operation, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. No retroactive adjustment may be made to the rate.

   a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. By August thirty-first, the facility shall file an interim cost report for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

   b. If the effective date of the interim rate is on or after January first and on or before June thirtieth, the interim rate must remain in effect through the end of the subsequent rate year. By March first, the facility shall file a cost report for the partial report year ending December thirty-first of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

2. For a facility with renovations or replacements in excess of fifty thousand dollars, and without a significant capacity increase, the rate established for direct care, indirect care, food and plant, and the operating margin, based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective on the first of the month following the time the project is completed and placed into service or on the first of the month following submission of a request for a projected property rate, whichever is later. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing prior to renovation, plus ninety percent of the increase in licensed bed capacity and unavailable licensed beds existing prior to the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

3. For a facility with a significant capacity increase, the rate established for direct care, indirect care, food and plant, and the operating margin, based on the last report year, must be applied to all licensed beds. A property rate must be established based on projected property costs and projected census. The property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the state department of health through the end of the rate year.

4. For a facility with no significant capacity increase and no renovations or replacements in excess of fifty thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

5. Rates for a facility changing ownership during the rate period are set under this subsection. The total rate established by adding the components of the rate may not exceed the limit rate established under subsection 1 of section 75-02-07.1-22.

   a. The rates established for direct care, indirect care, food and plant, and the operating margin for the previous owner must be retained through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

      (1) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; or

      (2) For a facility with less than four months of operations under the new ownership during the report year:

         (a) By indexing the rate established for the previous owner forward using the adjustment factors as set forth in section 75-02-07.1-21; or

         (b) If the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the next rate year, by establishing a rate based on the previous owner's cost report.

b. Unless a facility elects to have a property rate established under subdivision c, the rate established for property for the previous owner must be retained through the end of the rate period and the property rate for the next rate period following the change in ownership must be established:

(1) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and

(2) For a facility with less than four months of operation under the new ownership during the report year:

(a) By using the rate established for the previous owner for the previous rate year; or

(b) If the previous owner submits a cost report and allows the audit of that cost report, and if the change of ownership occurred after the report year end but prior to the beginning of the next rate year, by establishing a rate based on the previous owner's cost report.

c. A facility may choose to have a property rate established during the remainder of the rate year and the subsequent rate year based on interest and principal payments on the allowable portion of debt expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The difference between a property rate established based on the facility's election and a property rate established based on subdivision b, multiplied by actual census for the period, must be determined. The property rate established in each of the twelve years, beginning with the first rate year following the use of a property rate established using this subdivision, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

6. For a facility terminating its participation in the aid to vulnerable aged, blind, and disabled persons program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until eligible beneficiaries can be relocated.

7. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subsection 2 or 3 and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using subsection 2 or 3 may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

8. For purposes of this section, "new facility" means a facility operated in a premises for which no costs were claimed and no rate was set under this chapter for any period prior to July 1, 1995, but does not mean a facility with:

a. Renovations or replacements;

b. A capacity increase; or

c. A change of ownership.

9. When a nursing facility converts licensed bed capacity to basic care bed capacity and the nursing facility does not share basic services with a licensed basic care facility prior to the conversion:

a. For the rate year in which the conversion occurs, the personal care rate shall be the sum of the limit rates for the direct and indirect cost category, the maximum operating margin,

and the room and board rate shall be calculated using the nursing facility's food and plant and property costs and census applicable to the rate year;

b. For the first rate year following the rate year in which the conversion occurs, the personal care rate shall be the sum of the limit rates for the direct and indirect cost category, the maximum operating margin, and the room and board rate shall be calculated using the nursing facility's food and plant and property costs and census applicable to the rate year; and

c. A cost report must be used to establish the rates for all subsequent rate years.

10. When a nursing facility converts licensed bed capacity to basic care bed capacity and the nursing facility shares basic services with a licensed basic care facility prior to the conversion, the rates established for the licensed basic care facility shall apply to the converted bed capacity.

11. A facility that meets the definition of a specialized facility for individuals with mental disease as a result of a reduction in licensed capacity to less than seventeen may choose to have an interim rate established for the remainder of the rate year following the capacity decrease and the subsequent rate based on the lesser of the limit rates for a specialized facility for individuals with mental disease for the rate year in which the institution for mental disease decreases its licensed capacity, plus the maximum operating margin, plus a room and board rate equal to the average food and plant rate, of all facilities for which a rate was established for the rate year, plus a projected property rate calculated based on projected property costs and imputed census, or a rate established based on an annual budget submitted by the facility. The interim rate may be in effect for no more than eighteen months. Retroactive adjustments may not be made to the rate.

a. If the effective date of the interim rate is on or after September first and on or before December thirty-first, the interim rate must be effective for the remainder of that rate year and must continue through December thirty-first of the subsequent rate year. By August thirty-first, the facility shall file an interim cost report for the period ending June thirtieth of the period in which the facility first provides services. The interim cost report is used to establish the actual rate to be effective January first of the subsequent rate year.

b. If the effective date of the interim rate is on or after January first and on or before June thirtieth, the interim rate must remain in effect through the end of the subsequent rate year. By March first, the facility shall file a cost report for the partial report year ending December thirty-first of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year.

c. If the effective date of the interim rate is on or after July first and on or before August thirty-first, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. By March first, the facility shall file a cost report for the period ending December thirty-first of the current rate year. This cost report must be used to establish the rate for the subsequent rate year.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; February 1, 2007; October 1, 2011.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-26. One-time adjustments.

1. **Adjustments to meet licensure standards.**

a. The department may provide for an increase in the established rate for additional costs incurred to meet licensure standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary or other costs increased to correct the deficiencies cited in the survey process.

b. The facility shall submit a written request to the department within thirty days of submitting the plan of correction to the state department of health. The request must:

(1) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's licensure survey;

(2) Identify the number of new staff or additional staff hours and the associated costs required to meet the licensure standards;

(3) Provide a detailed list of any other costs necessary to meet licensure standards;

(4) Describe how the facility shall meet licensure standards if the adjustment is received, including the number and type of staff to be added to the current staff and the projected salary and fringe benefit cost for the additional staff; and

(5) Document that all available resources, including efficiency incentives, if used to increase staffing, are not sufficient to meet licensure standards.

c. The department shall review the submitted information and may request additional documentation or conduct onsite visits.

d. If an increase in costs is approved, the adjustment must be calculated based on the costs necessary to meet licensure standards less any incentives included when calculating the established rate. The net increase must be divided by resident days and the amount calculated must be added to the established rate. This rate must then be subject to any rate limitations that may apply.

e. Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

f. If the actual cost of implementation exceeds the amount included in the adjustment, no retroactive settlement may be made.

2. **Adjustments for unforeseeable expenses.**

a. The department may provide for an increase in the established rate for additional costs incurred to meet major unforeseeable expenses. The expenses must be resident related and beyond the control of those responsible for the management of the facility.

b. Within sixty days after first incurring the unforeseeable expense, the facility shall submit to the department a written request containing:

(1) An explanation as to why the facility believes the expense was unforeseeable;

(2) An explanation as to why the facility believes the expense was beyond the managerial control of the owner or administrator of the facility; and

(3) A detailed breakdown of the unforeseeable expenses by expense line item.

c. The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on their background and knowledge of basic care industry and business trends.

d. The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward not to exceed the limit rate.

e. Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

3. **One-time adjustments for cost increases approved by the legislative assembly.**

a. The department shall increase rates otherwise established by this chapter for supplemental payments or one-time adjustments to historical costs approved by the legislative assembly.

b. Any additional funds made available by the supplemental payments or one-time adjustments must be used for the legislatively prescribed purpose and are subject to audit. If the department determines that the funds were not used for the legislatively prescribed purpose, an adjustment must be made in accordance with section 75-02-07.1-23.

History: Effective July 1, 1996; amended effective July 1, 1998; July 1, 2001; July 1, 2009; October 1, 2011; July 1, 2014.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-27. No rate adjustments of less than twenty-five cents per day.

Under no circumstances, including an appeal or judicial decision to the effect that a rate was erroneously established, may a rate adjustment be made unless the cumulative impact of adjustments equals or exceeds twenty-five cents per day.

History: Effective July 1, 1996; amended effective January 1, 2002.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-28. Notification of rates.

The department shall notify each facility of the desk audit rate on or before May twenty-first of the year in which the rate year begins.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-29. Reconsiderations and appeals.

1. **Reconsiderations.**

a. Any requests for reconsideration of the final rate must be filed with the department within thirty days of the date of the rate notification.

b. A request for reconsideration must include:

(1) A statement of each disputed item and the reason or basis for the dispute;

(2) The dollar amount of each adjustment that is disputed; and

(3) The authority in statute or rule upon which the facility is relying for each disputed item.

c. The department may request additional documentation or information relating to the disputed item. If additional documentation is not provided within fourteen days of the department's request, the department shall make its determination based on the information and documentation available as of the fourteenth day following the date the department requested additional documentation.

d. The department shall make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. **Appeals.**

a. A provider dissatisfied with the final rate established may appeal upon completion of the reconsideration process as provided for in subsection 1. An appeal may be perfected by mailing or delivering, on or before five p.m. on the thirty-first day after the date of mailing of the determination made with respect to a request for reconsideration, the information described in this subsection to the department, at the address the department designates. An appeal under this section is perfected only if accompanied by written documents including:

(1) A copy of the letter received from the department advising of the decision on the request for reconsideration;

(2) A statement of each disputed item and the reason or basis for the dispute;

(3) A computation and the dollar amount that reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item;

(4) The authority in statute or rule upon which the appealing party relies for each disputed item; and

(5) The name, address, and telephone number of the person to whom all notices regarding the appeal may be sent.

History: Effective July 1, 1996; amended effective July 1, 1998.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

75-02-07.1-30. Resident personal funds.

1. A facility may not require a resident to deposit personal funds with the facility.

2. Upon written authorization of a resident or the resident's legal representative, a facility shall hold, safeguard, manage, and account for the resident's personal funds deposited with the facility.

3. A facility may not charge the resident for holding, safeguarding, managing, or accounting for the resident's personal funds. Any related administrative costs, including bank charges, must be included in the daily rate. A facility may not impose a charge against a resident's personal funds for any item or service included in the daily rate.

4. A facility may maintain a resident's personal funds not exceeding one hundred dollars in a noninterest-bearing account. A facility shall deposit any resident's personal funds in excess of one hundred dollars in an interest-bearing account separate from any of the facility's accounts. The facility shall credit interest earned to the resident's account.

5. A facility shall maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds. An individual financial record must be available on request and a written accounting of transactions must be provided quarterly to the resident or the resident's legal representative.

6. A resident's personal funds may not be commingled with any facility funds or with funds of any person other than another resident.

7. Upon death of a resident, a facility shall promptly convey the resident's personal funds, and a final accounting of those funds, to the individual administering the resident's estate. For purposes of this section, an "individual administering the resident's estate" includes a person lawfully empowered to facilitate the transfer of small estates without the use of a personal representative.

History: Effective July 1, 1996.
General Authority: NDCC 50-06-16, 50-24.5-02(3)
Law Implemented: NDCC 50-24.5-02(3)

BASIC CARE RATE SETTING

Basic care rate setting applies only to licensed basic care facilities that are enrolled as basic care assistance program (BCAP) providers. Licensed basic care facilities providing Alzheimer's or traumatic brain injury services may not participate in BCAP.

Rate setting includes two distinct processes. The first process establishes the rates for Direct Care, Indirect Care and Property. The second process then allocates the allowed rates for each of the cost categories between the two funding sources of Medicaid and Basic Care Assistance program (BCAP).

In the past, the limit rates for basic care facilities were rebased annually. The limit setting process was to undertake a significant change in 2016. Beginning on July 1, 2016, the Department of Human Services was to establish the limits by using the average of the highest and lowest rates from the 2014 rate year. The Direct Care limit was mandated to be 95% of the average and the Indirect Care limit was to be ninety percent of the average. Using this methodology, the Direct Care limit was to be $67.44 on 7-1-16. The Indirect limit was to be $58.77. In 2016 when Governor Dalrymple ordered allotment cuts, the new basic care limit setting system was indefinitely delayed. Based on action during the 2017 legislative session the Direct Care limit was set at $57.32, Indirect limit was set at $49.95, both effective July 1, 2017. The new limit methodology was implemented effective July 1, 2019.

The allowable rates for a Basic Care facility are the lesser of the facility's established rate for Direct Care and Indirect Care or the limit rate for each of those categories plus the facility's Property rate and Food and Plant rate.

The allowable rates for the facility must then be allocated between the Personal Care rate which is paid using a combination of recipient liability (the portion of the resident's income in excess of $834 that must be used for medical expenses) and Medicaid funding; and the Room and Board rate which is paid using a combination of recipient responsibility, (the portion of the resident's income which cannot be used for medical expenses less the personal needs allowance) and BCAP funding.

To be eligible to receive assistance with room and board payments an individual must meet functional criteria for basis care services and must be Medicaid eligible financially. To receive assistance with the personal care services the individual must meet the functional criteria for personal care services and be Medicaid eligible. The criteria for basic care versus personal care is slightly different and it is possible (although highly unlikely) that an individual could be eligible for basic care services and not be eligible for personal care services.

Direct Care Rate

Costs in the Direct Care Category include resident care salaries and benefits, routine care supplies, food, laundry costs, social service costs and activity costs. Direct Care costs for salaries and benefits of nonlicensed residential care staff and laundry staff are allocated to the personal care rate for Direct Care. The remaining costs are allocated to Direct Care Room and Board. The Direct Care limit on July 1, 2019 is $57.32.

Indirect Care Rate

Costs in the Indirect Care Category include administration, chaplain, housekeeping, dietary salaries, benefits, and supplies, utilities, and plant operations. Indirect care costs for salaries and benefits of dietary staff and a portion of housekeeping staff are included in the indirect personal care rate with remaining costs allocated to the Indirect Room and Board rate. The Indirect limit on July 1, 2019 is $49.95.

Property Rate

Property costs include depreciation, interest, property taxes, lease and rental costs, and start-up costs. There are no limits on this cost category.

Food and Plant

Food and Plant includes food, utilities, maintenance and repair costs. There are no limits on this cost category.

Medically Necessary Items, Services and Durable Medical Equipment

Basic care facilities must provide residents with routine hair and personal hygiene items and services that are furnished routinely and relatively uniformly to all residents; items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities; and items used by individual residents that are reusable, vary by the needs of the individual, and are expected to be available in the facility.

The facility does not need to provide medically necessary items, services, and durable medical equipment which could otherwise be billed directly to Medicaid. If the facility chooses to provide any such items, services or DME then the cost of the items, services or DME must be included in reported costs and may not be billed separately to either Medicaid or a Medicaid eligible individual. Items, services or DME included as reported costs must be available to all residents.

Medically necessary items, services and DME coverage for individuals residing in a basic care facility is governed by the coverage rules for individuals living in their own home. Over-the-counter items that are billable directly by a supplier include:

- Ace wraps
- Over the counter analgesics; aspirin, acetaminophen, NSAIDs
- Antacids, anti-ulcer products
- Artificial tears
- Bandaids
- Diabetic supplies, blood glucose monitors, test strips, lancets, syringes
- Hearing aid batteries
- Incontinence supplies: diapers, attends, chux
- Iron supplements
- Rubbing alcohol

Over-the-counter items specifically not covered by Medicaid include:

- Antihistimines
- Glycerin suppositories
- Laxatives, stool softeners
- Vitamins

Section 9
Alzheimers, Dementia and Memory Care Facilities

Adult Residential Care 525-05-30-16

(Revised 12/1/10 ML #3252)

View Archives

Purpose

To provide an array of services to an individual in a 24-hr setting. Adult residential programs specialize in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments. It is also a service in which assistance with ADL's/IADL's, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement in independence of the recipient.

Service Eligibility, Criteria for

The individual receiving Residential Care service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services.
2. Be at least age 18.
3. Must not be severely impaired in eating, transferring, or toileting.
4. Does not have medical or behavioral needs that require professional evaluation and management on an ongoing basis.
5. Need the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.
    - Community Integration is provided to enable the individual to promote independence and alleviate social anxiety. Some activities to be considered are

community social events (such as fairs, sports leagues, church functions), volunteer or paid employment, educational/vocational activities.

- Social Appropriateness assists the individual with the development of social skills needed to interact with individuals in the facility or in the community. Such activities include (but are not limited to): respecting others' space and privacy, non-offensive communication, obeying laws and rules, timeliness, safety/risk procedures;

Or

Require protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs.

6. Pre approval from the Department of Human Services is required before this service can be authorized.

Room and Board is the responsibility of the recipient and not included in the provider's daily rate.

Service Tasks

1. This service includes 24-hour, on-site response staff;
2. Transportation may be provided as a component of this service and included in the daily rate paid to providers. Contact a HCBS Program Administrator to determine if transportation has been included in a rate for a specific residential care provider.
3. Assistance with ADLs and IADLs within the guidelines of the Basic Care licensure standards;
4. Allowable service tasks as identified on the SFN 1699 Authorization to Provide Service

Limits

Limited to the tasks as in agreement between the Department of Human Services and the Residential Care facility provider and as authorized by the County Social Service Board Case Manager.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult family foster care, respite, transitional care, attendant care, environmental modification, and non-medical transportation are not allowable service combinations for individuals receiving adult residential services. Non-medical transportation is not allowed because it included in the rate for adult residential services.

Residential Services is an all inclusive services with the exception of Supported Employment Services for a individual who was determined eligible for Adult Residential Care as a result of a need for the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.

Individual Program Plans

An individual who was determined eligible for Adult residential Care as a result of a need for the services, of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building must have an Individual Program Plan completed by the interdisciplinary team (to at least include the service provider, the individual and/or their legal representative) and the case manager.

This plan must be completed within 30 days of the arrival of the individual to the residential care facility. The Plan must include how the facility will meet the needs of the client, AND the plan be designed for the promotion of the client's independence in ADLs and IADLs, social, behavioral, and adaptive skills.

The Plan must also identify the goal or goals of the individual and how the goals will be accomplished. This Plan will be subject to review by the HCBS Case Manager during the initial Plan implementation period and every six months thereafter. At the team meeting, the team will review the goals and progress, and strategies for accomplishing the plan goal or goals.

Section 10
Other Resources

Guidelines for Assessment and Interventions for Residents Who Exhibit Behaviors

Common Behavior Problems

- Physical aggression (hitting, kicking, biting, scratching, grabbing)
- Verbal aggression (threatening others, screaming at others, cursing)
- Wandering
- Inappropriate sexual behavior
- Disruptive vocalizations (calling out, yelling)
- Other behavioral symptoms not directed toward others (hitting or scratching self, pacing, public sexual acts, disrobing in public)
- Rejection of care

Managing Behavior Problems

- **Staff communication and reporting is essential when a behavior occurs**
  - Take immediate action to control a threatening or dangerous behavior problem. Consider the safety of all residents including the individual displaying the behavior
  - Complete a Behavior Assessment
  - Observe, describe, track, and trend the behavior
    - What is the specific behavior exhibited
    - Does the behavior occur during a certain time of day/night
    - Does the behavior occur in certain locations
    - Is the behavior directed to particular residents
    - Does the behavior occur with only certain staff
    - Are the circumstances which triggered the behavior
    - What interventions work
  - Care plan realistic and specific goals for behavior change and then evaluate if intervention is working
- **Completing an Assessment will assist staff in developing a specific plan of care. An assessment includes but is not limited to:**
  - Diagnosis
  - Medical Evaluation (see Attachment A)
  - Evaluation of unmet needs, environmental changes, social changes, psychosis/depression/mood changes (see Attachment A)
  - Actively listen to what resident says and what is nonverbally communicated
  - Likes and dislikes
  - Past/present family situation
  - Past lifestyle
  - Past behavior problems
  - Preferred routines and habits
  - Physical limitations (hearing, vision, speech, mobility)
  - Identify things that provide comfort to resident

- **Prevention**
  - Take immediate action to control a threatening or dangerous behavior problem
  - Care should reflect interventions to prevent (as much as possible) behaviors from occurring and to ensure the safety of the resident and others
  - Develop an individualized care plan and describe the specific steps needed to address the behavior
- **Investigation**
  - Complete an investigation, if applicable
  - Collect and review evidence/information that describes and explains the event
  - Document who, what was done/seen/heard/smelled, when, where, etc.
  - If needed, take immediate action to protect the resident or others from harm
- **Possible Interventions**
  - Assign new roommate
  - Assign resident to a different unit in the facility
  - Move resident closer to nurses' station
  - Move resident to a secured unit
  - Pain management
  - Provide food as resident my exhibit behaviors due to hunger
  - Provide comfort objects, such as dolls or stuffed animals
  - Provide comfort by covering with warm blankets
  - Provide a quiet environment (due to overstimulation)
  - Involve resident in activities (due to not enough stimulation)
  - Utilize communication cards for residents with hearing loss
  - Use validation verses orientation
  - Aromatherapy
  - Provide simple repetitive tasks such as folding linens or rolling yarn into a ball
  - Provide routine toileting
  - Provide one-on-one oversight during needed times based on assessment.
  - Install building alarm system
  - Make environmental changes (lighting, decrease noise level)
  - Ensure safe environment (lock up chemicals/cleaning supplies and unsafe objects, walking areas clear of objects)
  - Provide indoor and outdoor areas for the resident to wander
  - Supervised walks
  - Check on resident
  - If resistive to cares, provide an object for resident to hold
  - Provide busy boxes
  - Provide snacks
  - Provide planned phone calls to family or friends who can provide reassurance
  - Use family photos/albums
  - Provide recorded messages from family or friends
  - Provide naps or reduce naps

- Reduce caffeine
- Provide back rubs
- Provide soothing music
- Use staff who have the best relationship with the resident
- Use two staff to provide cares
- Attach an alarm to resident's bed, door, or chair (if thoroughly assessed)
- Provide opportunities for exercise

Rejection of Cares

Activities that may cause a resident to be resistant to cares include bathing, dressing, eating, and medication administration. Techniques that may alleviate resistance include:

- Bathing
  - Give baths only when actually needed. Elderly may not need a complete bath more than once a week
  - Adjust bath schedule to the resident's former habits. Resident may have strong feelings about nudity, create a feeling of privacy. Ex: If resident refuses to take gown off before showering, leave it on. When it becomes wet and uncomfortable, the resident may agree to remove it. Or, wrap a towel around the resident's shoulders when washing the lower half of the body.
  - Use tub or shower depending on which one causes least resistance
  - Make the bathing room home like
  - Make the water and room temperature agreeable to the resident
  - Make sure the gender of the aide is acceptable to the resident
  - Don't ask resident to undress ahead of time. Wait until resident is in shower room or about to get into tub
  - Have only one staff member assist with the bath
  - Let the resident hear the noise of running water first. Then start washing the feet and work up slowly
  - Give a sponge bath at resident's bedside
  - Don't argue with resident over the need for a bath. Proceed calmly, one step at a time. If severe resistance occurs, stop and try again later
  - Resident may have strong fears of bathing and/or water. Try switching to a new method of bathing or try a program such as:
    - Take the resident to shower room and just sit with him/her
    - Let resident hear the noise of the water running
    - Let resident get toes wet and slowly work up the body a little more each time
    - Reward the resident for each step with praise and encouragement
- Dressing
  - Limit the choice the resident has
  - Lay clothes out in order that resident will put them on

- Simplify clothing and closures. (pants with elastic waistbands, slipover blouses, slip on shoes, Velcro instead of buttons, snaps, or zippers

- Eating
  - Try different textures of food. The resident's sense of smell or taste may be gone and texture may be the only way to judge the food.
  - Give foods that are familiar and reflect cultural and ethnic habits
  - Resident may not know what is edible and what is not or may not know how to eat
  - Ensure resident can see the plate or food (mashed potatoes or white chicken, on white plate, on white table cloth)
  - Gently remind resident and begin the action for the resident
  - Give finger foods that resident can pick up easily
  - Remove noise and activity that may distract resident. Arrange eating in small groups if resident is easily distracted
  - Limit the number of foods and utensils. Try one food at a time, offer one utensil instead of 3

Attachment A

Medical Causes - Unmet Needs - Environmental Changes - Social Changes - Mood Changes

Check Vital Signs

- Temperature
- Blood Pressure - lying down and standing
- Respiratory rate, pulse rate
- Blood Glucose for diabetics

Review Medication Record

- Meds added
- Meds stopped
- Medication dose changes
- Routes of medication administraiton changes

Review Chart

- Changes in urination or bowel habits
- Changes in food/fluid intake
- Changes in sleep patterns
- Falls or injuries
- Recent illness

Check General Body Position

- Guarding or protecting any body part
- New neurologic deficits
- New asymmetries or swellling

Examine Skin

- Bruises
- Redness
- Swelling

Check for Unmet Needs

- Pain relief
- Hunger
- Thirst
- Boredom
- Loneliness

Check Join Range of Motion

- Limitation
- Tenderness
- Pain
- Fractures

Examine Abdomen

- Distension
- Enlarged bladder
- Catheter problem

Check for Environmental Changes

- Room change
- New roommate
- Remodeling

Check for Recent Social Changes

- Family visit
- Personal loss
- Activities
- Unpleasant event

Check for Psychosis/Depression/ Mood Changes

- Delusions
- Hallucinations
- Anxiety
- Irritability
- Loss of interest, feeling of worthlessness, withdrawn
- Sleep problems
- Fatigue, decreased energy
- Difficulty concentrating
- Slowed speech
- Sadness, crying
- Over-concern with health

Key Infection Control Recommendations

for the Control of Norovirus Outbreaks in Healthcare Settings

Patient Cohorting and Isolation Precautions

Place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms

When symptomatic patients cannot be accommodated in single occupancy rooms, efforts should be made to separate them from asymptomatic patients. These efforts may include placing patients in multi-occupancy rooms, or designating patient care areas or contiguous sections within a facility for patient cohorts.

- Staff who have recovered from recent suspected norovirus infection associated with an outbreak may be best suited to care for symptomatic patients until the outbreak resolves.

Consider the following precautions:

- Minimize patient movements within a ward or unit during norovirus outbreaks
- Restrict symptomatic and recovering patients from leaving the patient-care area unless it is for essential care or treatment
- Suspend group activities (e.g., dining events) for the duration of a norovirus outbreak.

Hand Hygiene

- Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis
- During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis.

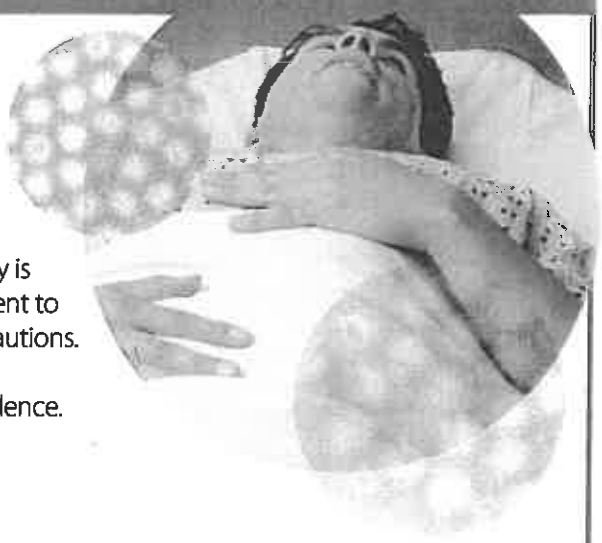
*For all other hand hygiene indications refer to the 2002 HICPAC Guideline for Hand Hygiene in Health-Care Settings (http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf).

Personal Protective Equipment (PPE)

- If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individuals entering the patient care area (i.e., gowns and gloves upon entry).

CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS216887-A NorovirusControlRecomm



Patient Transfer and Ward Closure

- Consider the closure of wards to new admissions or transfers as a measure to attenuate the magnitude of a norovirus outbreak.
- Consider limiting transfers to those for which the receiving facility is able to maintain Contact Precautions; otherwise, it may be prudent to postpone transfers until patients no longer require Contact Precautions. During outbreaks, medically suitable individuals recovering from norovirus gastroenteritis can be discharged to their place of residence.

Diagnostics

- In the absence of clinical laboratory diagnostics or in the case of delay in obtaining laboratory results, use Kaplan's clinical and epidemiologic criteria to identify a norovirus gastroenteritis outbreak.

Kaplan's Criteria:

1. Vomiting in more than half of symptomatic cases, and
2. Mean (or median) incubation period of 24 to 48 hours, and
3. Mean (or median) duration of illness of 12 to 60 hours, and
4. No bacterial pathogen isolated from stool culture

- Consider submitting stool specimens as early as possible during a suspected norovirus gastroenteritis outbreak and ideally from individuals during the acute phase of illness (within 2-3 days of onset).
- Specimens obtained from vomitus may be submitted for laboratory identification of norovirus when fecal specimens are unavailable (consult with your lab). Testing of vomitus as compared to fecal specimens may be less sensitive due to lower detectable viral concentrations.
- Routine collecting and processing of environmental swabs during a norovirus outbreak is not required.

Environmental Cleaning

- Perform routine cleaning and disinfection of frequently touched environmental surfaces and equipment in isolation and cohorted areas, as well as high traffic clinical areas. Frequently touched surfaces include, but are not limited to, commodes, toilets, faucets, hand/bedrailing, telephones, door handles, computer equipment, and kitchen preparation surfaces.
- Increase the frequency of cleaning and disinfection of patient care areas and frequently touched surfaces during outbreaks of norovirus gastroenteritis (e.g., increase ward/unit level cleaning twice daily to maintain cleanliness, with frequently touched surfaces cleaned and disinfected three times daily using EPA-approved products for healthcare settings).

- Clean and disinfect surfaces starting from the areas with a lower likelihood of norovirus contamination (e.g., tray tables, counter tops) to areas with highly contaminated surfaces (e.g., toilets, bathroom fixtures). Change mop heads when new solutions are prepared, or after cleaning large spills of emesis or fecal material.
- No additional provisions for using disposable patient service items such as utensils or dishware are suggested for patients with symptoms of norovirus infection. Silverware and dishware may undergo normal processing and cleaning using standard procedures.
- Use Standard Precautions for handling soiled patient-service items or linens, which includes the appropriate use of PPE.
- Consider changing privacy curtains routinely and upon patient discharge or transfer.

Staff Leave and Policy

- Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced.
- Establish protocols for staff cohorting in the event of an outbreak of norovirus. Ensure staff care for one patient cohort on their ward and do not move between patient cohorts (e.g., patient cohorts may include symptomatic, asymptomatic exposed, or asymptomatic unexposed patient groups).
- Exclude non-essential staff, students, and volunteers from working in areas experiencing outbreaks of norovirus.

Communication and Notification

- Notify appropriate local and state health departments if an outbreak of norovirus gastroenteritis is suspected.

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GOOD SAMARITAN SOCIETY - ARTHUR (PRAIRIE VILLA) (8062A)			MARY VANGERUD LERAAS			BC
GOOD SAMARITAN SOCIETY - ARTHU 150 COUNTY RD 34 ARTHUR, ND 58006	(701) 967-8316 (701) 967-8961 mvangeru@good-sam.com		CASS	Mary Bushy (701) 967-8316		01-ACTIVE 0/56
Edgewood Bismarck Senior Living, LLC (8058A)			DENISE LUTZ			BC
EDGEWOOD BISMARCK SENIOR LIVI 3406 DOMINION ST BISMARCK, ND 58503	(701) 258-7489 (701) 258-7491 deniselutz@edgewoodvista.com		BURLEIGH	Denise Lutz (701) 400-1829		01-ACTIVE 0/41
The Terrace (8055A)			DENISE TIGGELAAR			BC
THE TERRACE 901 E BOWEN AVE BISMARCK, ND 58504	(701) 258-1980 (701) 258-8022 terraceadmin@bchabis.com		BURLEIGH	Denise Tiggelaar (701) 390-3577		01-ACTIVE 0/40
Touchmark On West Century (8072A)			TABATHA FLETCHER			BC
TOUCHMARK ON WEST CENTURY LL 1000 W CENTURY AVE BISMARCK, ND 58503	(701) 323-7000 (701) 221-2525 tnf@touchmark.com		BURLEIGH	Tabatha Fletcher (701) 368-2923		01-ACTIVE 0/52
Maple View (8101A)			LANA CHARVAT			BC
MAPLE VIEW 4217 MONTREAL ST BISMARCK, ND 58503	(701) 223-4133 (701) 258-5194 lanac@lifeattheview.com		BURLEIGH	Lana Charvat (701) 223-4133		01-ACTIVE 0/36
Edgewood Vista At Edgewood Village (8081A)			APRIL BISHOP			BC
EDGEWOOD VISTA AT EDGEWOOD VI 3124 COLORADO LANE BISMARCK, ND 58503	(701) 751-5300 (701) 751-5528 april.bishop@edgewoodvista.com		BURLEIGH	April Bishop (701) 290-2199		01-ACTIVE 0/27
Augusta Place - a Prospera Community (8084A)			BRUCE KALLIS			BC
AUGUSTA PLACE - A PROSPERA COM 316 VERSAILLES AVE BISMARCK, ND 58503	(701) 255-1084 (701) 751-1342 bkallis@good-sam.com		BURLEIGH	Bruce Kallis (320) 292-1954		01-ACTIVE 0/18
Benedictine Living Communities-Bismarck Housing,LLC (8202)			DAVE BRENNAN			BC
BENEDICTINE LIVING COMMUNITIES- 4580 COLEMAN STREET BISMARCK, ND 58503	(701) 751-4224 (701) 751-4225		BURLEIGH	Dave Brennan		01-ACTIVE 0/41

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St. Francis Residence (8048A) ST FRANCIS RESIDENCE 701 11TH STREET CANDO, ND 58324	(701) 968-2600 (701) 968-2613 benb@tcmedcenter.org		BEN BUCHER TOWNER	Ben Bucher (701) 771-1037		BC 01-ACTIVE 0/5
St. Luke's Sunrise Care Center (8106A) ST LUKES SUNRISE CARE CENTER 705 SE 4TH ST CROSBY, ND 58730	(701) 965-6086 (701) 965-6381 tpetersont@dcstlukes.org		TAMMRA PETERSON DIVIDE	Tammra Peterson (701) 965-6384		BC 01-ACTIVE 0/16
Odd Fellows Home (8007A) ODD FELLOWS HOME 1107 WALNUT ST E DEVILS LAKE, ND 58301	(701) 662-3330 (701) 662-6672 ndioof@gondtc.com		MARK ULRICH RAMSEY	Mark Ulrich (701) 230-2335		BC 01-ACTIVE 0/43
Good Samaritan Society - Lake Country Manor (8091B) GOOD SAMARITAN SOCIETY - LAKE C 1332 10TH ST NE DEVILS LAKE, ND 58301	(701) 662-1880 (701) 662-1084 ntrottier@good-sam.com		NATHAN TROTTIER RAMSEY	Nathan Trottier (563) 380-0547		BC 01-ACTIVE 0/27
Evergreen (8054A) EVERGREEN 2143 6TH AVE W DICKINSON, ND 58601	(701) 483-6606 (701) 483-6721 dbaranko@kensington-evergreen.com		DARLA BARANKO STARK	Darla Baranko (701) 290-2764		BC 01-ACTIVE 0/51
Dickinson Country House (8066A) DICKINSON COUNTRY HOUSE 628 24TH ST W DICKINSON, ND 58601	(701) 483-2266 (701) 483-2269 tjohnson@countryhouse.net		TESSA JOHNSON STARK	Tessa Johnson (701) 483-2266		BC 01-ACTIVE 0/30
Manor St. Joseph (8009A) MANOR ST JOSEPH 404 4TH AVE W EDGELEY, ND 58433	(701) 493-2477 (701) 493-2712 stjoseph@drtel.net		TAMMY JANGULA LAMOURE	Tammy Jangula (701) 709-0184		BC 01-ACTIVE 0/28
Edmore Memorial Rest Home (8010A) EDMORE MEMORIAL REST HOME 301 E 4TH AVE EDMORE, ND 58330	(701) 644-2202 (701) 644-2698 tammyberg@dvl.midco.net		TAMMY BERG RAMSEY	Tammy Berg (701) 351-1816		BC 01-ACTIVE 0/15

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Dakota Hill Housing (8011A) DAKOTA HILL HOUSING 606 DAKOTA ST N ELGIN, ND 58533	(701) 584-3266 (701) 584-3300 dakhills@westriv.com		BRENDA ESLINGER GRANT	Brenda Eslinger (701) 425-2309		BC 01-ACTIVE 0/33
Ellendale Evergreen Place (8040B) ELLENDALE EVERGREEN PLACE 241 MAIN ST ELLENDALE, ND 58436	(701) 349-4550 (701) 349-4656 tony.hanson@bhshealth.org		TONY HANSON DICKEY	Tony Hanson (701) 899-4186		BC 01-ACTIVE 0/20
Evergreens of Fargo (8039B) EVERGREENS OF FARGO 1401 W GATEWAY CIR FARGO, ND 58103	(701) 239-4524 (701) 298-2985 nicolepesta@ecumen.org		NICOLE PESTA CASS	Nicole Pesta (320) 232-7008		BC 01-ACTIVE 0/18
Evergreens of Fargo (8042B) EVERGREENS OF FARGO 1411 W GATEWAY CIR FARGO, ND 58103	(701) 239-4524 (701) 298-2985 nicolepestat@ecumen.org		NICOLE PESTA CASS	Nicole Pesta (320) 232-7008		BC 01-ACTIVE 0/18
Evergreens of Fargo (8045B) EVERGREENS OF FARGO 1405 W GATEWAY CIRCLE FARGO, ND 58103	(701) 239-4524 (701) 298-2985 nicolepesta@ecumen.org		NICOLE PESTA CASS	Nicole Pesta (320) 232-7008		BC 01-ACTIVE 0/18
Touchmark at Harwood Groves (8069A) TOUCHMARK AT HARWOOD GROVES 1200 HARWOOD DR S FARGO, ND 58104	(701) 476-1200 (701) 476-1201 kbd@touchmark.com		KARI DICK CASS	Kari Dick (701) 240-2643		BC 01-ACTIVE 0/37
Edgewood Fargo Senior Living (8103A) EDGEWOOD FARGO SENIOR LIVING 4420 37TH AVE S FARGO, ND 58104	(701) 365-8200 (701) 365-8202 Mitch.Peters@edgewoodvista.com		MITCH PETERS CASS	Mitch Peters (701) 290-3855		BC 01-ACTIVE 0/35
Good Samaritan Society - Fargo (8104A) GOOD SAMARITAN SOCIETY - FARGO 4502 37TH AVE S FARGO, ND 58104	(701) 282-2651 (701) 282-1220 pmiddend@good-sam.com		PATRICIA MIDDENDORP CASS	Pattie Middendorp (701) 371-7622		BC 01-ACTIVE 0/70

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Bethany Towers (8076A)			SHAWN STUHAUG			BC
BETHANY TOWERS 201 S UNIVERSITY DR FARGO, ND 58103	(701) 239-3000 (701) 239-3237 sstuhaug@bethanynd.org	30781	CASS	Shawn Stuhaug (701) 261-4559		01-ACTIVE 0/77
Fargo Maple View, LLC (8098)			JORDYN HAIDER			BC
FARGO MAPLE VIEW, LLC 4552 36TH AVE S FARGO, ND 58104	(701) 478-8655 (701) 212-4914 jordynh@lifeatmapleview.com		CASS	Jordyn Haider (701) 317-3668		01-ACTIVE 0/48
Gackle Future Development Company (8014A)			KIMBERLY SCHLECHT			BC
GACKLE CARE CENTER 304 1ST AVE W GACKLE, ND 58442	(701) 485-3395 (701) 485-3962 kschlecht@daktel.com		LOGAN	Kimberly Schlecht (701) 830-0600		01-ACTIVE 0/34
Edgewood Parkwood Place, LLC (8015A)			CHIVON KAPPHAHN			BC
EDGEWOOD PARKWOOD PLACE 749 30TH ST S GRAND FORKS, ND 58201	(701) 757-2727 (701) 757-1131 Chivon.Kapphahn@edgewoodvista.com		GRAND FORKS	Chivon Kapphahn (218) 779-6244		01-ACTIVE 0/40
St. Anne's Guest Home (8016A)			Sr REBECCA METZGER			BC
ST ANNES GUEST HOME 524 N 17TH ST GRAND FORKS, ND 58203	(701) 746-9401 (701) 795-7825 stannes@midconetwork.com		GRAND FORKS	Sister Rebecca Metzger (701) 746-9401		01-ACTIVE 0/47
Tufte Manor (8105A)			ANGIE GOULET			BC
TUFTE MANOR 3300 CHERRY ST GRAND FORKS, ND 58201	(701) 787-7600 (701) 775-2259 agoulet@valleymemorial.org		GRAND FORKS	Angie Goulet (701) 787-7616		01-ACTIVE 0/70
Maple View (8107A)			JESSICA BAILEY			BC
MAPLE VIEW GRAND FORKS MEMOR 4650 S WASHINGTON ST GRAND FORKS, ND 58201	(701) 772-3400 (701) 757-1308 jessicab@lifeatmapleview.com		GRAND FORKS	Jessica Bailey (701) 772-3400		01-ACTIVE 0/36
Senior Suites at Sakakawea (8019B)			TERI PARKER			BC
SENIOR SUITES AT SAKAKAWEA 813 7TH ST NE HAZEN, ND 58545	(701) 748-2290 (701) 748-3883 tparker@smcnd.org		MERCER	Terry Parker (701) 748-2290		01-ACTIVE 0/34

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Roseadele (8038B) ROSEADELE 1505 3RD ST SE JAMESTOWN, ND 58401	(701) 251-1741 (701) 252-1207 shipleybc@daktel.com		JORDAN SHIPLEY STUTSMAN	Jordan Shipley (701) 320-9023		BC 01-ACTIVE 0/20
Rock of Ages (8021B) ROCK OF AGES HOME, INC 1315 4TH ST NE JAMESTOWN, ND 58401	(701) 252-9292 (701) 252-0417 roainc@daktel.com		JORDAN SHIPLEY STUTSMAN	Jordan Shipley (701) 320-9021		BC 01-ACTIVE 0/52
Edgewood Jamestown, Llc (8204) EDGEWOOD JAMESTOWN, LLC 1104 25TH ST SW JAMESTOWN, ND 58401	(701) 952-8750 (701) 952-8757 tonya.perkins@edgewoodvista.com		TONYA PERKINS STUTSMAN	Tonya Perkins		BC 01-ACTIVE 0/61
Good Samaritan Society - Lakota (8205) GOOD SAMARITAN SOCIETY - LAKOT/ 608 4TH AVE SW LAKOTA, ND 58344	(701) 247-2902 (701) 247-2608 ahalvor1@good-sam.com		ANNA HALVORSON NELSON	Anna Halvorson		BC 01-ACTIVE 0/5
Good Samaritan Society - Larimore (8109) GOOD SAMARITAN SOCIETY - LARIM(501 EAST FRONT STREET LARIMORE, ND 58251	(701) 343-6244 (701) 343-2153 rraffety@good.sam.com		RITA RAFFETY GRAND FORKS	Rita Raffety (701) 213-2316		BC 01-ACTIVE 0/6
North Dakota Veterans Home (8044A) NORTH DAKOTA VETERANS HOME 1600 VETERANS DR LISBON, ND 58054	(701) 683-6500 (701) 683-6550 mjohn@nd.gov		MARK JOHNSON RANSOM	Mark B Johnson, Admin (701) 678-4023		BC 01-ACTIVE 0/98
Parkside Lutheran Home (8080A) PARKSIDE LUTHERAN HOME 501 3RD AVE W LISBON, ND 58054	(701) 683-5239 (701) 683-4109 timk@drtel.net		TIM KENNEDY RANSOM	Tim Kennedy (701) 212-8890		BC 01-ACTIVE 0/10
Maddock Memorial Home (8024A) MADDOCK MEMORIAL HOME 301 ROOSEVELT AVE MADDOCK, ND 58348	(701) 438-2641 (701) 438-2187 memorialhome@gondtc.com		ROBERTA JACOBSON BENSON	Roberta Jacobson (701) 351-3881		BC 01-ACTIVE 0/21

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Dakota Pointe (8059A) DAKOTA POINTE 3503 43RD ST NW MANDAN, ND 58554	(701) 667-4552 (701) 667-8651 ejacobson@hitinc.org		ELICIA JACOBSON MORTON	Carol Morast (701) 351-0404		BC 01-ACTIVE 0/10
Lakewood Landing, Inc (8097) LAKEWOOD LANDING, INC 4401 21ST ST SE MANDAN, ND 58554	(701) 751-6191 (701) 751-6195 blaine@lakewoodlandingnd.com		BLAINE KINCAID MORTON	Blaine Kincaid (701) 751-4283		BC 01-ACTIVE 0/38
Edgewood Mandan, LLC (8099) EDGEWOOD MANDAN, LLC 2801 39TH AVE SE MANDAN, ND 58554	(701) 663-5664 (701) 751-3944 scott.bernstein@edgewoodvista.com		SCOTT BERNSTEIN MORTON	Scott Bernstein		BC 01-ACTIVE 0/57
Sheridan Memorial Home (8025A) SHERIDAN MEMORIAL HOME 610 S MAIN ST MC CLUSKY, ND 58463	(701) 363-2203 (701) 363-2718		CONNIE WERTH SHERIDAN	Connie Werth (701) 363-2203		BC 01-ACTIVE 0/16
Edgewood Minot Senior Living, LLC (8049A) EDGEWOOD MINOT SENIOR LIVING, I 706 16TH AVE SE MINOT, ND 58701	(701) 852-1399 (701) 838-0613 carma.mclaughlin@edgewoodvista.com		CARMA MCLAUGHLIN WARD	Carma McLaughlin (701) 720-3359		BC 01-ACTIVE 0/26
Edgewood Minot Senior Living, LLC - Alzheimers (8057A) EDGEWOOD MINOT SENIOR LIVING, I 715 17TH AVE SE MINOT, ND 58701	(701) 852-1399 (701) 838-0613 carma.mclaughlin@edgewoodvista.com		CARMA MCLAUGHLIN WARD	Carma McLaughlin (701) 720-3359		BC 01-ACTIVE 0/22
Edgewood Vista (8067A) EDGEWOOD MINOT SENIOR LIVING 520 28TH AVE SE MINOT, ND 58701	(701) 852-1399 (701) 838-0613 carma.mclaughlin@edgewoodvista.com		CARMA MCLAUGHLIN WARD	Carma McLaughlin (701) 721-0445		BC 01-ACTIVE 0/28
Maple View Memory Care Of Minot (8093A) MAPLE VIEW MEMORY CARE OF MIN(2805 ELK DR MINOT, ND 58701	(701) 852-1800 (701) 852-1801 kellyh@lifeattheview.com		KELLY HAASE WARD	Kelly Haase (701) 852-1800		BC 01-ACTIVE 0/43

North Dakota Department of Health

ASPEN: Facility Directory (FD)

Basic Care Facility

Sorted By: City

Printed 01/11/2019

Facility Legal Name (Facility ID) / Working Name / Address / City, State, Zip	Phone / Fax / Email	Medicare ID / Medicaid ID	Administrator / Title / County	Emergency Contact / Emergency Phone	Team Mgmt	Type / Operating Status / Certified/Total Beds
Borg Pioneer Memorial Home (8027A) BORG PIONEER MEMORIAL HOME 61 BORG DR MOUNTAIN, ND 58262	(701) 993-8345 (701) 993-8620 borghome@polarcomm.com		PAM BYRON PEMBINA	Pam Byron (701) 331-1892		BC 01-ACTIVE 0/39
Napoleon Care Center (8203) NAPOLEON CARE CENTER 311 EAST 4TH STREET NAPOLEON, ND 58561	(701) 754-2381 (701) 754-2384 rregner.ncc@bektel.com		RICHARD REGNER LOGAN	Richard Regner		BC 01-ACTIVE 0/8
Lutheran Home Of The Good Shepherd (8095A) LUTHERAN HOME OF THE GOOD SHE 1226 1ST AVE N NEW ROCKFORD, ND 58356	(701) 947-2944 (701) 947-2290 kjensrud@lhgs.org		KIM JENSRUD EDDY	Kim Jensrud (701) 289-0358		BC 01-ACTIVE 0/6
Lakeside Community Living Center (8088B) LAKESIDE COMMUNITY LIVING CENTI 603 1ST ST NW NEW TOWN, ND 58763	(701) 627-4711 (701) 627-4013 juran@restel.com		JEANINE URAN MOUNTRAIL	Jeanine Uran (701) 898-1449		BC 01-ACTIVE 0/9
Osnabrock Community Living Center, Inc. (8096A) OSNABROCK COMMUNITY LIVING CE 326 RAINBOW RD OSNABROCK, ND 58269	(701) 496-3131 (701) 496-3133 oclc@utma.com		BRITTANIE MOSTAD CAVALIER	Brittanie Mostad (701) 496-3131		BC 01-ACTIVE 0/17
Good Samaritan Society - Park River (8086A) GOOD SAMARITAN SOCIETY - PARK F 301 S COUNTY ROAD 12B PARK RIVER, ND 58270	(701) 284-7115 (701) 284-7117 jolson@good-sam.com		JOAN OLSON WALSH	Joan Olson (701) 331-2573		BC 01-ACTIVE 0/12
HAALAND ESTATES BASIC CARE (8031A) HAALAND ESTATES BASIC CARE 1025 3RD AVE SE RUGBY, ND 58368	(701) 776-5203 (701) 776-6688 kclements@hamc.com		KELLY CLEMENTS PIERCE	Kelly Clements (701) 771-8672		BC 01-ACTIVE 0/60
Golden Manor (8087A) GOLDEN MANOR INC 214 4TH ST NW STEELE, ND 58482	(701) 475-2251 (701) 475-2250 goldenmanor@bektel.com		MARY JO FRIES KIDDER	Mary Jo Fries (701) 212-3959		BC 01-ACTIVE 0/25

North Dakota Department of Health

ASPEN: Facility Directory (FD)

Basic Care Facility

Sorted By: City

Printed 01/11/2019

Facility Legal Name (Facility ID) / Working Name / Address / City, State, Zip	Phone / Fax / Email	Medicare ID / Medicaid ID	Administrator / Title / County	Emergency Contact / Emergency Phone	Team Mgmt	Type / Operating Status / Certified/Total Beds
HI Soaring Eagle Ranch (8032A)			MARY SIMONSON			BC
HI SOARING EAGLE RANCH	(701) 845-1124			Mary Simonson		01-ACTIVE
3731 117TH R AVE SE	(701) 845-1175		BARNES	(701) 840-1798		0/10
VALLEY CITY, ND 58072	mary.simonson@odcvc.com					
Siena Court (8052A)			JIM CORNELIUS			BC
SIENA COURT	(701) 642-6667			Jim Cornelius		01-ACTIVE
711 14TH AVE N	(701) 642-2485		RICHLAND	(701) 351-4497		0/16
WAHPETON, ND 58075	jim.cornelius@bhshealth.org					
Leach Home (8033A)			LINDSAY KATH			BC
LEACH HOME	(701) 642-4283			Lindsay Kath		01-ACTIVE
714 N 4TH ST	(701) 642-1500		RICHLAND	(218) 517-0949		0/39
WAHPETON, ND 58075	lkath@702com.net					
McKenzie County Healthcare Systems Basic Care (8051A)			DANIEL KELLY			BC
MCKENZIE COUNTY HEALTHCARE SY	(701) 444-2331			Daniel Kelly		01-ACTIVE
709 4TH AVE NE	(701) 444-2339		MCKENZIE	(701) 444-2331		0/9
WATFORD CITY, ND 58854	dkelly@mchsnd.org					
Sheyenne Crossings - Prairie Square (8100A)			BRADY JOHNSRUD			BC
SHEYENNE CROSSINGS - PRAIRIE SC	(701) 478-6002			Brady Johnsrud		01-ACTIVE
225 13TH AVE W	(701) 478-6001		CASS	(701) 200-8406		0/24
WEST FARGO, ND 58078	bjohnsrud@eventide.org					
New Perspective - West Fargo (8201)			LORI TERHAAR			BC
NEW PERSPECTIVE - WEST FARGO	(701) 540-6405			Lori Terhaar		01-ACTIVE
645 33RD AVENUE EAST	(701) 203-4871		CASS	(701) 540-6405		0/47
WEST FARGO, ND 58078	lterhaar@npseniorliving.com					
Bethel Lutheran Nursing & Rehabilitation Center (8034A)			TAMMRA PETERSON			BC
BETHEL LUTHERAN NURSING & REH/	(701) 572-6766			Tammra Peterson		01-ACTIVE
1515 2ND AVE W	(701) 572-7579		WILLIAMS	(701) 570-7948		0/19
WILLISTON, ND 58801	tpeterson@blnrc.com					
Redwood Village (8035B)			JESSICA NEIBAUER			BC
REDWOOD VILLAGE	(701) 734-6409			Jessica Neibauer		01-ACTIVE
213 7TH ST N	(701) 734-6410		MCLEAN	(701) 426-2127		0/16
WILTON, ND 58579	jessican@prideinc.org					

TOTAL: 64

Grand Total of Beds 2030

North Dakota

		Phone
Agency	Department of Health, Division of Health Facilities	(701) 328-2352
Contact	Darleen Bartz, PhD	
E-mail	dbartz@nd.gov	
Second Agency	Department of Health, Division of Food & Lodging for Assisted Living (Food Sanitation and Life Safety)	(701) 328-2523
Second Contact	Julie Wagendorf	
Second E-mail	jwagendorf@nd.gov	
Web Site	http://www.ndhealth.gov/ http://www.nd.gov/dhs/	

Licensure Term	Basic Care Facilities and Assisted Living Facilities
Opening Statement	The Department of Health establishes rules for basic care facilities and the Department of Human Services oversees licensing and rules of assisted living facilities, which must also meet Department of Health Rules. The primary differences between these licensure categories are: (1) the extent to which they are regulated--the assisted living regulations are very brief; and (2) only basic care facilities are required to provide meals. Basic care facilities are not certified to participate in Medicare or Medicaid, but are eligible for state funding for basic care services.
Legislative and Regulatory Update	Basic care facilities regulations were revised effective January 1, 2018. Revisions were made to the definitions section, including unsecured facility and unsecured unit. Updates were also made to the regulations for optional Alzheimer's, dementia, special memory care, or traumatic brain injury facility or unit services. There is a moratorium on expansion of the state's basic care bed capacity from August 1, 2017 through July 31, 2019, except under certain circumstances outlined in 23-09.3-01.1. Effective January 1, 2018, the North Dakota Department of Health has revised the North Dakota Food Code by adopting the 2013 FDA Food Code by reference.
Definition	Basic Care Facility: Provides room and board and health, social, and personal care to assist the residents to attain or maintain their highest level of functioning, consistent with the resident assessment and care plan, for five or more residents not related to the owner or manager by blood or marriage. A basic care facility is licensed by

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the Department of Health under North Dakota Century Code chapter 23-09.3. These services must be provided on a 24-hour basis within the facility, either directly or through contract, and shall include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); provision of leisure, recreational, and therapeutic activities; and supervision of nutritional needs and medication administration.

Assisted Living Facility: A building or structure containing a series of at least five living units operated as one entity to provide services for five or more individuals who are not related by blood, marriage, or guardianship to the owner or manager of the entity and which is kept, used, maintained, advertised, or held out to the public as a place that provides or coordinates individualized support services to accommodate the individual's needs and abilities to maintain as much independence as possible. An assisted living facility is licensed by the Department of Human Services under North Dakota Century Code 50-32, and by the Department of Health under North Dakota Century Code 23-09. An assisted living facility does not include a facility that is a congregate housing facility, licensed as a basic care facility, or licensed under Chapters 23-16 or 25-16 or Section 50-11-01.4.

Disclosure Items

Basic Care Facility: None specified.

Assisted Living Facility: Must maintain a written agreement with each tenant that includes the rates for rent and services provided, payment terms, refund policies, rate changes, tenancy criteria, and living unit inspections. Additionally, facilities must provide each tenant with written notice of how to report a complaint regarding the facility.

Facility Scope of Care

Basic Care Facility: Must provide personal care services to assist residents to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. It must provide assistance with: ADLs and IADLs; arrangements to seek health care when resident has symptoms for which treatment may be indicated; arrangements for appropriate transfer and transport as needed; functional aids or equipment, such as hearing aids; and clothing and other personal effects, as well as maintenance of living quarters.

Assisted Living Facility: Tenants choose and pay for only those services needed or desired. An assisted living facility may provide assistance to adults who may have physical or cognitive impairments and who require at least a moderate level of assistance

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	with one or more ADLs and assistance with IADLs.
Third Party Scope of Care	Basic Care Facility: Home health agencies may provide nursing services under contract with the facility. A facility that intends to retain residents who require end-of-life care must enter into an agreement with licensed and Medicare-certified hospice agencies. The agreement must delineate responsibilities. Assisted Living Facility: Home health agencies may provide services under contract with the resident. Long term care insurance may pay in basic care and assisted living facilities.
Admission and Retention Policy	Admission and discharge criteria are developed by each basic care or assisted living facility dependent upon their ability to meet the needs of the residents and the services available. Basic Care Facility: May admit or retain only individuals whose condition and abilities are consistent with National Fire Protection Association (NFPA) 101 Life Safety Code requirements and who must be capable of self-preservation. Basic care residents are admitted and retained in the facility in order to receive room and board and health, social, and personal care, and whose condition does not require continuous, 24-hour-a-day onsite availability of nursing or medical care. Assisted Living Facility: None specified
Resident Assessment	In basic care and assisted living facilities, the facilities develop and utilize their own forms. Basic Care Facility: An assessment is required for each resident within 14 days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly. The assessment must include: a review of health, psychosocial, functional, nutritional, and activity status; personal care and other needs; health needs; capability of self-preservation; and specific social and activity interests. Assisted living Facility: None specified
Medication Management	In assisted living and in basic care facilities, unlicensed staff may administer medication except for 'as needed' controlled prescription drugs. Those personnel must have specific training and be monitored by a registered nurse.
Square Feet Requirements	Basic Care Facility: Private resident units must be a minimum of 100 square feet and semi-private resident units must provide a minimum of 80 square feet per resident. Generally, basic care

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	facilities have semi-private units. Assisted Living Facility: Square feet requirements are not specified. Generally living units are efficiency or one- or two-bedroom apartments. A living unit must contain a sleeping area, an entry door that can be locked, and a private bathroom with a toilet, bath tub or shower, and a sink.
Residents Allowed Per Room	Basic Care Facility: None specified. Assisted Living Facility: No more than two people may occupy one bedroom of each living unit.
Bathroom Requirements	Common toilets, lavatories, and bathing facilities are permitted. Basic Care Facility: There must be at least one toilet for every four residents and a bathtub or shower for every 15 residents. Assisted Living Facility: There must be a private bathroom with a toilet, bath tub or shower, and a sink.
Life Safety	Basic Care Facility: In general, in basic care facilities, automatic sprinkler systems are required to protect construction types that may be unprotected or of combustible materials. NFPA 13D, NFPA 13R, or NFPA 13 automatic sprinkler systems may be used. Smoke detectors are required in resident rooms, corridors, and common areas. There are exceptions where these requirements may not apply. Basic care facilities must comply with the NFPA safety code, 2012 edition, chapters 32 and 33, residential board and care occupancy, slow evacuation capability, or a greater level of fire safety. Fire drills must be held monthly with a minimum of 12 per year, alternating with all work shifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. Fire evacuation plans must be posted in a conspicuous place in the facility. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department. Each resident shall receive an individual fire drill walk-through within five days of admission. Any variation to compliance with the fire safety requirements must be approved in writing by the department. Residents of facilities meeting a greater level of fire

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safety must meet the fire drill requirements of that occupancy classification.

Basic care facilies that retain residents who require end-of-life care and are not capable of self-preservation must meet additional requirements.

Assisted Living Facility: Operators of assisted living facilities must certify that facilities are in compliance with all applicable federal, state, and local laws, and upon request make available to the department copies of current certifications, licenses, permits, and other similar documents providing evidence of compliance with such laws. Each assisted living facility must install smoke detection devices or other approved alarm systems of a type and number approved by the department, in cooperation with the state fire marshal. Assisted living facilities must meet exiting requirements. Access to fire escapes must be kept free and clear at all times of all obstructions of any nature. The proprietor of the assisted living facility must provide for adequate exit lighting and exit signs as defined in the state building code.

Each assisted living facility must be provided with fire extinguishers as defined by the NFPA standard number 10 in quantities defined by the state building code and the state fire code. Standpipe and sprinkler systems must be installed as required by the state building code and state fire code. Fire extinguishers, sprinkler systems, and standpipe systems must conform with rules adopted by the state fire marshal. A contract for sale or a sale of a fire extinguisher installation in a public building is not enforceable, if the fire extinguisher or extinguishing system is of a type not approved by the state fire marshal for such installation. No fire extinguisher of a type not approved by the state fire marshal may be sold or offered for sale within the state.

Assisted living facilities must meet smoke detector regulations as stated in North Dakota Administrative Code 33-33-05. These regulations require every sleeping room, passageway, and hallway to be equipped with a smoke detection device. In addition, at least one sleeping room in an assisted living facility shall be equipped with a listed smoke detection device for the hearing impaired. At least 10 percent of battery-operated smoke detectors must be tested weekly and at least 10 percent of hard-wired detectors must be tested monthly on a systematic basis. Records of those tests need to be kept for two years.

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	Assisted living facilities are required to have written disaster plans and emergency lighting. Passenger or freight elevators must comply with state building code fire protection requirements.
Unit and Staffing Requirements for Serving Persons with Dementia	Alzheimer's units are available in basic care facilities. They are not available in assisted living facilities. Basic care facilities that wish to advertise or hold itself out to the public to provide specialized care to residents with Alzheimer's, dementia, memory loss, or care for residents with traumatic brain injury unless licensed consistent with section 33-03-24.1-24 of the regulations. A basic care facility licensed to provide specialized services to residents in this section may admit and retain residents who require twenty-four-hour per day dedicated personal care staff, but do not need more than intermittent nursing or medical care. Such facilities must develop a written policy related to resident rights and provide the policy to the resident or designee, verbally and in writing. Regulations specify a number of other requirements.
Staffing Requirements	Basic Care Facility: An administrator must be in charge of the general administration of the facility. While there are no staffing ratios, basic care facilities must provide 24-hour staffing. Assisted Living Facility: Staff must be available 24 hours a day to meet the needs of the residents, not necessarily on site. A manager and direct care staff are required. There are no staffing ratios. If the facility provides medication administration, a registered nurse must be available to administer medications and/or to train and supervise certified medication assistants.
Administrator Education/Training	Basic Care Facility: Administrators must complete at least 12 hours of continuing education per year relating to care and services for residents. Assisted Living Facility: Administrators must complete 12 hours of continuing education per year.
Staff Education/Training	Basic Care Facility: All employees must have in-service training annually on: 1) fire and accident prevention and safety; 2) mental and physical health needs of the residents, including behavior problems; 3) prevention and control of infections, including universal precautions; and 4) resident rights. In basic care facilities, the staff responsible for food preparation are required to attend a minimum of two dietary educational programs per year and staff responsible for activity services are required to attend a minimum of two activity-related programs per year. A Basic Care Facility licensed to provide specialized services to residents with Alzheimer's, dementia, or special memory care needs must meet additional

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training requirements. For example, all nursing and personal care staff must complete: a minimum of eight education hours on specified topics within three months of hire, a minimum of four hours annually thereafter, and competency evaluation annually.

Assisted Living Facility: All employees must receive annual training on: 1) resident rights; 2) fire and accident prevention and training; 3) mental and physical health needs of tenants; 4) behavior problems and prevention; and 5) control of infection, including universal precautions.

Entity Approving CE Program

None specified for either basic care or assisted living facilities.

Medicaid Policy and Reimbursement

A 1915(c) waiver covers services in basic care facilities that have experience providing services to individuals with a diagnosis of either dementia or brain injury. The Medicaid State Plan also covers personal care services for providers that are licensed and enrolled as a basic care facility.

Citations

North Dakota Legislative Branch, Chapter 75-03-34: Licensing of Assisted Living Facilities. [July 1, 2006]
http://www.legis.nd.gov/information/acdata/pdf/75-03-34.pdf?20150112162529

North Dakota Legislative Branch, Chapter 23-09: Lodging Establishments and Assisted Living Facilities.
http://www.legis.nd.gov/cencode/t23c09.pdf?20150112163253

North Dakota Legislative Branch, Chapter 50-32: Assisted Living Facilities.
http://www.legis.nd.gov/cencode/t50c32.pdf

North Dakota Legislative Branch, Chapter 33-03-24.1: Basic Care Facilities. [January 1, 2018]
http://www.legis.nd.gov/information/acdata/pdf/33-03-24.1.pdf?20150112162840

North Dakota Legislative Branch, Chapter 33-03-24.2 General Standards for Construction and Equipment for Basic Care Facilities. [July 1, 2015]
http://www.legis.nd.gov/information/acdata/pdf/33-03-24.2.pdf

North Dakota Legislative Branch, Chapter 23-09.3: Basic Care Facilities.
http://www.legis.nd.gov/cencode/t23c09-3.pdf?20150112163011

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North Dakota Department of Human Services. Medicaid Waiver for Home and Community Based Services (Medicaid Waiver). https://www.nd.gov/dhs/services/adultsaging/homecare3.html

North Dakota Department of Health, Division of Health Facilities (701) 328-2352

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State and Federal Agencies Reference Guide

Ada Accessibility and building codes

Contact: ND Department of Commerce
1600 East Century Ave, Suite 2
PO Box 2057
Bismarck, ND 58502-2057
701.328.5300
commerce.nd.gov

Fire Protection, Life Safety Code

Contact: ND Department of Health
Division of Life Safety
600 E Boulevard Ave, Dept 301
Bismarck, ND 58505-0200
701.328.2352
ndhealth.gov/LifeSafety

Sanitation Requirements for Food Establishments, Services Animals

Contact: ND Department of Health
Division of Food and Lodging
600 E Boulevard Ave, Dept 301
Bismarck, ND 58505-0200
701.328.1291
ndhealth.gov/FoodLodging

RN, LPN, Nursing

Contact: ND Board of Nursing
919 South 7th Street, Suite 504
Bismarck, ND 58504-5881
701.328.9777
ndbon.org

Nurse Aides, CNAs, Medication Assistants, Registries

Contact: ND Department of Health
Division of Health Facilities
600 E Boulevard Ave, Dept 301
Bismarck, ND 58505-0200
701.328.2352
health.nd.gov

Infection Control and Prevention

Centers for Disease Control and Prevention

Contact: ND Department of Health
Division of Disease Control
2635 E Main Ave
PO Box 5520
Bismarck, ND 58502-5520
701.328.2378
health.nd.gov/disease

Basic Care Assistance Program

Contact: ND Department of Human Services
Economic Assistance Policy Division
Basic Care Assistance Program
600 E Boulevard, Dept. 325
Bismarck ND 58505-0250
701-328-2332
dhseap@nd.gov

Rate Setting for Basic Care, Adult Residential Services, HCBS

Contact: ND Department of Human Services
Medical Services Division
600 E Boulevard, Dept. 325
Bismarck ND 58505-0250
701-328-2321