Pursuant to the authority vested in the State Hospital Review and Planning Council and the Commissioner of Health by 2803(2), 2803(6), 2803-c, and 2803-h of the Public Health Law, Parts 414, 415, 416, 420 and 421 and Articles 4 and 5 of Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are hereby repealed effective October 1, 1990 and new Parts 414 and 415 are hereby added to be effective October 1, 1990:

Chapter V
Medical Facilities
Subchapter A
Medical Facilities - Minimum Standards

Article 3
Residential Care Facilities

Part 414
Nursing Homes - Continuous Violation Penalties

Part 415
Nursing Homes - Minimum Standards

(Statutory Authority: Public Health Law 2803(2), 2803(6), 2803-c, and 2803-h)
Part 415  
Nursing Home - Minimum Standards

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415.1 Basis and Scope

(a) Statement of Purpose
New York's residential health care facilities are responsible for the health and well-being of more than 100,000 residents ranging from infants with multiple impairments to young adults suffering from the sequelae of traumatic brain injury to the frail elderly with chronic disabilities. For the vast majority of residents, the residential health care facility is their last home. A license to operate a nursing home carries with it a special obligation to the residents who depend upon the facility to meet every basic human need.

Each resident comes to the nursing home with unique life experiences, values, attitudes and desires, and a singular combination of clinical and psychosocial needs. In order to assure the highest practicable quality of life, the individuality of the nursing home resident must be recognized, and the exercise of self-determination protected and promoted, by the operator and staff of the facility. The physical environment, care policies and staff behavior must at once acknowledge the dependence of the residents while fostering their highest possible level of independence.

In writing a code of minimum operating standards for nursing homes, it is also critical that the regulator recognize the infinite diversity of the nursing home population. A code intended to assure the highest possible quality of care and most meaningful quality of life for all residents must not only accept, but in fact invite variety in nursing home environments, policies and practices, and encourage creativity among nursing home managers and staff.

In order to meet obligations to nursing home residents, this set of requirements, to the extent possible, expresses expectations for facility operation in terms of performance and outcomes rather than by dictating structure and process. It is the intent of these requirements to grant a high degree of latitude and flexibility to administrators and staff while insisting upon conformance to fundamental principles of individual rights and to accepted professional standards. In those areas where a detailed process or procedure is mandated, it is based upon a firm belief that experience has proven the specific practice to be necessary in all cases to assure the high quality of care we expect nursing homes to provide.

In addition to the emphasis on individuality and self-determination, the code reflects certain precepts: that nursing homes should be viewed as homes as much as medical institutions, with the resident's psychosocial needs deserving a prominence at least equal to medical condition; that clinical interventions for the nursing home resident must be part of a comprehensive approach planned and provided by an interdisciplinary care team, with the participation of the resident, rather than through a physician-directed acute care orientation; and that quality assurance is a work ethic rather than an oversight method or a department.

(b) General Information.
(1) Nursing homes, which shall include all facilities subject to Article 28 of the Public Health Law and providing residential skilled nursing care and services and residential health related care and services, shall provide such care and services in a manner and quality consistent with generally accepted standards of practice.

(2) In accordance with Article 28 of the Public Health Law, nursing homes, as defined in section 415.2 of this Part, and which include facilities referred to elsewhere in this Title as skilled nursing facilities, health related facilities or residential health care facilities, shall comply with all the requirements of this Part.

(3) Nursing homes shall comply with construction standards contained in Article 2 of Subchapter C of this Chapter (Medical Facility Construction).

(4) Nursing homes shall comply with all pertinent federal, state and local laws, regulations, codes, standards and principles including but not limited to those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, protection of human subjects of research and fraud and abuse and the Public Health Law, Mental Hygiene Law, Social Services Law and Education Law of the State of New York.

(5) The provisions of Parts 700 and 702, of Article 1 of Subchapter C of this Chapter shall not apply to nursing homes.
415.2 Definitions The following definitions, unless context clearly requires otherwise, shall apply to this Article:

(a) Ambulant resident (see 415.37(a)(3))

(b) Certified nurse aide shall mean an individual who is listed in the New York State Nursing Home Nurse Aide Registry as specified in 415.26(d) of this Part.

(c) Clinical Skills Advisor (see 415.26(d)(1)(iii))

(d) Commissioner shall mean the State Commissioner of Health.

(e) Department shall mean the New York State Department of Health.

(f) Designated representative shall mean the individual or individuals designated in accordance with this subdivision to receive information and to assist and/or act in behalf of a particular resident to the extent permitted by State law; it being understood that a designated representative specified in subparagraph (iii) of paragraph (1) of this subdivision is not a health care agent as defined in Article 29-C of the Public Health Law and may not give effective consent to treatment.

(1) Such individual or individuals shall be designated, with such designation noted in the clinical record:

(i) by a court of law when the designation of an individual, committee or guardian has been sought;

(ii) by the resident if the resident has the capacity to make such designation; or

(iii) by family members and other parties who have an interest in the well-being of the resident who, after discussion with the facility, identify the individual or individuals most personally involved in the resident's care, if the resident lacks the capacity to make such designation.

(2) The designated representative shall:

(i) receive any written and oral information required by this Part to be provided to the resident if such resident lacks the capacity to understand or make use of such information, and also receive any information required to be provided to both the resident and the designated representative; and

(ii) participate to the extent authorized by State law in decisions and choices regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make such decisions and choices provided, however, that only court appointed surrogates and health care agents appointed under Article 29-C or 29-B of the Public Health Law may give effective consent to treatment.

(g) Governing body shall mean the policy-making body of a government agency, the board of directors or trustees of a corporation or the
propriator or proprietors of a proprietary nursing home to which the
department has issued an operating certificate.

(h) Nurse aide (see 415.13(c)(1))

(i) Nurse aide trainee shall mean an individual who is participating
in a State approved residential health care facility nurse aide training
program.

(j) Nurse aide training program coordinator (see 415.26(d)(1)(i))

(k) Nursing home, also referred to in this Part as a residential
health care facility or a facility, shall mean a facility, institution,
or portion thereof subject to Article 28 of the New York State Public
Health Law, providing therein, lodging for 24 or more consecutive hours
to three or more nursing home residents who are not related to the
operator by marriage or by blood within the third degree of
consanguinity, who need regular nursing services or other professional
services but who shall not need the services of a general hospital.

(l) Primary Instructor (see 415.26(d)(1)(ii))

(m) Resident, or nursing home resident, shall mean an individual
who has been admitted to and who resides in a nursing home and who is
entitled to receive care, treatment and services in accordance with the
requirements of this Part.

(n) Resident care unit or nursing unit shall mean a designated area
including a group of resident rooms with adequate supporting rooms,
areas, facilities, services, and personnel providing nursing care and
management of residents which is planned, organized, operated and
maintained to function as a unit so as to encourage the efficient
delivery of resident services and effective observation of and
communication with residents.

(o) Resident Council shall mean the resident organization created
by residents of a nursing home and recognized by the facility as the
group that represents the interests of its membership.

(p) Respiratory care and therapy shall mean the care for any portion
of the respiratory tract, especially the lungs. This care may include
but not be limited to the following: percussion or cupping, postural
drainage, positive pressure machine and where appropriate, use of
oxygen to administer drugs.

(q) Respiratory therapist or respiratory therapy technician shall
mean a person who holds a baccalaureate degree, associate degree,
certificate or diploma in respiratory or inhalation therapy from a
college, university, institution, hospital school or program accredited
by the State Education Department of the Joint Review Committee for
Inhalation Therapy Education, or who demonstrates equivalent
proficiency to the employing facility by means of an evaluation by two
qualified medical specialists.

(r) Qualified specialist shall mean a physician who holds a current
license to practice medicine in the State of New York, and who:
(i) is a diplomate of the appropriate American board or who has been certified as a specialist by the American Osteopathic Specialty Board for the respective specialty; or

(ii) has been notified or admissibility to examination by such board, or presents evidence of completion of an approved qualifying residency in such specialty; or

(iii) holds the rank of attending or associate attending specialist in an accredited voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

(iv) holds an appropriate specialist rating granted by the Workers' Compensation Board after May 1960, provided the award is based on training approved by the respective specialty board.

(s) Sponsor shall mean the agency or the person or persons, other than the resident, responsible in whole or in part for the financial support of the resident, including the costs of care in the facility.

(t) Equity withdrawal (see 415.26(h)(7))
415.3 Residents' Rights

(a) The facility shall ensure that all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident, and shall encourage and assist each resident in the fullest possible exercise of these rights as set forth in subdivisions (b) - (h) of this section. The facility shall also consult with residents in establishing and implementing facility policies regarding residents' rights and responsibilities.

(1) The facility shall advise each member of the staff of his or her responsibility to understand, protect and promote the rights of each resident as enumerated in this section.

(2) The facility shall fully inform the resident and the resident's designated representative both orally and in writing in a method of communication that the individuals understand of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification shall be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, shall be acknowledged in writing. A summary of such information shall be provided by the Department and posted in the facility in large print and in language that is easily understood.

(3) The written information provided pursuant to paragraph (2) of this subdivision shall include but not be limited to a listing of those resident rights and facility responsibilities enumerated in subdivisions (b) through (h) of this section. The facility's policies and procedures shall also be provided to the resident and the resident's designated representative upon request.

(4) The facility shall communicate to the resident an explanation of his or her responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents.

(5) Any written information required by this Part to be posted shall be posted conspicuously in a public place in the facility that is frequented by residents and visitors, posted at wheelchair height.

(b) Admission rights. The nursing home shall protect and promote the rights of residents and potential residents by establishing and implementing policies which ensure that the facility:

(1) shall not require a third party guarantee of payment to the facility as a condition of admission, or expedited admission, or continued stay in the facility;

(2) shall not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid by third party payors, any gift, money, donation or other consideration as a precondition of
admission, expedited admission or continued stay in the facility except that arrangements for prepayment for basic services not exceeding three months shall not be precluded by this paragraph;

(3) shall not require residents or potential residents to waive their rights to Medicare or Medicaid;

(4) shall not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits;

(5) shall obey all pertinent state and local laws which prohibit discrimination against individuals entitled to Medicaid benefits;

(6) may require an individual who has legal access to a resident's income or resources available to pay for facility care, to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources;

(7) may charge a resident who is eligible for Medicaid only for items and services the resident has requested and received, and that are not specified at the time of admission as included in basic nursing home services; and

(8) may solicit, accept or receive a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident, or potential resident, only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility.

(c) Protection of Legal Rights. (1) Each resident shall have the right to:

(i) exercise his or her rights as a resident of the facility and as a citizen or resident of the United States and New York State including the right to vote, with access arranged by the facility and to this end may voice grievances without discrimination or reprisal for voicing the grievances, and have a right of action for damages or other relief for deprivations or infringements of his or her right to adequate and proper treatment and care established by any applicable statute, rule, regulation or contract;

(ii) recommend changes in policies and services to facility staff and/or to any outside representatives, free of interference, coercion, discrimination, restraint or reprisal from the facility and to obtain prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents;

(iii) exercise his or her individual rights or have his or her rights exercised by a person authorized by state law;

(iv) inspect and purchase at cost of production not exceeding the cost incurred by the provider, photocopies of all records pertaining to the resident, upon written request and 48 hours notice to the facility or such greater period as State statute may permit;
(v) examine the results of the most recent survey of the facility conducted by federal or State surveyors including any statement of deficiencies, any plan of correction in effect with respect to the facility and any enforcement actions taken by the Department of Health. The results shall also be posted by the facility in a place readily accessible to residents;

(vi) receive information from agencies acting as resident advocates, and be afforded the opportunity to contact these agencies;

(vii) be free from verbal, sexual, mental or physical abuse, corporal punishment and involuntary seclusion, and free from chemical and physical restraints except those restraints authorized in accordance with section 415.4 of this Part;

(viii) exercise his or her civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, which shall not be infringed; and

(ix) request, or have the resident's designated representative request, and be provided information concerning his or her specific assignment to a patient classification category as contained in Appendix 13-A of this Title, entitled, "Patient Categories and Case Mix Indices Under Resource Utilization Group (RUG-II) Classification System."

(2) With respect to its responsibilities to the resident the facility shall:

(i) furnish a written description of legal rights which includes:

(a) a description of the manner of protecting personal funds, under subdivision (h) of section 415.26 of this Part; and

(b) a statement that the resident may file a complaint with the facility or the New York State Department of Health concerning resident abuse, neglect, and misappropriation of resident property in the facility. The statement shall include the name, address and telephone number of the office established by the Department to receive complaints and of the State Office for the Aging Ombudsmen Program;

(ii) promptly notify the resident and the resident's designated representative when there is:

(a) a change in room. Such change in room shall require a minimum of 30 days prior notice and consultation with the resident unless:

(1) the resident has requested or agrees to the change;
(2) the medical condition of the resident requires a more immediate change; or
(3) an emergency situation develops;

(b) a change in roommate assignment which shall be acceptable, where possible, to all affected residents; or
a change in resident rights under Federal or State law or
regulations as specified in this section;

(iii) record and periodically update the address and phone number
of the resident's legal representative or interested family member;

(iv) provide immediate access to any resident by the following:

(a) any representative of the Secretary of Health and Human
Services;

(b) any representative of the Department of Health;

(c) the resident's individual physician;

(d) ombudsmen who are duly certified and designated by the State
Office for the Aging;

(e) representatives of the Commission on Quality of Care for the
Mentally Disabled which is responsible for the protection and advocacy
system for developmentally disabled individuals and mentally ill
individuals;

(f) immediate family or other relatives of the resident, subject
to the resident's right to deny or withdraw consent at any time, and

(g) others who are visiting with the consent of the resident,
subject to reasonable restrictions and the resident's right to deny or
withdraw consent at any time;

(v) provide reasonable access to any resident by any entity or
individual that provides health, social, legal or other services to the
resident, subject to the resident's right to deny or withdraw consent
at any time;

(vi) comply with the provisions of Part 411 of this Title regarding
Ombudsmen Access to Residential Health Care Facilities; and

(vii) inform residents of the facility's visiting hour policies.

(d) Right to Privacy. Each resident shall have the right to:

(i) personal privacy and confidentiality of his or her personal and
clinical records which shall reflect:

(i) accommodations, medical treatment, written and telephone
communications, personal care, associations and communications with
persons of his or her choice, visits, and meetings of family and
resident groups. Resident and family groups shall be provided with
private meeting space and residents shall be given access to a private
area for visits or solitude. Such requirement shall not require the
facility to provide a private room for each resident; and

(ii) the resident's right to approve or refuse the release of
personal and clinical records to any individual outside the facility
except when:
(a) the resident is transferred to another health care institution; or

(b) record release is required by law or third-party contract;

(2) privacy in written communications, including the right to:

(i) send and receive mail promptly that is unopened; and

(ii) have access to stationery, postage and writing implements at the resident's own expense; and

(3) regular access to the private use of a telephone that is wheelchair accessible and useable by hearing impaired and visually impaired resident;

(e) Right to Clinical Care and Treatment. (1) Each resident shall have the right to:

(i) adequate and appropriate medical care, and to be fully informed by a physician in a language or in a form that the resident can understand, using an interpreter when necessary, of his or her total health status, including but not limited to, his or her medical condition including diagnosis, prognosis and treatment plan. Resident shall have the right to ask questions and have them answered;

(ii) refuse to participate in experimental research and to refuse medication and treatment after being fully informed and understanding the probable consequences of such actions;

(iii) choose a personal attending physician from among those who agree to abide by all federal and state regulations and who are permitted to practice in the facility;

(iv) be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being;

(v) participate in planning care and treatment or changes in care and treatment. Residents adjudged incompetent or otherwise found to be incapacitated under the laws of the State of New York shall have such rights exercised by a designated representative who will act in their behalf in accordance with state law; and

(vi) self-administer drugs unless the interdisciplinary team, as defined by Section 415.11, has determined for each resident that this practice is unsafe;

(2) With respect to its responsibilities to the resident, the facility shall:

(i) inform each resident of the name, office address, phone number and specialty of the physician responsible for his or her own care.
(ii) except in a medical emergency, consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is:

(a) an accident involving the resident which results in injury;

(b) a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services;

(c) a need to alter treatment significantly; or

(d) a decision to transfer or discharge the resident from the facility as specified in subdivision (h) of this section; and

(iii) provide all information a resident or the resident's designated representative when permitted by State law, may need to give informed consent for a order not to resuscitate and comply with the provisions of section 405.43 of this Subchapter regarding orders not to resuscitate. Upon resident request the facility shall furnish a copy of the pamphlet, "Do Not Resuscitate Orders - A Guide for Patients and Families".

(f) Residential Rights. Each resident shall have the right to:

(1) refuse to perform services for the facility. The resident may perform such services, if he or she chooses, only when:

(i) there is work available in the facility that the resident is capable of safely performing;

(ii) the facility has documented the need or desire for work in the plan of care;

(iii) the plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iv) compensation for paid services is at or above prevailing rates; and

(v) the resident agrees to the work arrangement described in the plan of care;

(2) retain, store securely and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of the resident or other residents in which case the facility shall explore alternatives through discussion with the resident, the resident council or interdisciplinary care team, and provide or assist in the arrangement of storage for possessions. The resident shall have the right to locked storage space in his or her room;

(3) share a room with his or her spouse, relative or partner when these residents live in the same facility and both consent to the arrangement. If a spouse, relative or partner resides in a location
out of the facility, the resident shall be assured of privacy for visits;

(4) participate in the established residents' council;

(5) meet with, and participate in activities of social, religious and community groups at his or her discretion; and

(6) receive, upon request, kosher food or food products prepared in accordance with the Hebrew orthodox religious requirements when the resident, as a matter of religious belief, desires to observe Jewish dietary laws.

(g) Financial Rights. (1) Each resident shall have the right to manage his or her financial affairs or authorize in writing the facility to manage personal finances in accordance with paragraph (5) of subdivision (h) of section 415.26 of this Part. The facility may not require residents to deposit their personal funds with the facility;

(2) With respect to its responsibilities to the resident, the facility shall:

(i) inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing home or, when the resident becomes eligible for Medicaid of:

(a) the items and services that are included in nursing home services under the State plan and for which the resident may not be charged;

(b) those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(c) the clear distinction between the two lists required by clauses (a) and (b) of this subparagraph.

(ii) inform each resident when changes are made to the items and services specified in clauses (a) and (b) of subparagraph (i) of this paragraph;

(iii) inform each resident verbally and in writing before, or at the time of admission, and periodically when changes occur during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered by sources of third party payment or by the facility's basic per diem rate; and

(iv) prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits;

(h) Transfer and Discharge Rights. (1) With regard to the transfer or discharge of residents, the facility shall:
(i) permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility.

(a) The resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determines that:

(1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility;

(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(3) the health or safety of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem.

(b) Transfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third party insurance) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility the facility may charge a resident only allowable charges under Medicaid. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds;

(c) Transfer or discharge shall also be permissible when the facility discontinues operation and has received approval of its plan of closure in accordance with subdivision (i) of Section 401.3 of this Subchapter.

(ii) ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (i) of this paragraph. The documentation shall be made by:

(a) the resident's physician and interdisciplinary care team, as appropriate, when transfer or discharge is necessary under subclause (1) or (2) of clause (a) of subparagraph (i) of this paragraph; and

(b) a physician when transfer or discharge is necessary due to the endangerment of the health of other individuals in the facility under subclause (3) of clause (a) of subparagraph (i) of this paragraph;

(iii) before it transfers or discharges a resident:
(a) notify the resident and designated representative of the transfer or discharge and the reasons;

(b) record the reasons in the resident's clinical record; and

(c) include in the notice the items described in subparagraph (v) of this paragraph;

(iv) provide the notice of transfer or discharge required under subparagraph (iii) of this paragraph at least 30 days before the resident is transferred or discharged, except that notice shall be given as soon as practicable before transfer or discharge under the following circumstances:

(a) the safety of individuals in the facility would be endangered;

(b) the health of individuals in the facility would be endangered;

(c) the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(d) an immediate transfer or discharge is required by the resident's urgent medical needs; or

(e) the transfer or discharge is being made in compliance with a request by the resident.

(v) include in the written notice specified in subparagraph (iii) of this paragraph the following:

(a) for transfers or discharges a statement that the resident has the right to appeal the action to the State Department of Social Services pursuant to 18 NYCRR 358 for Medicaid residents and in accordance with paragraph (3) of this subdivision or to the State Department of Health in accordance with paragraph (2) of this subdivision for all other residents. The statement shall include current phone numbers for these Departments which can be used to initiate an appeal;

(b) the name, address and telephone number of the State long term care ombudsman; and

(c) for nursing facility residents who are mentally ill or who have developmental disabilities, the mailing address and telephone number of the Commission on Quality of Care for the Mentally Disabled which is responsible for the protection and advocacy of such individuals; and

(vi) provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in deciding where to go.
(2) Appeals of transfer and discharge decisions to the Department of Health as permitted by clause (a) of subparagraph (v) of paragraph (1) of this subdivision shall be in accordance with the following:

(i) the resident has the right to:

(a) a pre-transfer on-site fair hearing under the auspices of the Department of Health, provided that the resident has appealed the transfer or discharge within 15 days of the notice, except in cases involving imminent danger to others in the facility, and
(b) remain in the facility pending an appeal determination, or
(c) a post-transfer hearing within 30 days of transfer if the resident did not request a hearing prior to transfer; and
(d) return to the facility to the first available bed if the resident wins the appeal.
(e) examine his/her medical records.

(ii) the presiding officer shall have the power to obtain medical and psychosocial consultations.

(iii) The nursing home shall have the burden of proof that the transfer is/was necessary and the discharge plan appropriate.

(iv) In cases involving imminent danger to others in the facility, an involuntary transfer may be arranged before a hearing. However, the facility shall be required to hold the resident's bed until after the hearing decision. If the transfer is found to be appropriate, the facility may charge a private pay resident for the time the bed was held. If the transfer is found to be inappropriate, the facility shall readmit the resident to his or her bed on a priority basis.

(v) The Department shall conduct a review and render a decision on the appeal as required in clause (a) of subparagraph (i) of this paragraph within 15 days of the request.

(3) If an appeal decision rendered after discharge finds the discharge or transfer to be inappropriate, the facility shall readmit the resident prior to admitting any other person.

(4) The facility shall establish and implement a bed-hold policy and a readmission policy that reflect at least the following:

(i) At the time of admission and again at the time of transfer for any reason, the facility shall verbally inform and provide written information to the resident and a family member or legal representative that specifies:

(a) the duration of the bed-hold policy during which the resident is permitted to return and resume residence in the facility; and
(b) The facility's policies regarding bed hold periods, which must be consistent with subparagraph (iii) of this paragraph, permitting a resident to return.

(ii) At the time for therapeutic leave, a nursing home shall provide written notice to the resident and a family member or legal...
representative, which specifies the duration of the bed hold policy described in subparagraph (i) of this paragraph.

(iii) A nursing home shall establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(a) requires the services provided by the facility; and
(b) is eligible for Medicaid nursing home services.

(5) With regard to the assurance of equal access to quality care, the facility shall establish and maintain identical policies and practices regarding transfer, discharge and the provision of all required services for all individuals regardless of source of payment.
415.4 Resident Behavior and Facility Practices.

The facility shall provide residents with considerate and respectful care designed to promote the resident's independence and dignity in the least restrictive environment commensurate with the resident's preference and physical and mental status.

(a) Physical and Chemical Restraints. The facility and all medical, nursing, and other professional staff shall assure that:

(1) the resident is free, consistent with subdivision (1) of section 415.12 of this Part, from any psychotropic drug administered for purposes of discipline or convenience, and not required to treat the resident's medical conditions or symptoms; and

(2) physical restraints, any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body, are:

(i) used only to protect the health and safety of the resident and to assist the resident to attain and maintain optimum levels of physical and emotional functioning;

(ii) an integral part of the interdisciplinary care plan that is individualized as to the type of restraint, release schedules, type of exercise, necessary skin care and ambulation to be provided, and is intended to lead to less restrictive treatment to manage the problem for which the restraint is applied;

(iii) used only in unusual circumstances and only after all reasonable less restrictive alternatives have been considered and rejected for reasons related to the resident's well-being which shall be documented showing evidence of consultation with appropriate professionals such as social workers and physical therapists. Less restrictive measures that would not clearly jeopardize the resident's safety shall not be rejected before a trial to demonstrate whether a more restrictive restraint would promote greater functional independence.

(iv) not used for staff convenience, for purposes of discipline or as substitutes for direct care, activities and other services;

(v) an enabler of the highest practicable physical, mental or psychosocial well-being; and

(vi) implemented only after the resident or designated representative, to the extent permitted by state law, agrees to this treatment alternative, except in an emergency situation in accordance with paragraph (6) of this subdivision. If the resident or designated representative withdraws agreement to the treatment after implementation, the usage shall be stopped.

(3) When physical restraints are used:
(i) They are used in accordance with paragraph (2) of this subdivision and are time limited. They are used for specified periods of time, properly applied allowing for some body movement and not impairing circulation;

(ii) They are monitored closely as specified in paragraph (5) of this subdivision; and

(iii) All plans for restraints are reviewed at a frequency determined by the resident's condition or more frequently if requested by the resident or designated representative. The clinical record shall include documentation of periodic reevaluation of the need for the restraint and efforts made to substitute other measures.

(4) Policies and procedures regarding the ordering and use of physical restraints and the recording, reporting, monitoring and review and modification thereof are:

(i) incorporated into the inservice education programs of the facility, with changes made in such programs when policies and procedures are modified; and

(ii) made known to all medical, nursing and other appropriate resident care personnel in advance of implementation.

(5) When physical restraints are used the resident is:

(i) released as frequently as necessary to meet resident care needs, but at least every two hours except when asleep in bed, then released as indicated by the type of restraint and by the residents' condition;

(ii) provided with changes of position, ambulation or exercise at the time of release; and

(iii) observed at least as frequently as at the time of dressing and undressing for any evidence of adverse effects, including but not limited to circulatory problems or skin abrasions;

(6) In an emergency situation a physical restraint may only be used if it is:

(i) approved by the medical director, attending physician or nursing director, or in his or her absence, by a registered professional nurse;

(ii) used for that specific emergency and for a limited period of time with physician consultation regarding the physical measure or safety device obtained within 24 hours;

(iii) applied under the direction of a licensed nurse who documents in the clinical record the circumstances necessitating the physical restraint and the resident's response; and

(iv) monitored frequently by a licensed nurse until the resident is seen by a physician:
(7) There are written policies specifying and defining each type of physical restraint that is acceptable and available in the facility and the purposes for which each shall be used. Locked restraints shall not be considered acceptable.

(b) Staff treatment of residents. The nursing home shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents.

(1) The facility shall:

(i) Not use, or permit, verbal, mental, sexual or physical abuse, including corporal punishment, or involuntary seclusion of residents; and

(ii) Not knowingly employ individuals who have been convicted of abusing, neglecting or mistreating individuals.

(2) The facility shall ensure that alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the administrator of the facility and, when required by law or regulation, to the Department of Health in accordance with Section 2803-d of the Public Health Law and Part 81 of this Title through established procedures.

(3) The facility shall document that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or his or her designated representative or to other officials in accordance with State law and if the alleged violation is verified, effective corrective action shall be taken.
415.5 Quality of Life. The facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) Self-determination and participation. The resident shall have the right to:

1. Choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care;
2. Interact with members of the community both inside and outside the facility; and
3. Make choices about aspects of his or her life in the facility that are significant to the resident.

(c) Participation in resident and family groups.

1. A resident shall have the right to organize and participate in resident groups in the facility;
2. A resident's family shall have the right to meet in the facility with the families of other residents in the facility;
3. The facility shall provide a resident or family group, if one exists, with private space;
4. Staff or visitors shall be allowed to attend meetings at the group's invitation;
5. The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;
6. When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

(d) Participation in other activities.

1. A resident shall have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.
2. The facility shall arrange for opportunities for religious worship and counseling for any residents requesting such services.

(e) Accommodation of needs. A resident shall have the right to:

1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the
health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident's room or roommate in the facility is changed.

(f) Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive resident assessment, the interests and the physical, mental and psychosocial well-being of each resident. The activities program shall:

(i) encourage the resident's voluntary choice of activities and participation; and

(ii) promote and maintain the resident's sense of usefulness to self and others, make his or her life more meaningful, stimulate and support the desire to use his or her physical and mental capabilities to the fullest extent and enable the resident to maintain a sense of usefulness and self-respect.

(2) The activities program shall be directed by a qualified professional who:

(i) Is a qualified therapeutic recreation specialist who is eligible for certification as a therapeutic recreation specialist by a recognized accrediting body on or after August 1, 1989; or

(ii) Has 2 years of experience in an age-appropriate social or recreational program within the last 5 years, 1 of which was full-time in a patient or resident activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant.

(3) The activities program director shall be responsible to the administrator or his or her designee for administration and organization of the activities program and shall:

(i) assist in the selection and evaluation of activities program staff and volunteers;

(ii) assign duties and supervise all activities staff and assigned volunteers;

(iii) ascertain, initially from the resident's attending physician, and on an ongoing basis from other appropriate professional staff, which residents are not permitted for specific documented medical reasons, to participate in certain activities;

(iv) develop and prepare with the resident and designated representatives, as appropriate, a written plan for individual, group and independent activities in accordance with his or her needs,
interests and capabilities, and in recognition of his or her mental and physical needs and interests, as well as education and experiences.

(v) incorporate the activities into the resident's interdisciplinary care plan;

(vi) periodically, and at least quarterly, review with the resident, designated representative and staff, as appropriate his or her activities program participation and revise the plan as necessary;

(vii) coordinate and incorporate the activities program with the resident's schedule of other services through discussions with the interdisciplinary care team;

(viii) develop a monthly activities schedule based upon individual and group needs, interests and capabilities considering the special needs of residents including but not limited to dementias, physical handicaps, visual, hearing and speech deficiencies and wheelchair or bed restrictions;

(ix) post the current monthly activities schedule where it is accessible to residents and staff and can be easily read and provide a copy to each resident;

(x) provide the administrator with a monthly report of the type, frequency of and number of residents participating in the activities program; and

(xi) include in the resident's clinical record a quarterly assessment of the resident's degree of participation in and response and benefit from the activities program.

(4) The facility shall:

(i) employ such additional qualified personnel responsible to the activities director, as are needed;

(ii) provide a planned program to include individual, group and independent programs for all residents at various times of the day and evening seven days of the week;

(iii) provide safe and adequate space and an adequate number and variety of equipment and supplies for the conduct of the on-going program;

(iv) develop, facilitate access and implement programs to encourage residents to establish and maintain community contacts; and

(v) maintain a monthly statistical report of type, frequency of and number of residents participating in the activities program.

(g) Social Services.

(1) The facility shall provide for a social service program to meet the psychosocial needs of the individual resident which will provide services, based upon a comprehensive assessment, which will assure the
maximum attainable quality of life for the residents, the residents' emotional and physical well-being, self-determination, self respect and dignity. Such services shall include:

(i) conducting an initial admissions assessment and interview with the resident and family to evaluate the appropriateness of placement and identify the need for special services;

(ii) interpreting the residents' rights to family and staff;

(iii) advocating for the resident with personal and social problems and problems involved with institutionalization;

(iv) facilitating needed communication with other disciplines on behalf of the residents, including medical, nursing, dietary, rehabilitation and psychiatric services;

(v) coordinating and monitoring needed available services for individual residents to assure optimum level of emotional, physical and psychological well-being and independence based upon educational background;

(vi) involving the resident, other disciplines and administration as appropriate regarding matters such as bed retention, room change, transfer and discharge;

(vii) interpreting residents' needs and behaviors and extending professional intervention to all levels of staff suggesting positive approaches; such as alternatives to the use of restraints and psychotropic drugs.

(viii) initiating and facilitating small group meetings of residents, family and staff directed at a fuller understanding of the institutionalized resident and fuller joint participation in improving the residents' emotional and physical well-being;

(ix) initiating and participating in interdisciplinary meetings and team conferences;

(x) providing assistance and support to residents' family members;

(xi) arranging for residents and families to meet with Department of Health surveillance staff as necessary;

(xii) participating, if requested by residents, in the organization and on-going functioning of the resident and family councils;

(xiii) making available social work staff at varying schedules, including weekends and evenings;

(xiv) coordinating and facilitating the referral of residents for needed and requested services and outside resources not available in the facility; and

(xv) organizing bereavement counseling for roommates, families and other affected individuals.
(2) The facility shall employ a qualified social worker. Facilities with more than 120 beds shall employ such individual on a full time basis; facilities with 120 beds or fewer shall employ such individual on a full or part time basis. A qualified social worker for purposes of this Part is an individual who:

(i) holds a masters degree in social work or is a Certified Social Worker and has pertinent experience in a health care setting;

(ii) holds a bachelor's degree in social work, or in a related field, and has regular access through a contract which meets the provisions of subdivision (e) of section 415.26 of this Part with a person who meets the requirement of subparagraph (i) of this paragraph; or

(iii) had four years of social work experience in a nursing home in New York State prior to October 1, 1990, as a social work assistant or case aide and has regular access through a contract which meets the provisions of subdivision (e) of section 415.26 of this Part with a person who meets the requirement of subparagraph (i) of this paragraph.

(h) Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior;

(3) Clean bed and bath linens that are in good condition;

(4) Comfortable and safe temperature levels;

(5) For the maintenance of comfortable sound levels.
415.11 Resident Assessment and Care Planning. Upon admission and periodically thereafter the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Based on the results of these assessments, the facility shall develop and keep current an individualized comprehensive plan of care to meet each resident's needs.

(a) Comprehensive Assessments. (1) The facility shall conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and identifies significant impairments in functional capacity.

(2) The comprehensive assessment shall include at least the following information:

(i) Medically defined conditions and prior medical history,
(ii) Medical status measurement,
(iii) Functional status,
(iv) Sensory and physical impairments,
(v) Nutritional status and requirements,
(vi) Special treatments or procedures,
(vii) Discharge potential,
(viii) Psychosocial status,
(ix) Dental condition,
(x) Activities potential,
(xi) Rehabilitation potential,
(xii) Cognitive status, and
(xiii) Drug therapy.

(3) Frequency. Comprehensive assessments shall be conducted:

(i) No later than 4 working days after the date of admission;
(ii) Promptly after a significant improvement or decline in the resident's physical, mental or psychosocial status in accordance with generally accepted standards of care and services; and
(iii) In no case less often than once every 12 months for each resident. Every 12 months the comprehensive assessment shall include annual review of residents with known or suspected mental impairment or mental retardation utilizing the pertinent portions of the SCREEN instrument set forth in Section 400.12 of this Title. Residents screened as mentally impaired or mentally retarded by this process shall be referred to the commissioner's designee for evaluation of the need for active treatment for a mental impairment or mental retardation and for need for nursing home services.

(4) Review of assessments. Professional staff shall examine each resident no less than once every 3 months, and as appropriate, revise the resident's comprehensive assessment to assure the continued accuracy of the assessment.

(5) Use. The results of the comprehensive assessment shall be used by the interdisciplinary care team as defined in subparagraph (ii) of paragraph (2) of subdivision (c) of this section to develop, review,
and revise the resident's comprehensive plan of care, under paragraph (d) of this section.

(b) Accuracy of assessments. (1) Coordination. (i) Each assessment shall be conducted or coordinated, with the participation of appropriate health professionals.

(ii) Each assessment shall be conducted, or coordinated, by a registered professional nurse who signs and certifies the completion of the assessment.

(2) Certification. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.

(3) Penalty for Falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment shall be subject to civil money penalties under federal statutes and regulations.

(4) Use of independent assessors. If the department determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (b)(3) of this subdivision, the department shall require remedial measures, which may include but not be limited to requiring that resident assessments under this section be conducted and certified at the facility's expense by individuals who are independent of the facility and who are approved by the department.

(c) Comprehensive care plans. (1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet each resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment.

(2) A comprehensive care plan shall be:

(i) Developed within 7 working days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team that includes the attending physician, a registered professional nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and with the participation of the resident, the resident's family or legal representative to the extent practicable; and

(iii) Periodically reviewed and revised as necessary by an interdisciplinary team of qualified persons after each comprehensive assessment or reassessment.

(3) The services provided or arranged by the facility shall:

(i) Meet prevailing standards of care and service; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(d) Discharge summary. When the facility anticipates discharge, the facility shall prepare a discharge summary that includes:

(1) A recapitulation of the resident's stay;

(2) A final summary of the resident's status to include information set forth in paragraph (2) of subdivision (a) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) A post-discharge plan of care that shall be developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident.
Quality of Care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:

(i) Bathe, dress and groom;
(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and
(v) Use speech, language or other functional communication systems.

(2) A resident shall be given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (1) of this subdivision; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments;

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices if such services are not provided on-site; and

(3) By promoting the safekeeping, maintenance, and use of vision or hearing assistive devices which the resident needs.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who is incontinent of bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible; and

(2) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays psychosocial adjustment difficulty, receives appropriate treatment and services to achieve as much remotivation and reorientation as possible; and

(2) A resident whose assessment did not reveal a psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) Enteral feeding tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat alone or with assistance is not fed by an enteral feeding tube unless the resident's clinical condition demonstrates that use of such a tube was unavoidable; and

(2) A resident who is fed by an enteral feeding tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

(h) Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.
(i) Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections;
(2) Parenteral and enteral fluids;
(3) Colostomy, ureterostomy or ileostomy care;
(4) Tracheostomy care;
(5) Tracheal suctioning;
(6) Respiratory care;
(7) Podiatric care; and
(8) Prostheses.

(1) Drug Therapy. (1) Unnecessary drugs. Each resident's drug regimen shall include only those medications prescribed to treat a specific documented illness or condition and not otherwise contraindicated for a given resident. The drug regimen shall be monitored for evidence of both adverse actions and therapeutic effect. Dose changes or discontinuation of the drug must be made if the drug is ineffective and/or is causing disabling or harmful side effects and/or the condition for which it was prescribed has resolved.

(2) Psychotropic Drugs. Based on a comprehensive assessment of a resident and consistent with the provisions of subdivision (a) of section 415.4 of this Part, the facility shall ensure that:

(i) the use of psychotropic drugs shall:

(a) meet all conditions of paragraph (1) of this subdivision;

(b) be ordered by a physician who, in accordance with generally accepted standards of care and services, specifies the problem for which the drug is prescribed;

(c) be used, except in emergencies, only as an integral part of a resident's comprehensive care plan and only after alternative methods for treating the condition or symptoms have been tried and have failed; and

(d) be discontinued if harmful effects of the medication outweigh the beneficial effects of the drug.
(ii) residents who use psychotropic drugs receive gradual dose reductions, drug holidays or behavioral programming, unless clinically contraindicated, in an effort to discontinue these drugs and assist the resident to attain and maintain optimum physical and emotional functioning.

(m) Medication Errors. The facility shall ensure that:

(1) It is free of significant medication error rates; and

(2) Residents are free of any significant medication errors.
415.13 Nursing Services

The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility shall assure that each resident receives treatments, medications, diets and other health services in accordance with individual care plans.

(a) Sufficient staff. (1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Registered professional nurses or licensed practical nurses;

(ii) Certified nurse aides; and

(iii) Other nursing personnel.

(2) The facility shall designate a registered professional nurse or licensed practical nurse to serve as a charge nurse on each tour of duty who is responsible for the supervision of total nursing activities in the facility. Alternatively, as necessitated by resident care needs, the facility may designate one charge nurse for each tour of duty on each resident care unit or on proximate nursing care units in the facility provided that each nursing care unit in the facility is under the supervision of a charge nurse.

(b) Registered professional nurse. (1) The facility shall use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(2) The facility shall designate a registered professional nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) Nurse aide.

(1) For the purpose of this section and subdivision (d) of section 415.26 of this Part, nurse aide shall mean any person who provides direct personal resident care and services including, but not limited to, safety, comfort, personal hygiene or resident protection services under the supervision of a registered professional nurse or licensed practical nurse in the facility. Certification of such nurse aide shall be in accordance with the provisions of subdivision (d) of section 415.26 of this Part.

(2) Only individuals who meet the following qualifications may be assigned to perform nurse aide functions, as defined in paragraph (1) of this subdivision:
(i) a person listed in the New York State RHCF Nurse Aide Registry developed and maintained as set forth in Section 2803-j of the Public Health Law and as described in Section 415.31 of this Part.

(ii) a graduate of a nursing program approved by the New York State Commissioner of Education and who is waiting to take the next scheduled state licensing examination or is waiting for the results of such examination;

(iii) a nurse aide trainee who has successfully completed a State approved RHCF nurse aide training program as described in subdivision (d) of section 415.26 of this Part or a program designed for such purpose and approved by the State Commissioner of Education and who is waiting to take the RHCF clinical skills and written nurse aide competency examinations at the next scheduled opportunity, such competency examination to be passed within three consecutive attempts within 4 months of completion of the State approved RHCF nurse aide training program and waiting for the official results of the examination;

(iv) a nurse aide trainee who has taken the competency examinations and is waiting for the official results of the examination;

(v) a certified nurse aide who is currently listed in another state's nursing home nurse aide registry, as verified by the facility, and who has applied to the Department to obtain State certification and has not been denied; and

(vi) a nurse aide trainee provided the individual is concurrently enrolled in a State approved residential health care facility nurse aide training program which meets all requirements set forth in this section and completes such program within ninety (90) days of employment, in accordance with the following:

(a) the nurse aide trainee may assume specific duties involving direct resident care and services as training and successful demonstration of competencies in the specific duties/skills are completed, but not before completing at least sixteen (16) hours of classroom instructions in the following areas:

(1) communication and interpersonal skills;
(2) infection control;
(3) safety/emergency procedures;
(4) promoting residents' independence;
(5) respecting residents' rights; and
(6) resident abuse, mistreatment and neglect reporting requirements as set forth in Section 2803-d of the Public Health Law; and

(b) The nurse aide trainee shall be under the direct supervision of a nurse when the trainee is providing direct resident care or services and identifiable as a nurse aide trainee.
Dietary Services. The facility shall provide each resident with a nourishing, palatable well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(a) Direction. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis who shall be responsible for the nutrition services in the nursing home.

(1) The facility shall designate a qualified dietitian or a dietetic service supervisor qualified on the basis of education, formal training and experience in food service management to serve as the director of food service. Such formal training shall include but not be limited to food production, budgeting, sanitation, menu writing, recordkeeping, employee interviewing and supervision.

(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, and experience in identification of dietary needs, planning and implementation of dietary programs.

(b) Sufficient staff. The facility shall employ sufficient professional and support personnel competent to carry out the functions of the dietary service.

(1) The availability of qualified dietitian services shall be related to the number of beds in the nursing homes, the amount and type of dietary supervision required, and the complexity of resident needs and additional full or part-time qualified dietitians shall be utilized commensurate with such factors. Each resident's nutritional care shall be under the direction of a qualified dietitian.

(2) The facility utilizes one or more dietetic service supervisors with consultation by a qualified dietitian to manage the food service in the absence of the qualified dietitian.

(c) Menus and nutritional adequacy.

(1) Menus shall meet the nutritional needs of residents in accordance with dietary allowances that meet generally recognized standards of care and shall take into account the cultural background and food habits of residents.

(i) The facility shall have an effective means of recording and transmitting to the food service diet orders and changes; and

(ii) The facility shall maintain a current list of residents identified by name, location and diet order and such identification shall accompany each resident's meal when it is served.

(2) Menus shall be prepared in advance in accordance with a diet manual acceptable to the medical, nursing and dietary services and retained for one year from the date of serving; and

(3) Menus shall be followed.
(d) Food. Each resident shall receive and the facility shall provide:

1. Food prepared by methods that conserve nutritive value, flavor and appearances;
2. Food that is palatable, attractive, and at the proper temperature;
3. Food prepared in a form designed to meet individual needs; and
4. Substitutes offered of similar nutritive value to residents who refuse food served.

(e) Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician, when indicated, based on the findings of the comprehensive resident assessment.

(f) Frequency of meals. (1) Each resident receives and the facility provides at least three substantial meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in paragraph (4) of this subdivision.

(3) The facility shall offer snacks at bedtime daily.

(4) If a nourishing snack as determined by a qualified dietitian in accordance with generally accepted standards of care, is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day provided that a resident group agrees to this meal span and a nourishing snack is served.

(g) Assistive devices. The facility shall provide assistance with eating and special eating equipment and utensils for residents who need them.

(h) Sanitary conditions. The facility shall store, prepare, distribute and serve food under sanitary conditions; and in accordance with the sanitary requirements of Part 14 (Service Food Establishments) of Chapter I (State Sanitary Code) of this Title.

(i) Kosher food. The facility shall provide, as part of the basic services, kosher food or food products prepared in accordance with the Hebrew orthodox religious requirements when the resident, as a matter of religious belief, desires to observe Jewish dietary laws; and shall

1. establish a plan and procedure for obtaining, preparing and serving kosher foods and food products in accordance with Hebrew Orthodox religious requirements;
2. incorporate the provision of kosher food and food products prepared in accordance with Hebrew orthodox religious requirements into the resident's comprehensive care plan; and
(3) assure that employees who are involved with such plan of care are trained in the procedures that satisfy Hebrew orthodox dietary requirements.
415.15 Medical Services. The nursing home shall develop and implement medical services to meet the needs of its residents.

(a) Medical director. The facility shall designate a full-time or part-time physician to serve as medical director. The medical director shall be responsible for:

(1) Implementation of resident medical care policies;

(2) The coordination of physician services and medical care in the facility;

(3) Coordinating the review, prior to granting or renewing professional privileges or association, of any physician, dentist or podiatrist as required by Public Health Law Section 2805-j. Hospital-based nursing homes may utilize the hospital’s medical staff membership review system to facilitate this review. Such review shall be coordinated with the activities of the Quality Assessment and Assurance Committee established in section 415.27 of this Part and shall:

(i) provide for the maintenance and continuous collection of information concerning the facility's experience with negative health care outcomes and incidents injurious to residents, resident grievances, professional liability premiums, settlements, awards, costs incurred by the facility for resident injury prevention and safety improvement activities;

(ii) periodically reconsider the credentials, physical and mental capacity and competency in delivery of health care services of all physicians, dentists or podiatrists who are employed or associated with the facility;

(iii) gather information concerning individual physicians, dentists and podiatrists within the individual physician's, dentist's or podiatrist's personnel file maintained by the facility; and

(iv) prior to renewal of privileges of physicians dentists, or podiatrists, solicit and consider information provided by the Resident Council about each such practitioner; and

(4) assuring that each resident's physician attends to the resident's medical needs, participate in care planning, follows the schedule of visits maintained in accordance with subdivision (b) of this section, and complies with facility policies. When a physician fails to provide services which meet generally accepted standards of practice, the medical director shall take necessary corrective measures and refer the matter to the Office of Professional Medical Conduct of the Department as appropriate.

(b) Physician services. The facility shall ensure that a physician personally approves a recommendation that an individual be admitted to a nursing home. Each resident shall remain under the care of a physician and shall be provided care that meets prevailing standards of medical care and services.
(1) Physician supervision. The facility shall ensure that:

(i) The medical care of each resident is supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs; and

(ii) Another physician supervises the medical care of residents when the resident's attending physician is unavailable.

(2) Physician visits and responsibilities. The facility shall ensure that the responsible physician:

(i) participates as a member of the interdisciplinary care team in the development and review of the resident's comprehensive care plan;

(ii) visits the resident whenever the resident's medical condition warrants medical attention and establishes and maintains a schedule of visits appropriate to the resident's medical condition. The frequency of visits shall be no less often than once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter;

(iii) reviews the resident's total program of care, including medications and treatments, at each regularly scheduled visit;

(iv) prepares, authenticates and dates progress notes at each visit;

(v) Authenticates all orders;

(vi) provides residents and designated representatives with his or her name, office address and telephone number and responds to calls from residents to discuss the resident's medical care;

(vii) participates in facility training programs to familiarize him or herself with State regulations and facility policies; and

(viii) is informed of the results of all Department of Health surveys related to medical service deficiencies and is involved in resolving such problems.

(ix) At the option of the physician and the facility, scheduled visits after the initial visit may alternate between personal visits by the responsible physician and visits by a registered physician's assistant or certified nurse practitioner in accordance with paragraph (4) of this subdivision.

(3) Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(4) Physician delegation of tasks. (i) Except as specified in subparagraph (ii) of this paragraph, a facility may permit a physician to delegate tasks to a registered physician's assistant or certified nurse practitioner who:
(a) Meets the applicable requirements of Part 94 of this Title or is certified as a nurse practitioner, respectively;

(b) Is acting within the scope of practice as defined by State law; and

(c) Is under the supervision of the physician.

(ii) The facility shall not permit a physician to delegate a task when the regulations specify that the physician must perform it personally or when the delegation is prohibited by the facility's own policies.
415.16 Rehabilitative services. Facilities shall provide or obtain rehabilitative services such as audiology, speech therapy, speech-language pathology, and occupational therapy to every resident it admits in accordance with the resident's comprehensive plan of care to obtain or maintain the highest practicable physical well-being in accordance with generally accepted standards of rehabilitative care and services.

(a) Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the facility shall:

(1) Provide the required services; or

(2) Obtain the required services from an outside resource, in accordance with Section 400.4 of this Title, who is a provider of specialized rehabilitative services.

(b) Qualifications. Specialized rehabilitative services shall be provided by qualified personnel pursuant to the written order of a physician.

(c) Organization. The facility shall designate an occupational therapist, physical therapist and speech-pathologist to assist the facility in the development and implementation, in cooperation with nursing and medical services, of written policies and procedures for rehabilitative services within the facility which:

(1) establish restorative and maintenance rehabilitation as components of inter-disciplinary resident care planning and treatment;

(2) establish a system of determining rehabilitative goals for each resident based on the resident's need relative to his or her physical and mental level of functioning, the overall plan of care for the resident and the resident preferences. These treatment goals shall range on a continuum, progressing from all specialized restorative rehabilitative services to routine maintenance rehabilitation; and

(3) establish a system to monitor the maintenance of optimum levels of functioning for those residents who have been discharged from a formal rehabilitative program and who are on a maintenance program primarily provided by nursing staff on the floor.
415.17 Dental services. The facility shall provide oral hygiene care and routine and 24-hour emergency dental care in accordance with the comprehensive resident care plan and which meets generally accepted standards of dental and dental hygiene care and services.

(a) Organization. The facility shall appoint a licensed and currently registered dentist to assist the facility in the development and implementation, in cooperation with nursing and medical services, of written dental service and oral hygiene policies and procedures which:

(1) establish oral hygiene and dental care as components of interdisciplinary resident care planning and treatment;

(2) develop an oral hygiene program to be jointly administered by nursing, dental and dental hygiene staff;

(3) set forth in detail how emergency care to alleviate pain, infection, or swelling and routine dental services are to be provided and the specific arrangements with dentist(s) who are to provide these services; and

(4) establish a system of determining dental treatment goals for each resident based on the resident's need relative to his or her physical and mental level of functioning, the overall plan of care for the resident and the resident's preferences. These treatment goals shall range on a continuum, progressing from all essential dental services to only routine oral hygiene services and emergency services. The decision to defer treatment of identified dental conditions shall be documented based on physical or mental contraindications for care and the resident's informed choice.

(b) Admission. An initial screening of each resident's oral health status shall be conducted within 48 hours of admission to determine the need for emergency care to alleviate pain, infection, or swelling. The presence and functioning of any oral prostheses shall be observed, and, with the resident's consent, the prostheses shall be indelibly marked for identification.

(c) Oral Examination and Treatment. A complete oral examination of each resident shall be conducted by a licensed and currently registered dentist or dental hygienist within 7 days following completion of the initial comprehensive assessment in accordance with Section 415.11 of this Part and by a dentist at least annually thereafter. Based on treatment priorities determined at each time of examination, an individual plan of continuing oral hygiene and dental care meeting generally accepted standards of dental and dental hygiene care and services shall be established, or updated, and carried out for each resident. If treatment by a dentist is needed, such treatment shall begin within 30 days of the examination. This shall include arrangements for transportation when the services of a provider outside the facility are required.

(d) Records. The admission dental record and records of all subsequent dental care shall be maintained as part of the resident clinical record.
415.18 Pharmacy Services. (a) The facility shall provide pharmaceutical services and develop and implement policies and procedures that assure the accurate acquisition, receipt, dispensing and administering of all drugs and biologicals required to meet the needs of each resident. The facility shall provide routine and emergency drugs and biologicals directly to its residents, or obtain them under a contract as described in section 400.4 of Part 400 of this Subchapter. The facility shall be licensed under Article 33 of the Public Health Law and Part 80 of this Title.

(b) Service consultation. The facility shall employ or obtain the services of a registered pharmacist who:

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled consistent with the requirements of Article 33 of the Public Health Law and Part 80 of this Title.

(c) Drug regimen review. (1) The drug regimen of each resident shall be reviewed at least once a month by a registered pharmacist.

(2) The pharmacist shall report any irregularities to the medical director, attending physician, administrator or the director of nursing, or a combination of these, appropriate to the nature of the irregularity and these reports shall be acted upon promptly. The findings and corrective actions shall be regularly reviewed by the quality assessment and assurance committee established pursuant to section 415.27 of this Part.

(3) Psychotropic drugs may be administered only on the orders of a physician and only as part of a plan of care, developed in accordance with sections 415.4 and 415.11 of this Part, designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent external consultant reviews and advises the facility as to the appropriateness of the drug plan of each resident receiving such drug.

(d) Labeling of drugs and biologicals. The facility shall label drugs and biologicals in accordance with currently accepted standards of practice and include the appropriate accessory and cautionary instructions and the expiration date. Labeling of all medications shall be accordance with Article 137 of the State Education Law and 8 NYCRR Part 29. Facilities which use a unit dose drug distribution system shall develop and implement an appropriate method of providing accessory and cautionary instructions.

(e) Storage of drugs and biologicals. (1) The facility shall store all drugs and biologicals in locked compartments under proper temperature controls, and permit access only to authorized personnel.
(2) The facility shall provide separately locked, permanently affixed, compartments for storage of controlled drugs and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Storage of controlled substances shall be in accordance with Article 33 of the Public Health Law and Part 80 of this Title.

(3) Poisons and medications for "external use only" shall be kept in a locked cabinet and separate from other medications; and

(4) Medications whose shelf life has expired or which are otherwise no longer in use shall be disposed of or destroyed in accordance with State and Federal laws and regulations.

(f) Return of unused medications. (1) When services are provided by a cooperating vendor pharmacy, the facility shall establish policies and procedures which permit either the staff registered pharmacist or consultant registered pharmacist to return to the vendor pharmacy from which it was purchased any unused medications or drug products, provided such medication is sealed in unopened, individually packaged, units and within the recommended period of shelf life for the purpose of redispensing and which are in accord with the following provisions:

(i) Drug products which may be returned are limited to:

(a) oral and parenteral medication in single-dose hermetically sealed containers; and
(b) parenteral medication in multiple-dose hermetically sealed containers from which no doses have been withdrawn.

(ii) The drug products returned show no obvious sign of deterioration.

(iii) Drug products packaged in manufacturer's unit-dose packages may be returned for redispensing provided that they are redispensed in time for use before the expiration date, if any, indicated on the package.

(iv) Drug products repackaged by the pharmacy into unit-dose or multiple-dose "blister packs" may be returned for redispensing provided that:

(a) the date on which the drug product was repackaged, its lot number and expiration date are indicated clearly on the package;
(b) not more than 90 days have elapsed from the date of the repackaging;
(c) a repackaging log is maintained by the pharmacy in the case of drug products repackaged in advance of immediate needs.

(v) "Blister packs". (a) Partially used "blister packs" may be redispensed only as returned.
(b) Partially used "blister packs" may not be emptied and repackaged.
(c) Additional units of medication may not be added to partially used "blister packs".

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(vi) No drug product dispensed in bulk in a dispensing container may be returned.

(vii) No medication or drug product defined as a controlled substance in section 3306 of the Public Health Law may be returned.

(2) The vendor pharmacy to which such drug products are returned shall reimburse or credit the nursing home or purchaser of such drug products for the unused medication that is restocked and redispensed and shall not otherwise charge any individual resident or the State, if a resident is a recipient or beneficiary of a State-funded program, for unused medication or drug products returned for reimbursement or credit.

(g) Emergency medications. The facility shall ensure the provision of an emergency medication kit(s) as follows:

(1) The contents of each kit shall be approved by the medical director, pharmacist and director of nursing.

(2) Controlled substances shall be prohibited in emergency kits.

(3) The medication contents of each kit shall be limited to injectables except that the kit may also include:

(i) sublingual nitroglycerin; and

(ii) up to five noninjectable, prepackaged medications, not to exceed a 24-hour supply, which are the same noninjectable, prepackaged medications in all emergency kits throughout the facility.

(4) Each kit shall be kept and secured within or near the nurses’ station.

(h) Medications for leaves. Medication shall be released to discharged residents or to a resident going on temporary leave. The medication supply in the facility may be used to supply the medications needed for a temporary leave of absence.

(i) Verbal orders. All medications administered to residents shall be ordered in writing by a legally authorized practitioner unless unusual circumstances justify a verbal order, in which case the verbal order shall be given to a licensed nurse, or to a licensed pharmacist, immediately reduced to writing, authenticated by the nurse or registered pharmacist and countersigned by the prescriber within 48 hours. In the event a verbal order is not signed by the prescriber or a designated alternate physician within 48 hours, the order shall be terminated and the facility shall ensure that the resident’s medication needs are promptly evaluated by the medical director or another legally authorized prescribing practitioner.
415.19 Infection Control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

(a) Infection control program. The facility shall establish an infection control program with written policies and procedures under which it:

(1) Investigates, controls and takes action to prevent infections in the facility;

(2) Determines what procedures such as isolation and universal precautions should be utilized for an individual resident and implements the appropriate procedures; and

(3) Maintains a record of incidence and corrective actions related to infections.

(b) Preventing spread of infection. (1) When the infection control program determines that isolation is needed to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall assure that all equipment and supplies are cleaned and properly sterilized where necessary and are stored in a manner that will not violate the integrity of the sterilization.

(3) The facility shall prohibit persons, including but not limited to, staff, volunteers, and visitors known to have a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(4) The facility shall require physicians and staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

(c) Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

(d) Reporting. The facility shall report increased incidence of infections, including nosocomial infections as defined in Section 2.2 of this Title, to the appropriate area office of the Office of Health Systems Management and shall report, immediately, the presence of any communicable disease as defined in section 2.1 of Part 2 of this Title to the city, county or district health officer.

(e) Notice to Funeral Director. If, at the time of death, a resident was diagnosed as having a specific communicable disease designated in Part 2 of this Title or an infectious disease, including but not limited to AIDS or HIV positive status, a written report of such disease shall accompany the body when it is released to the funeral director or his or her agent.
Laboratory and Blood Bank  (a) Approved laboratory or blood bank. The facility shall provide for blood and laboratory services to meet the needs of its residents, pursuant to orders by authorized licensed practitioners, and shall be responsible for the quality and timeliness of such services:

(1) by promptly performing such services as the facility is licensed to provide directly under Subparts 58-1 and 58-2 of this Title, as appropriate, and is certified to perform by the Medicare program; and

(2) by promptly arranging for an approved blood bank or laboratory services to perform such services as the facility may require, but not provide. Such services shall be obtained from entities approved under Subparts 58-2 and 58-2 of this Title, as appropriate, which are certified by the Medicare program to provide such services.

(b) Transportation. The facility shall assist the resident in making transportation arrangements to and from the source of laboratory or blood bank service, if the resident needs assistance.

(c) Records. The facility shall ensure that authenticated and dated reports of clinical laboratory and blood bank services are placed in the resident's clinical record.
415.21 Radiology and Other Diagnostic Services. (a) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents pursuant to an order by an appropriate practitioner. The facility is responsible for the quality and timeliness of such services.

(1) The facility shall promptly perform such services as the facility is licensed to provide directly under Part 16 of this Title. The services shall be provided in accordance with generally recognized standards of care and services.

(i) The diagnostic radiology and other diagnostic services shall be free from hazards for residents and staff.

(ii) Personnel. A qualified full-time, part-time, or consulting physician, who is qualified by education and experience in radiology, shall supervise the ionizing radiology services and shall interpret those tests that are determined by the governing body, and the medical director, to require such physician's specialized knowledge. Upon recommendation of such qualified physician, the medical director shall designate the practitioners and staff, in accordance with Part 89 of this Title, who may use the radiologic equipment, administer procedures and interpret test results.

(iii) Records. Records of diagnostic radiologic services shall be maintained.

(a) The practitioner who performs radiology services shall prepare and authenticate reports of his or her interpretations.

(b) The facility shall maintain for at least six years or three years after a resident who is a minor reaches the age of majority (18) films, scans, and other image records which have not been incorporated into the resident's clinical record.

(2) The facility shall promptly arrange for ordered radiology and other diagnostic services which the facility is not licensed to provide. Such services shall be obtained from entities approved under Part 16 of this Title and which are certified by the Medicare program.

(b) The facility shall:

(1) Promptly notify the ordering practitioner of the results of radiologic and other diagnostic services.

(2) Assist the resident, if needed, with transportation arrangements to and from the source of services.

(3) File in the resident's clinical record authenticated and dated reports of diagnostic radiology and other diagnostic services.
415.22 Clinical Records. (a) The facility shall maintain clinical records for each resident in accordance with accepted professional standards and practice. The records shall be:

(1) Complete;

(2) Accurately documented;

(3) Readily accessible; and

(4) Systematically organized.

(b) Clinical records shall be retained for six years from the date of discharge or death or for residents who are minors, for three years after the resident reaches the age of majority (18).

(c) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

(1) Transfer to another health care institution;

(2) Law;

(3) Third party payment contract; or

(4) The resident.

(e) The facility shall:

(1) Permit each resident to inspect his or her records on request; and

(2) Provide copies of the record to each resident no later than 48 hours after a written request from a resident or such greater period as state statute may permit, at a photocopying cost not to exceed the cost of production incurred by the provider.

(f) The clinical record shall contain:

(1) sufficient information to identify the resident;

(2) A record of the resident's assessments;

(3) The plan of care and services provided;

(4) The results of any preadmission screening conducted by the State;

(5) Progress notes by all practitioners and professional staff caring for the resident; and
(6) Reports of all diagnostic tests and results of treatments and procedures ordered for the resident.
415.26 Organization and Administration.

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(a) Administration
(b) Governing Body
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A nursing home shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(a) Administration. (1) No nursing home shall operate unless it is under the supervision of an administrator who holds a currently valid nursing home administrator's license and registration, or temporary license, issued pursuant to article 28-D of the Public Health Law. The administrator shall set an example for all staff members, consultants and others affiliated with the facility which recognizes that the institution exists to serve the interests of and the needs of the residents, which emphasizes the importance of a resident's right to independence regarding all aspects of institutional life and encourages residents to participate together with staff in resolving conflicts and problems which frequently arise in a group residential setting. The administrator shall:

(i) be readily accessible to residents and staff for consultations;

(ii) involve the Resident Council in addressing the need to seek compromises between conflicting resident and staff interests and needs;

(iii) encourage professional and respectful behavior on the part of the staff toward residents; and

(iv) seek to involve staff at all levels in developing and implementing an interdisciplinary approach to resident services, in order to better serve the individual and group interests of residents.

(2) Administrator Coverage

(i) Nursing homes with 41 or more beds shall employ a full-time administrator.

(ii) Nursing homes with 40 beds or less shall designate in writing a licensed and registered administrator for an amount of time in accordance with the following:
(a) In no event shall an administrator be employed for fewer than twelve hours per week; such hours to be served during normal business hours of 7:00 a.m. to 5:30 p.m. Monday thru Friday.

(b) The Department may require employment greater than 12 hours per week based on:

(1) the size of the facility;

(2) the history and nature of any operating deficiencies; and

(3) any investigations or other problems brought to the attention of the Commissioner.

(iii) The governing body shall designate in writing a staff member to serve as acting administrator for all hours that the primary administrator is absent from duty to ensure that all shifts, 24 hours-a-day, 7 days-a-week are covered by administrative supervision.

(iv) No person whose license to practice nursing home administration has been forfeited, revoked, annulled or suspended shall be involved in the administration and direction of a nursing home either on a full-time, part-time or acting basis.

(3) When, by reason of death, resignation, incapacity, illness or other reason, the nursing home does not have a licensed and currently registered nursing home administrator capable of carrying out such functions, the governing body shall immediately notify the commissioner, assign such duties to a named individual acceptable to the commissioner in accordance with that individual's training, experience and prior record of work performance at the nursing home, and provide for supervision of the nursing home by a licensed and currently registered nursing home administrator in accordance with the following:

(i) A plan for the supervision of the unlicensed acting nursing home administrator shall be submitted to the Department which provides that:

(a) The nursing home is making a bonafide effort to recruit a licensed and registered nursing home administrator;

(b) There is no other licensed and registered person in the facility available, capable and willing to accept the position;

(c) The supervising administrator will provide a minimum of four hours of on-site supervision weekly unless the Department determines that more hours are necessary based on:

(1) the quality of care in the facility

(2) the qualifications of the unlicensed acting administrator; and

(3) the on-site presence of qualified administrative staff.

(ii) The unlicensed acting administrator shall serve for a maximum of three months except that the nursing home may request and receive
from the Department one additional three month extension upon a finding that the unlicensed acting administrator has performed his or her duties effectively and that the quality of resident care and services has not deteriorated.

(iii) If the unlicensed acting administrator becomes temporarily licensed under Public Health Law Section 2896-f during the period of service identified in subparagraph (ii) of this paragraph, the individual shall be eligible to serve an additional six months without additional supervision.

(4) In addition to the other responsibilities delineated herein, the administrator shall:

(i) report to the governing body at regular intervals;

(ii) implement the policies of the nursing home by making operating decisions, including but not limited to general supervision, employing and discharging of staff, programming and, where appropriate, integrating the services of the nursing home with the community's health resources;

(iii) assure that the residents' council:

(a) meets as often as the membership deems necessary;

(b) is directed by the residents and is chaired by a resident or another person elected by the membership; and

(c) may meet with any member of the supervisory staff provided that reasonable notice of the council's request is given to such staff;

(iv) agree to assign a staff person in consultation with the Resident Council, acceptable to such Council, to act as advisor or coordinator, to facilitate the Council in holding regular meetings and to assist members in carrying out Council activities, including obtaining necessary information to become informed of facility policies, exploring the solutions to problems and conveying to the administrator issues and suggestions which require administrative action;

(v) assure that any complaints, problems or issues reported by the council to the designated staff person or administration are addressed; and that a written report addressing the problem, issues or suggestions is sent to the council when requested; and

(vi) assure that except in extraordinary circumstances such as health emergencies, the facility has visiting hours encompassing at least 10 hours within a 24 hour period, including at least two meal periods, and that a statement as to the visiting hours is posted in a public place such as the main lobby or the residents' dining room.

(5) The facility shall provide such secretarial, accounting, receptionist and other supportive personnel, and such office equipment and supplies, as are needed for satisfactory administration of the nursing home.
(b) Governing Body. The nursing home shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body shall:

(1) appoint an administrator who is eligible for such appointment and who functions in accordance with subdivision (a) of this section;

(2) determine and establish written policies consistent with the stated purposes of the facility, the program of services provided, its physical structure and equipment, the number and qualifications of staff members, and their job classifications and descriptions;

(3) be responsible for the operation of the facility;

(4) be responsible for providing or arranging services for residents as required in this Subchapter;

(5) employ or otherwise arrange for the services of such personnel as are required in this Subchapter;

(6) assure that a method is implemented to promptly deal with complaints and recommendations made by residents or designated representatives which:

(i) enables complaints and recommendations to be made orally or put in writing;

(ii) brings complaints and recommendations promptly to the attention of the administration for review and resolution;

(iii) responds to all residents or designated representatives as to action taken or the reason why no action was taken, as soon as possible and except under extraordinary circumstances such as health or administrative emergencies, within 21 days after the complaint or recommendation was made; and

(iv) provides for review and evaluation of the effectiveness of the complaint process;

(7) assure that the complaint and recommendation method is made known to:

(i) all residents upon admission and their designated representatives; and

(ii) all nursing, social service and other appropriate personnel, in order to assist residents who want to make a complaint or recommendation;

(8) assure that the facility establishes a residents' council;

(9) be responsible for compliance with all provisions of this Subchapter;
(10)(i) post in a public place a notice supplied by the New York State Department of Health containing:

(a) the time and date the facility shall assess residents to determine case mix intensity, pursuant to section 86-2.30 of this Title; and

(b) department auditors will be in the facility to review the data submitted by the facility in the patient review instrument for the current assessment period; and

(c) a statement that each resident and/or the resident's designated representative has the right to know the specific assignment to a patient classification category; and

(d) the person within the facility to contact for this information.

(ii) notify the resident and/or the resident's designated representative according to the following procedures, that a process exists for reimbursement purposes to assign residents to a patient classification category as contained in Appendix 13-A of this Title entitled "Patient Categories and Case Mix Indices Under Resource Utilization Group (RUG-II) Classification System":

(a) upon admission to the facility, at the initial resident assessment required pursuant to section 415.11 of this Part a designated professional staff member shall inform the resident and/or resident's designated representative of this process and that further information on the classification system is available upon request; and

(b) the process by which residents are classified for reimbursement purposes into the RUG-II classification system shall be, at least annually, an item for discussion on the agenda at a resident council as required by paragraph (8) of this subdivision;

(11) furnish for the staff telephone services consisting of at least one operational, unlocked, noncoin telephone installation on each floor of the facility, for the use of professional staff in the performance of their duties;

(12) permit activities related only to the operation of the facility except that the operator, subject to prior written approval of the commissioner, may, where such arrangement will not result in any diminishment of resident care or services, or adversely affect the cost of delivering nursing home services;

(i) enter into a written contract for the purpose of leasing unneeded space and equipment on the premises of the facility to a health care practitioner licensed by the State Education Department, or to a provider licensed under the Public Health Law, Mental Hygiene Law, or Social Services Law to provide health care services to residents or nonresidents, where such arrangements will also promote needed health care services for residents; or
(ii) prepare food for consumption off-site as part of a nutrition program or make available service of meals, nutrition education, and nutrition counseling for nonresidents on-site;

(13) notify the department immediately of anticipated or actual termination of any service vital to the continued safe operation of the facility or to the health and safety of its residents and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, contract food, or contract laundry services, and the services of key full- or part-time personnel such as the administrator, director of nurses, consultant physician, consultant dietitian or others; and apply remedial measures promptly and notify the department immediately regarding the nature of results of such measures;

(14) transfer residents to another appropriate facility only after consultation, as appropriate, with the resident, his or her physician, and designated representative except in an emergency situation, in which case the operator shall notify the physician and designated representative immediately and record the reason for the transfer; and

(15) ensure that members of the governing body make themselves available to hold meetings with representatives of the Resident Council at least 3 times a year to discuss matters contained in a jointly developed agenda.

(c) Staff qualifications and personnel management. The nursing home shall employ on a full time, part time or consultant basis a sufficient number of professional staff members who are educated, oriented and qualified to carry out the provisions of this Part and to assure the health, safety, proper care and treatment of the residents.

(1) With regard to personnel management, the facility shall:

(i) provide personnel in accordance with paragraph (2) of this subdivision, with a planned orientation to nursing home operation and resident care and such on-the-job training as is necessary for each properly to perform his or her individual job assignments:

(ii) have on file and furnish each employee with a copy of written policies governing conditions of employment, including the job description for his or her position;

(iii) assure that each part-time, full-time or private duty employee, consultant, volunteer, or other person serving in any other capacity in the nursing home shall:

(a) receive an orientation which shall include but not be limited to the following:

(1) a review and explanation of relevant personnel policies and procedures, including his or her job description;

(2) an orientation to the facility's organization, its long-term care philosophy, the roles of all personnel in the organization;
(3) an orientation to the physical plant, infection control, quality assessment and assurance and the environmental aspects of the facility;

(4) the facility safety program, including fire safety, accident prevention, resident emergency procedures, and facility operation during disruption of services;

(5) resident's rights; and

(6) resident abuse and neglect reporting requirements as set forth in section 2803-d of the Public Health Law.

(b) be on duty, alert and appropriately dressed during the entire tour of duty, part-time assignment, consultation visit, volunteer work, private duty or other employment in the nursing home;

(c) maintain personal cleanliness and hygiene; and

(d) conduct himself or herself in a professionally acceptable manner with all residents, employees and guests, including refraining from abusive, immoral or other unacceptable conduct, behavior or language and demonstrating respect for each resident's dignity in full recognition of his or her individuality;

(iv) assign each employee duties consistent with his or her job description and with his or her level of competence, education, preparation and experience; and

(v) develop and implement policies and procedures which require:

(a) the provision for a physical examination and recorded medical history for all personnel including all employees, members of the medical and dental staff and volunteers whose activities are such that a health impairment would pose a risk to residents or personnel. The examination shall be of sufficient scope to ensure that, consistent with federal and state statutes prohibiting discrimination on the basis of disability or handicap, no person shall assume his/her duties unless he/she is free from a health impairment that would present a risk to the resident which cannot be reasonably accommodated, or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. The nursing home is required to provide such examination without cost for all employees. The nursing home shall require the following of all personnel as a condition of employment or affiliation:

(1) a ppd (Mantoux) skin test for tuberculosis prior to employment or affiliation and no less than every two years thereafter for negative findings. Positive findings shall require appropriate clinical follow-up but no repeat skin test; and

(2) a stool examination and/or culture for enteric pathogens, as may be required by the local board of health;
(b) the reassessment of the health status of all personnel as frequently as necessary, but no less than annually, to ensure that personnel are free from health impairments which pose a risk to residents or personnel which cannot be reasonably accommodated or which may interfere with the performance of duties;

c) that all personnel report immediately to their supervisor or the administrator any signs or symptoms of personal illness. All personnel making such report shall be referred to an appropriate health care professional for assessment of the risk to residents and personnel. Based on this assessment, the nursing home shall authorize appropriate measures to be taken, including but not limited to removal, reassignment or return to duty;

(2) For all personnel, the facility shall provide planned orientation and staff development programs, including but not limited to:

(i) an orientation for each new employee prior to or within one week of employment;

(ii) on-the-job skill training as is necessary for each to properly perform his or her job;

(iii) continuous staff development programs to increase knowledge, skills and understanding of problems and ways of dealing with problems associated with residents needing nursing home care including knowledge of the Quality Assurance and Assessment program in the facility; and

(iv) maintenance of records of these activities, including the methods used and an evaluation on their effectiveness.

(3) For all personnel who provide services in the nursing home, for whom licensure, registration or certification is required, the facility shall obtain and retain verification of license number or certification with expiration date of same.

(4) For all services and departments, the facility shall maintain:

(i) an organization chart;

(ii) a master plan for staffing; and

(iii) policies and procedure manuals.

(d) Nurse aide Certification and Training. (1) Definitions. The following terms used in this section shall be defined as follows:

(i) Nurse aide training program coordinator shall mean a person who is assigned the administrative responsibility and accountability for the RHCF nurse aide training program. The program coordinator (PC) shall be a registered professional nurse with at least two years experience in a nursing home and demonstrated competency to teach adult learners as evidenced and documented by at least one of the following:
(1) completion of the State approved 24 hour train-the-trainer program;

(2) three years of experience teaching nursing or nursing related programs to adults in an academic setting approved by the State Education Department or other recognized accrediting body; or

(3) two years of experience teaching nurse aides in a residential health care facility, and has developed and implemented a RHCF Nurse Aide Training Program which has been approved by the Department with no contingencies in a facility that has had no uncorrected deficiencies and no repeat deficiencies in the applicable areas of nursing (24 hour nursing services, rehabilitative nursing care, and supervision of patient nutrition) and the resident rights within the past three years, and has maintained an examination success rate of aides completing the program that is higher than one standard deviation below the mean.

(ii) Primary Instructor shall mean the person who is assigned the educational responsibility for the nursing home nurse aide training program. This person shall have the day to day responsibility for implementing the facility's training program in accordance with the facility's policies and procedures and State and federal requirements. The primary instructor (PI) shall be a registered professional nurse with at least one year of experience in a nursing home who has demonstrated ability to teach adult learners as evidenced and documented by at least one of the following:

(1) completion of the State approved 24 hour train-the-trainer program;

(2) three years of experience teaching nursing or nursing related programs to adults in an academic setting approved by the State Education Department or other recognized accrediting body; or

(3) two years of experience teaching nurse aides in a residential health care facility, and has developed and implemented a RHCF Nurse Aide Training Program which has been approved by the Department with no contingencies in a facility that has had no uncorrected deficiencies and no repeat deficiencies in the applicable areas of nursing (24 hour nursing services, rehabilitative nursing care, and supervision of patient nutrition) and resident rights within the past three years, and has maintained an examination success rate of aides completing the program that is higher than one standard deviation below the mean.

(iii) Clinical skills evaluator shall mean a person who administers the state authorized residential health care facility nurse aide clinical skills competency examination. This person shall be a registered professional nurse who either meets the qualifications of the PC or PI and has completed the 4 hour State approved clinical evaluator program or has 2 years of nursing home experience and has completed the 4 hour State approved clinical evaluator program.

(2) Nurse aide certification. In order to obtain nurse aide certification and be listed in the New York State RHCF Nurse Aide Registry as described in Section 415.31 of this Part, an individual must complete a State approved residential health care facility nurse aide
training program as described in paragraph (2) of this subdivision and pass the State authorized clinical skills competency examination and written or oral competency examination as described in paragraph (3) of this subdivision. The residential health care facility nurse aide training program shall be reviewed by the Department as to the requirements contained in this section:

(i) and approved or disapproved at the time of inception;
(ii) on-site within one year of inception; and
(iii) at least every two years thereafter.

(3) Nurse aide training program. The training program shall be supervised by a Program Coordinator who meets the definition specified in subparagraph (i) of paragraph (1) of this subdivision and conducted by the Primary Instructor who meets the definition specified in subparagraph (ii) of paragraph (1) of this subdivision. The program coordinator may be the director of nursing provided that the responsibilities of such director are covered full-time by a designated nurse.

(i) The nurse aide training program shall include classroom and clinical training which enhances both skills and knowledge and, when combined, shall be of at least 100 hours' duration. The clinical training shall as a minimum include at least 30 hours of supervised practical experience in a nursing home. The nurse aide training program shall include stated goals, objectives, and measurable performance criteria specific to the curriculum subject material, the resident population and the purpose of the facility, and shall be consistent with the curriculum outlined below. This curriculum shall be taught at a fourth (4th) to sixth (6th) grade English literacy level. Facilities with special populations shall supplement the curriculum to address the needs of such populations accordingly. The curriculum shall otherwise include but not be limited to the following:

(a) Normal aging:
   (1) anatomical changes;
   (2) physiological changes;
   (3) psychosocial aspects:
      (i) role changes;
      (ii) cultural changes;
      (iii) spiritual needs; and
   (iv) psychological and cognitive changes; and
   (5) concept of wellness and rehabilitation.

(b) Psychological needs of the resident:
   (1) adjustment to institutional living;
   (2) working with resident and family during admission/transfer/discharge;
   (3) residents' rights:

   (i) respect and dignity;
   (ii) confidentiality;
   (iii) privacy; and

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(iv) self-determination; and
(4) sexual adjustments in relation to illness, physical handicaps
and institutional living.

(c) Communication in health care facilities:

(1) relating to residents, families, visitors, and staff;
(2) methods of communication in overcoming the barriers of language
and cultural differences; and
(3) communicating with residents who have sensory loss, memory
and perceptual impairment.

(d) Personal care needs:

(1) care of the skin, mouth, hair, ears and nails; and
(2) dressing and grooming.

(e) Resident unit and equipment:

(1) bed-making; and
(2) care of personal belongings such as clothing, dentures,
eyeglasses, hearing aids and protheses.

(f) Nutritional needs:

(1) basic nutritional requirements for foods and fluids;
(2) special diets;
(3) meal services;
(4) assistance with eating:

(i) use of adaptive equipment; and
(ii) feeding the resident who needs assistance; and

(5) measuring and recording fluid and food intake.

(g) Elimination needs:

(1) physiology of bowel and bladder continence:

(i) maintaining bowel regularity; and

(2) nursing care for the resident with urinary and/or bowel
incontinence:

(i) toileting programs;
(ii) care of urinary drainage equipment;
(iii) use of protective clothing; and
(iv) enemas;

(3) measuring urinary output;
(4) bowel and bladder training programs; and
(5) care of ostomies, including but not limited to colostomy and
ileostomy.
(h) Mobility needs:

(1) effects of immobility; and
(2) ambulation and transfer techniques:

(i) use of assistive devices;
(ii) use of wheelchairs; and
(iii) use of mechanical lifters.

(i) Sleep and rest needs:

(1) activity, exercise and rest; and
(2) sleep patterns and disturbances.

(j) Nursing care programs for the prevention of contractures and decubitus ulcers (pressure sores):

(1) body alignment, turning and positioning;
(2) individualized exercise programs;
(3) special skin care procedures;
(4) use of special aids; and
(5) maintenance of individualized range of motion.

(k) Observing and reporting signs and symptoms of disability and illness:

(1) physical signs and symptoms:

(i) determination of temperature, pulse, respiration;
(ii) testing urine;
(iii) measuring height and weight;

(2) behavioral changes; and
(3) recognizing and reporting abnormal signs and symptoms of common diseases and conditions, including but not limited to:

(i) shortness of breath;
(ii) rapid respirations;
(iii) coughs;
(iv) chills;
(v) pain and pains in chest or abdomen;
(vi) blue color to lips;
(vii) nausea;
(viii) vomiting;
(ix) drowsiness;
(x) excessive thirst;
(xi) sweating;
(xii) pus;
(xiii) blood or sediment in urine;
(xiv) difficult or painful urination;
(xv) foul-smelling or concentrated urine; and
(xvi) urinary frequency.

(l) Infection control:
(c) Resident safety:

1. environmental hazards;
2. smoking;
3. oxygen safety; and
4. use of restraints.

(m) Nursing care needs of resident with special needs due to medical conditions such as but not limited to:

1. stroke;
2. respiratory problems;
3. seizure disorders;
4. cardiovascular disorders;
5. sensory loss and deficits;
6. pain management;
7. mentally impairing conditions:
   i. associated behavior disorders; and
   ii. characteristics of residents such as wandering, agitation, physical and verbal abuse, sleep disorders, and appetite changes.

(n) Mental health and social service needs:

1. self care according to the resident's capabilities;
2. modifying behavior in response to the behavior of others;
3. developmental tasks associated with the aging process; and
4. utilizing the resident's family as a source of emotional support.

(g) Resident rights; and

(g) Care of the dying resident including care of the body and personal effects after death.

(ii) The training program shall maintain a performance record of the major duties and skills taught each nurse aide trainee. At the end of the training program, a copy of the performance record is to be given to the trainee and the trainee's employer, if different from the training facility. As a minimum, the performance record shall include the following:

(a) a listing of the measurable performance criteria for each duty and skill expected to be learned in the program;
(b) an entry showing satisfactory or unsatisfactory performance;
(c) the date of the performance; and
(d) the name of the instructor supervising the performance.

(4) Nurse aide competency evaluation. Subsequent to the completion of the nurse aide training program and the satisfactory performance of all duties and skills listed in the performance record, the nurse aide
(5) The operator shall not charge a fee to any individual for the costs of training, including textbooks and materials, or for the costs of the competency examinations.

(6) Nurse aide recertification. The certified nurse aide shall be recertified every two years no later than the last day of the month in which certification was received. To obtain recertification the certified nurse aide shall demonstrate in the form indicated by the Department that he/she has worked for compensation as a residential health care facility nurse aide during the previous 24 month period. In addition, if there is any continuous period of 24 consecutive months during which the certified nurse aide did not provide nurse aide care for compensation in a residential health care facility, such nurse aide shall be required to requalify to be listed in the New York State RHCF Nurse Aide Registry.

(7) Subsequent to completion of the nurse aide training program, the nurse aide trainee and certified nurse aide shall attend inservice education programs as provided for all personnel.

(i) Written records shall be maintained which indicate the content of and attendance at each inservice training program; and

(ii) Each nurse aide trainee and certified nurse aide shall attend and be compensated for at least 12 hours of inservice education in every six month period.

(e) Use of Outside Resources. If the nursing home does not employ a qualified professional person to furnish a specific service to be provided by the facility, the nursing home shall have that service furnished to residents by a qualified person or agency outside the facility in accordance with the following:

(1) The operator shall enter into written agreement with the outside resource which shall comply with the provisions of this section and section 400.4 of this Title and shall:

(i) specify that the operator retains professional and administrative responsibility for obtaining services that meet
professional standards and principles that apply to professionals providing services in such a facility;

(iii) require that such services are provided on a timely basis;

(iii) set forth the responsibilities, function, objectives and terms of the agreement, including financial arrangements and charges of each such outside resource; and

(iv) be signed by an authorized representative of the facility and the person or the agency providing the service; and

(2) The outside resource, when acting as a consultant, shall apprise the administrator of recommendations, plans for implementation and continuing assessment in his or her areas of responsibility through dated, signed reports which shall be retained by the administrator for follow-up action and evaluation of performance.

(f) Disaster and Emergency Preparedness.

(1) The nursing home shall have a written plan, updated at least twice a year, with procedures to be followed for the proper care of residents and personnel, and for the reception and treatment of mass casualty victims, in the event of an internal or external emergency resulting from natural or man-made causes including but not limited to earthquake, severe weather, flood, bomb threat, chemical spills, strike, interruption of utility services, nuclear accidents, fire or similar occurrences.

(2) The nursing home shall develop and implement written policies concerning missing residents.

(3) The nursing home shall:

(i) train all employees in emergency procedures when they begin to work for the facility;

(ii) periodically, but at least annually review the written plan with existing staff; and

(iii) carry out staff drills in accordance with the written plan at least twice a year.

(g) Transfer Agreements. Nursing homes shall have in effect a written transfer agreement with one or more general hospitals as required to meet the medical care needs of residents. Such transfer agreements shall:

(1) comply with the provisions of section 400.9 of this Title;

(2) ensure that residents are admitted to the general hospital on a timely basis when such transfer is medically appropriate as determined by the attending physician or other approved practitioner; and
(3) provide for the transfer of medical and other information needed for care and treatment of residents, when the transferring facility deems it appropriate.

(h) Financial Policies

(1) The facility shall:

(i) specify its refund policies in writing to each resident, next of kin and/or sponsor prior to admission; and

(ii) refund promptly any amount or proportion of prepayment in excess of the amount or proportion thereof obligated for services already furnished in the event the resident leaves the nursing home prior to the end of the prepayment period for reasons beyond the control of the resident, next or kin and/or sponsor. In the event that the resident leaves for reasons within his or her control, or that of the next of kin and/or sponsor, the facility shall not retain from the prepayment or charge in the absence of a prepayment, an amount in excess of one day's basic rate in addition to any amount obligated for services already furnished.

(2) The facility shall not enter into any contract or agreement with the resident, next of kin and/or sponsor for life care of the resident.

(3) No facility or agent, consultant, employee or representative thereof shall:

(i) pay any commission, bonus, rebate or gratuity to any organization, agency, physician, employee or other person for referral of any resident to the nursing home;

(ii) request and/or accept any remuneration, tip or gratuity in any form from a resident, next of kin and/or sponsor for any services provided or arranged or for denial of services by the nursing home other than specified fees ordinarily paid for care, excluding donations, gifts and legacies given in behalf of the facility; or

(iii) accept any remuneration, rebate, gift, benefit or advantage of any form from any vendor or other supplier because of the purchase, rental or loan of equipment, supplies or services for the facility or resident, excluding normal business practices.

(4) In the event that the operator of the facility and the consulting physician or any other professional provider of services are one and the same person, he or she shall not reimburse himself or herself as consultant for such services provided to the facility or directly to any resident other than for services provided in an emergency.

(5) If a resident authorizes the facility in writing to manage his or her personal finances in accordance with 415.3(g)(1) of this Part, the facility shall hold, safeguard, manage and account for personal funds of the resident deposited with the facility in accordance with the following:
(i) Deposit of funds.

(a) Funds in excess of $50. The facility shall deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's account to his or her account.

(b) Funds less than $50. The facility shall maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account or petty cash fund.

(ii) Accounting and records. The facility shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system shall contain, as a minimum, the resident's name, Medicaid case number where applicable, date of admission, date and amount of each withdrawal or deposit, and balance at each transaction.

(a) The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(b) The individual financial record shall be available within one business day of a request, to the resident or his or her designated representative.

(c) The individual financial record shall document each deposit or withdrawal of funds including the signature of the resident or the resident's designated representative for each transaction.

(iii) Notice of certain balances. The facility shall notify the resident when the amount in the account of a resident who receives Medicaid benefits reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Social Security Act, and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, should reach the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI;

(iv) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey promptly the resident's funds, and a final accounting of those funds, to the individual administering the resident's estate.

(v) Assurance of financial security. The facility shall purchase a surety bond, or provide self-insurance, to assure the security of all personal funds of residents deposited with the facility.

(vi) Limitation on charges to personal funds. The facility shall not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The
facility may charge the resident for requested services that are more expensive than or in excess of covered services.

(a) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, the facilities shall not charge a resident for the following items and services:

1. Nursing services and specialized rehabilitative services.
2. Dietary services.
3. An activities program.
4. Room/bed maintenance services.
5. Routine personal hygiene items and services.

(b) Optional covered items and services. A facility may choose to provide residents with supplies, equipment and transportation essential to the activities program required by 415.5(g) of this Title. If it chooses to provide these items and services, they shall be included as covered Medicare or Medicaid services and reimbursed under those program benefits. No charges shall be made to residents for those services.

(c) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident and payment is not made by Medicare or Medicaid:

1. Telephone.
2. Television/radio for personal use.
3. Personal comfort items, including smoking materials, notions and novelties, and confections.
4. Cosmetic and grooming items and services, in excess of those for which payment is made under Medicaid or Medicare.
5. Personal clothing.
6. Personal reading matter.
7. Gifts purchased on behalf of a resident.
8. Flowers and plants.
9. Social events and entertainment offered off the premises and outside the scope of the activities program, provided under subdivision (g) of section 415.5.
10. Noncovered special care services such as private duty nurses consistent with Medicare and Medicaid rules and regulations for residents who are beneficiaries of these programs.
(11) Private room, except when therapeutically required (for example, isolation for infection control).

(12) Specially prepared or alternative food requested instead of the food generally prepared by the facility, if it is documented that the requested food costs more than food provided to other residents, except that food provided under paragraph (7) of subdivision (f) of section 415.3 of this Title shall not be charged to residents' funds.

(d) Requests for items and services.

(1) The facility shall not charge a resident or his or her designated representative for any item or service not requested by the resident or the designated representative.

(2) The facility shall not require a resident or his or her designated representative to request any item or service as a condition of admission or continued stay.

(3) The facility shall inform the resident or his or her designated representative requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(6) The facility shall:

(i) upon receiving prepayment or advance money for the purpose of being applied to payments in satisfaction of or as security for the performance of facility responsibilities, deposit such money, which shall continue to be the money of the person making the prepayment, in an interest-bearing account in a bank or with a financial agent;

(ii) not be required to deposit prepayment in an interest-bearing account where such money is to be applied to payments when due, until 61 days after such prepayment or advanced money is made;

(iii) notify in writing each of the persons making such prepayment of the name and address of the bank or financial agent with which the deposit is made and the amount of such deposit.

(iv) be entitled to receive an administrative expense equivalent to one percent per annum upon the prepayment money deposited, which shall be in lieu of all other administrative expenses;

(v) inform any person making prepayment as security for the performance of facility responsibilities that waivers of the provisions of this paragraph are void.

(7) Equity withdrawal. No facility or governing body may withdraw or reduce a facility's equity so as to create or increase a negative net worth by means of a withdrawal without the prior approval of the commissioner.

(i) The term withdrawal shall mean:
(a) any payment of cash or transfer of other assets by a facility directly or indirectly to or for the benefit of its operator or owner; and

(b) any liability or contingent liability incurred within any period of 12 consecutive months by a facility or its operator by reason of a mortgage, lease, borrowing or other transaction relating to such facility that exceeds, in the aggregate, $25,000.

(ii) Negative net worth shall be calculated without regard to any surplus created by reevaluation of assets.

(iii) An application for approval shall be submitted in writing at least 60 days prior to the proposed withdrawal and shall specify the purpose of the withdrawal and the details concerning such withdrawal including, where applicable, such items as the principal amount, interest rate, repayment terms, conditions of default, remedies upon default and obligee of any transaction to be consummated in a proposed withdrawal. The application shall contain a verified current balance sheet and a description of the facility's cash position, including as cash such cash equivalents as certificates of deposit and treasury bills.

(iv) In reviewing an application for withdrawal, the commissioner shall consider:

(a) the necessity for the withdrawal;

(b) whether such withdrawal would impair the facility's ability to render quality care;

(c) any expense which such withdrawal would generate; and

(d) the financial condition of the facility in general.

(8) No facility shall enter into a real property mortgage or lease transaction without 30 days' prior notice in writing to the commissioner.

(i) Admission Policies and Practices.

(1) The nursing home shall:

(i) admit a resident only on physician's orders and in accordance with the resident assessment criteria and standards as promulgated and published by the department, and specified in sections 86-2.30(i) and 400.12 of this Title, which shall include, as a minimum:

(a) an assessment, performed prior to admission by or on behalf of the agency or person seeking admission for the resident of the resident's level of care needs according to the resident assessment criteria and standards promulgated and published by the department (and specified in sections 86-2.30(i) and 400.12 of this Title);

(b) for those residents failing to meet the criteria and standards for admission to the nursing home (as indicated in New York State
criteria for level of care, specified in section 400.12 of this Title), a certification signed by a physician member of the transferring facility's utilization review agent or signed by the responsible social services district's local Medicaid medical director or designee, indicating the reason(s) the resident requires nursing home level of care; and

(c) for residents in general hospitals and residing in the community, the SCREEN, as specified in section 400.12 of this Title, performed prior to admission to the nursing home shall not be completed by personnel of a residential health care facility, except where a certified home health agency or other appropriate community-based assessor has been contacted by the resident or the resident's designated representative, for the purpose of completing the SCREEN, and has not completed the SCREEN within 48 hours;

(ii) accept and retain only those nursing home residents for whom it can provide adequate care;

(iii) admit each resident only after a pre-admission personal interview with the resident's physician, the resident, his or her next of kin and/or sponsor, as appropriate, except that a telephone interview may be substituted when a personal interview is not feasible, and a summary of all interviews shall be recorded on the resident's chart or other appropriate record;

(iv) maintain a written record of all financial arrangements with the resident, his or her next of kin and/or sponsor, with copies executed by and furnished to each party;

(v) make no arrangement for prepayment for basic services exceeding three months;

(vi) assess no additional charges, expenses or other financial liabilities in excess of the daily, weekly or monthly basic rate except:

(a) upon express written approval and authority of the resident, next of kin or sponsor;

(b) upon express written orders of the resident's personal, alternate or staff physician stipulating specific services and supplies not included as basic services;

(c) upon 30 days' prior written notice to the resident or designated representative, of additional charges, expenses or other financial liabilities due to the increased cost of maintenance and/or operation of the nursing home; and, upon request of the resident, designated representative or of the department, financial and statistical supportive evidence sufficient to reflect such change in economic status shall be provided; or

(d) in the event of a health emergency involving the resident and requiring immediate special services of supplies to be furnished during the period of the emergency;
(vii) provide to each resident or designated representative at the time of admission, a written copy of the following information and services which shall be considered as basic information and services to be made available to all residents:

(a) the daily, weekly or monthly rate;

(b) board, including therapeutic or modified diets, as prescribed by a physician;

(c) lodging; a clean, healthful, sheltered environment, properly outfitted;

(d) 24 hours-per-day nursing care;

(e) the use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of nursing home residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;

(f) fresh bed linen, as required, changed at least twice weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents;

(g) hospital gowns or pajamas as required by the clinical condition of the resident, unless the resident, next of kin or sponsor elects to furnish them, and laundry services for these and other launderable personal clothing items;

(h) general household medicine cabinet supplies, including but not limited to non-prescription medications, materials for routine skin care, oral hygiene, care of hair, and so forth, except when specific items are medically indicated and prescribed for exceptional use for a specific resident;

(i) assistance and/or supervision, when required, with activities of daily living, including but not limited to toilet, bathing, feeding and ambulation assistance;

(j) services, in the daily performance of their assigned duties, by members of the nursing home staff concerned with resident care;

(k) use of customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such item is prescribed by a physician for regular and sole use by a specific patient;

(l) activities program, including but not limited to a planned schedule of recreational, motivational, social and other activities, together with the necessary materials and supplies to make the resident’s life more meaningful;

(m) social services as needed;
(g) physical therapy, on either a staff or fee-for-service basis, as prescribed by a physician, administered by or under the direct supervision of a licensed and currently registered physical therapist;

(g) occupational therapy, on either a staff or fee-for-service basis, as prescribed by a physician, administered by or under the supervision of a qualified occupational therapist;

(g) speech pathology services, on either a staff or fee-for-service basis, as prescribed by a physician, administered by a qualified speech pathologist;

(g) audiology services, on either a staff or fee-for-service basis, as prescribed by a physician, administered by a qualified audiologist; and

(r) dental services, on either a staff or fee-for-service basis, as administered by or under either the personal or general supervision of a licensed and currently registered dentist;

(viii) apply the following restrictions to the admission and retention of residents:

(a) residents under 16 years of age shall be admitted only to a nursing home area approved for such occupancy by the department and separate and apart from adult residents;

(b) prenatal, intrapartum or postpartum, and maternity patients shall not be admitted;

(c) residents identified and assessed to need nursing home care shall not be barred from admission or retention solely on the basis that they are also maintained on alcohol or substance abuse treatment programs; and

(d) a resident suffering from a communicable disease shall not be admitted or retained unless a physician certifies in writing that transmissibility is negligible, and poses no danger to other residents, or the facility is staffed and equipped to manage such cases without endangering the health of other residents;

(ix) not discriminate because of race, color, blindness, sexual preference or sponsorship in admission, retention and care of residents;

(x) establish and implement written policies and procedures governing the admission process which ensure compliance with State and Federal anti-discrimination laws which apply to the governing body. Such laws include, but need not be limited to, the applicable provisions of this Part; Public Health Law, section 2801-a(9); the New York State Civil Rights Law, sections 40 and 40-c; article 15 (Human Rights Law) of the State Executive Law, sections 291, 292 and 296 and title 42 of the Unites States Code, sections 1981, 2000a, 2000a-2, 2000d, 3602, 3604 and 3607. Copies of the cited State and Federal statues are available from West Publishing Company, P.O. Box No. 64526, St. Paul, MN 55164-0526, the publisher of McKinney's Consolidated Laws of New York.
annotated and the United States Code annotated. Copies of such statues are also available for public inspection and copying at the Records Access Office, Department of Health, Tower Building, Empire State Plaza, Albany, NY 12237. The policies and procedures shall include but not be limited to the following:

(a) the prominent inclusion in admission application forms and policy statements of a legend summarizing the applicable Federal and State anti-discrimination laws;

(b) the prominent display in the admissions office of the New York State Division of Human Rights nondiscrimination regulatory poster. This poster is available from the State Division of Human Rights, 55 West 125 Street, New York, NY 10027. A copy of this poster is also available for public inspection and copying at the Department of Health's Records Access Office at the address set forth above.

(c) explicit advice to potential patients of their right to nondiscriminatory treatment in admissions;

(d) the training of admission personnel in the requirements of Federal and State anti-discrimination laws listed above; and

(e) written admission policies which specifically state the criteria used in making admission decisions. If a waiting list is used in making admission decisions, the list shall be maintained in written form including the date of each application. The operation and utilization of the waiting list shall be described in the written admission policies;

(xi) furnish to all hospitals within the long-term care planning area and to any hospital, referral agency, or individual upon request a copy of the facility's admission policies; and

(xii) maintain a centralized log on the receipt and disposition by the facility of persons referred for admission. For the purposes of this subdivision, receipt by the facility of a completed hospital/community patient review instrument for a person needing nursing home care shall constitute a patient referral. The log shall contain for each referral a patient identifier, and indicate the race, sex, color, national origin of the referral, the date of referral, referring hospital or agency, and date and type of disposition of referral by the facility. Records of such log shall be retained for 18 months from date of entry. In lieu of a log, a facility may meet the requirements of this subdivision by retaining the completed hospital/community patient review instrument forms received by the facility for 18 months from receipt in a central place organized by date of receipt and marked by date and type of disposition.

(2) The nursing home shall advise each potential resident or designated representative prior to or at the time of admission, that all medical and dental services which are provided by the facility will be provided by practitioners who have an affiliation with the facility. Potential residents whose personal attending physician or dentist is not approved to provide services to the resident after admission shall be duly notified prior to or at the time of admission. The facility
shall promptly receive and evaluate requests by such personal attending physician or dentist, to be approved to attend to such prospective resident consistent with resident care policies and procedures of the facility.

(3) The nursing home shall advise each potential resident or designated representative that he or she may seek a second opinion if he or she disagrees with the diagnosis or treatment being provided, and may call in a specialist selected by the resident or designated representative for medical consultation. The facility shall not be required to bear the expense of such visit.

(j) Misappropriation of Resident Property. The nursing home shall establish and implement policies and procedures for the receipt, review and investigation of allegations of misappropriation of resident property by individuals in the employ of and/or whose services are utilized by the facility. Such policies and procedures shall be coordinated with the process governing the handling of complaints as set forth in section 415.3 of this Part.

(1) For purposes of this subdivision, misappropriation of resident property shall mean the theft, unauthorized use or removal, embezzlement or intentional destruction of the resident's personal property including but not limited to money, clothing, furniture, appliances, jewelry, works of art, and such other possessions and articles belonging to the resident regardless of monetary value.

(2) In accordance with policies and procedures governing misappropriation of resident property, the nursing home shall:

(i) ensure that upon receipt of an allegation of misappropriation as submitted by the resident, designated representative, other individual or source, an investigation of the matter shall be undertaken not later than 48 hours after receipt;

(ii) maintain a log containing information regarding the receipt, review, investigation, and disposition of every allegation of misappropriation of resident's property including the name of the complainant and the resident, a description of the personal property involved, and staff designated to conduct the review and investigation;

(iii) notify the resident and complainant in writing as to the findings upon disposition of the allegation;

(iv) notify the appropriate police agency when the results of the investigation indicate there is reasonable cause to believe that a resident's personal property valued at more than two hundred fifty (250) dollars has been misappropriated or may elect to make such notification when the resident's personal property is valued at less than that amount;

(v) monitor the status of all referrals to a police agency on a regular basis but not less often than quarterly; and
(vi) notify the Department within 72 hours of receipt of the notice that such referral resulted in conviction of an individual who was involved in misappropriation of resident property.

(3) Upon receipt of such notice of conviction involving misappropriation of property by a nurse aide and after the department has provided to the individual an opportunity to be heard to dispute the allegations and conviction resulting from misappropriation of resident property, the department shall, pursuant to Public Health Law Section 2803-d, as amended by Chapter 717 of the Laws of 1989, report such finding to the New York State RHCF Nurse Aide Registry established in accordance with Public Health Law, Section 2803-d, as amended by such chapter. Any brief statement not exceeding 150 words by the nurse aide disputing the findings shall also be included in the report, provided that any such statement containing the names of any resident or complainant shall be returned to the submitting individual and shall not be reported to the registry.
Quality Assessment & Assurance

The facility shall establish and maintain a coordinated quality assessment and assurance program which integrates the review activities of all nursing home programs and services to enhance the quality of life and resident care and treatment.

(a) Facility-wide quality assurance. Quality assurance shall be the responsibility of all staff, at every level, at all times. Supervisory personnel alone cannot ensure quality of care and services. Such quality must be a part of each individual's approach to his or her daily responsibilities.

(b) Quality assessment and assurance committee. The facility shall maintain a quality assessment and assurance committee consisting of at least the following:

1. the administrator or his or her designee;
2. the director of nursing services;
3. a physician designated by the facility;
4. at least one member of the governing body who is not otherwise affiliated with the nursing home in an employment or contractual capacity; and
5. at least 3 other members of the facility's staff.

(c) Committee functions. The quality assessment and assurance committee shall:

1. meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary;
2. have a written plan for the quality assessment and assurance program which describes the program's objectives, organization, responsibilities of all participants, scope of the program and procedures for overseeing the effectiveness of monitoring, assessing and problem-solving activities. Such plan shall also provide for the development and implementation of quality improvement initiatives designed to advance the quality of life, care and services in the facility;
3. define methods for identification and selection of clinical and administrative problems to be reviewed. The process shall include but not be limited to:
   i. the establishment of review criteria developed in accordance with current standards of professional practice for monitoring and assessing resident care and clinical performance;
   ii. regularly scheduled reviews of clinical records, resident complaints and suggestions, reported incidents and other documents pertinent to problem identification;
   iii. consultation on at least a quarterly basis with the Resident Council to seek recommendations on quality improvements;
(iv) documentation of all quality assessment and assurance activities, including but not limited to the findings, recommendations and actions taken to resolve identified problems; and

(v) the timely implementation of corrective actions and periodic assessments of the results of such actions.

(4) ensure that the outcomes of quality assurance reviews are shared with appropriate staff to be used for the revision or development of facility policies and practices and in granting or renewing staff privileges, as appropriate;

(5) facilitate participation in the program by administrative staff and health-care professionals representing each professional service provided;

(6) report its activities, findings and recommendations to the governing body as often as necessary, but no less often than 4 times a year; and

(7) participate with the medical director in implementing Public Health Law 2805-j.
Disclosure of Ownership. The nursing home shall make available pertinent information concerning the identity of the owner and/or governing body and in addition shall:

(a) comply with the provisions of subdivision (b) of section 401.3 of this title regarding any proposed changes in the name of a business, corporation, partnership or governmental subdivision and any proposed initial use of, or change in, an assumed name of a business corporation, not-for-profit corporation, partnership, governmental subdivision or sole proprietor, operating a medical facility or fundraiser under Article 28 of the Public Health Law, or any proposed substitution of the individual or individuals constituting the governing body or owner of a proprietary medical facility or any proposed change in the rights, privileges or obligations of any such person;

(b) comply with the provisions of section 600.11 of this Title regarding Name Changes of Operators and Medical Facilities;

(c) Provide written notice to the Department, at the time of change, if a change occurs in the nursing home's administrator or director of nursing; and

(d) ensure that the notice provided in accordance with subdivision (c) of this section includes the identity of each new individual.
415.29 Physical Environment. The nursing home shall be designed, constructed, equipped and maintained to provide a safe, healthy, functional, sanitary and comfortable environment for residents, personnel and the public.

(a) Life safety from fire and other hazards. (1) Buildings and equipment shall be maintained and operated so as to prevent fire and other hazards to personal safety.

(2) Nursing homes shall comply with subdivision (a) of section 711.2 of this Title.

(3) The nursing home shall maintain a procedure to investigate fires. A written report of the investigation containing all pertinent information shall be made. The report shall remain on file for not less than six years.

(4) The nursing home shall maintain a procedure for reporting to a designated administrative officer on a standard form adopted for the purpose, all accidents to residents, staff, employees or visitors. The report shall include all pertinent information and shall be kept on file for not less than six years after the occurrence was reported.

(b) Equipment. The nursing home shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.

(c) Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents. The nursing home shall provide each resident with:

(1) A separate bed of proper size and height for the convenience of the resident;

(2) A clean, comfortable mattress;

(3) Bedding appropriate to the weather and climate; and

(4) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(d) Toilet, Handwashing and Bathing facilities. Plumbing and plumbing fixtures shall be properly maintained and operable.

(e) Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted;

(2) Be well ventilated, with smoking areas identified;

(3) Be adequately furnished; and

(4) Have sufficient space to accommodate all activities.
(f) Water supplies. Water supplies of nursing homes shall be operated in conformance with the following requirements:

(1) all water used in operation shall be provided from a public water supply or from an alternate source, in either event as approved by the department;

(2) no changes shall be made in the source or treatment of the water supply without approval of the department;

(3) water shall be adequate in volume and pressure for all medical purposes;

(4) the water system shall not be operated with physical connections to other piping systems or connections to fixtures that may permit contamination of the water supply;

(5) the water system shall be operated with a hot water system adequate for all medical purposes;

(6) the hot water supply used by residents or the public shall be regulated to maintain hot water temperature within the range of 90 degrees to 120 degrees F and

(7) the nursing home shall ensure that water is available to essential areas when there is a loss of normal water supply.

(g) Waste systems. Waste systems shall be operated so that all sewage and other liquid wastes are disposed of by connection to a public sewer system or by an alternate method, in either event as approved by the department.

(h) Ventilating, heating, and air conditioning systems. Such systems shall:

(1) be maintained in good repair and shall be operated in a manner which will not allow for the spread of infection and provide for resident health and comfort; and

(2) be maintained and operated in such manner that air shall not be circulated from resident isolation rooms, laboratories in which work is done in pathology, virology or bacteriology, autopsy rooms, kitchen and dishwashing areas, toilet and bath rooms, janitors' closets and soiled utility rooms or soiled linen rooms, to other parts of the facility.

(i) Grounds and building. Grounds and buildings shall be maintained:

(1) in a clean condition free of safety hazards;

(2) in such manner as will prevent standing water, flooding or leakage; and
Housekeeping.

(1) The entire nursing home, including but not limited to the floors, walls, windows, doors, ceilings, fixtures, equipment and furnishings, shall be clean. The facility shall be maintained in good repair including, but limited to buildings, utilities, fixed equipment, resident care equipment and furnishings.

(2) Responsibility for direct supervision of housekeeping service shall be assigned to a person, properly qualified by training and experience.

(3) Dusting, mopping and vacuum cleaning shall be done in a manner which will not spread dust or other particulate matter.

(4) Adequate supplies and equipment for housekeeping functions shall be provided with cleaning compounds and hazardous substances properly labeled and stored.

(5) The facility shall maintain an effective pest control program so that it is free of insects and rodents.

Waste

(i) Solid wastes, including garbage, rubbish and other refuse, biological wastes and infectious materials, shall be collected, stored and disposed of in a manner that will prevent the transmission of disease and not create a nuisance or fire hazard, nor provide a breeding place for insects or rodents.

(ii) Facilities shall manage regulated medical waste in accordance with the provisions of Part 70 of this Title.

Linen and Laundry. The nursing home shall:

(1) provide a sufficient quantity of clean linen to meet the requirements of residents; nursing homes shall maintain a linen inventory equal to at least three times the average daily census, and of this one-third shall be in use, one-third in laundry and one-third in reserve;

(2) maintain linen in proper condition for use, free from rips and tears;

(3) provide for satisfactory laundering of linens and other washable fabrics;

(4) handle, store and process laundry in a manner that will prevent the spread of infection and assure the maintenance of clean linen;

(5) wash all linen, including blankets, between resident use;
(6) bag or enclose all used linen in suitable containers within the resident care unit for transportation to the laundry;

(7) separately bag or enclose used linens from residents with a communicable disease in readily identifiable containers distinguishable from other laundry;

(8) properly maintain space and equipment for laundry storage and transportation;

(9) launder only in areas and with equipment properly maintained and approved for such purpose by the department;

(10) launder in a manner designed to prevent contamination of clean linen and to prevent infection; and

(11) transport clean linen in clean covered containers used exclusively for the purpose, and store clean linen in clean storage areas in a manner to prevent its contamination.

(1) Animals.

(1) No birds, turtles, dogs, cats or other animals, exclusive of those required for laboratory purposes, shall be allowed in a nursing home, except in a nursing home pet therapy program as permitted in paragraphs (2) and (3) of this subdivision. Guide dogs may accompany sightless persons.

(2) A nursing home may board one dog or one cat, provided that:

(i) the health, safety, welfare and rights of all residents on the unit are assured;

(ii) a staff member has been designated to be responsible for the care and management of the animal;

(iii) the animal is free from disease and has received all immunizations as recommended by a licensed veterinarian; and

(iv) the animal shall not be allowed in laundry, utensil storage or food preparation areas.

(3) Pet visitations are permitted in a nursing home provided that:

(i) the visit is prescheduled and approved by the facility;

(ii) the animal shall not be allowed in laundry, utensil storage or food preparation areas; and

(iii) the animal will at all times be accompanied by a person familiar with and capable of controlling the animal’s behavior.
415.30 General records. The nursing home shall maintain information necessary to permit the production of the following records immediately upon request and any other records required by the provisions of this Chapter:

(a) a chronological listing of residents admitted, by name, with identifying information and the place from which the resident is admitted or transferred;

(b) a chronological listing of residents discharged, by name, including the reason for discharge, adequate identifying information and the place to which the resident is discharge or transferred;

(c) a daily census record consisting of a summary report of the daily resident census with cumulative figures for each month and each year;

(d) a resident personal nonmedical record consisting of an appropriate record for each resident, including identification of next of kin, family and sponsor, all details of the referral and admission and nonmedical correspondence and papers concerning the resident;

(e) a general fiscal record for each resident, including copies of all agreements or contracts, account records, and a current inventory of personal property held in safekeeping;

(f) an accident and incident record which shall include a clear description of every accident and any other incident involving behavior of a resident or staff member that poses a threat to a resident or staff member, the resident's version of the accident or incident unless the resident objects or is unable to give a report due to his/her medical condition, names of individuals involved and a description of medical and other services provided, by whom such are provided, and the steps taken to prevent recurrence, with a copy of the resident's version as reported given to the resident and/or the resident's designated representative;

(g) personnel records for each employee, including the administrator, containing all available pre-employment information, orientation and full in-service record;

(h) personnel policies, including statements of all policies affecting personnel and a job description for each staff position;

(i) financial records which identify all income by source and describe all expenditures by category;

(j) records for nursing service administration, including:

(1) a nursing service organization chart;

(2) a master plan for staffing; and

(3) a nursing service policies and procedures manual;

(k) records for the dietary service, including:
(1) a plan for organization, management and day-to-day operation;
(2) a master plan and weekly work schedules for staffing;
(3) a current diet manual;
(4) written and dated menus for normal and therapeutic diets, as served; and
(5) receipted invoices for food and supplies;

(1) records for activities program, including:
(1) name and qualifications of the activities director;
(2) a current roster of residents participating in the program; and
(3) service policies and procedures.

(m) records for each specialized rehabilitative therapy service, including:
(1) service policies and procedures;
(2) a statistical summary, including but not limited to the frequency, type and duration of treatments given, number of residents treated and number of residents admitted and discharged from the service; and
(3) service budgets and equipment inventory.

(n) a record of staff medical policies, including any bylaws, rules and regulations adopted by the nursing home; and

(o) transfer or affiliation agreements consisting of all contracts, agreements, arrangements, understandings, and records of all efforts to establish same with hospitals, nursing homes, home health agencies, and other health institutions, agencies and services regarding the transfer of residents between the nursing home and such institutions or agencies.
415.31 New York State RHCF Nurse Aide Registry

(a) Content. The New York State RHCF Nurse Aide Registry shall include but not be limited to the following information concerning each certified nurse aide as applicable/appropriate:

1. full name of nurse aide, including maiden name and/or other surnames used;
2. address of nurse aide when certified/recertified;
3. date of birth;
4. social security number;
5. name and date of state approved training and competency program(s) successfully completed;
6. certification number of nurse aide with a descriptive modifier indicating how the nurse aide obtained certification;
7. most recent recertification date of nurse aide;
8. final findings of instances of resident abuse, mistreatment or neglect against a nurse aide with date of hearing or finding;
9. a record of criminal conviction for resident abuse, mistreatment, neglect or misappropriation of resident property against a nurse aide and the date of conviction; and
10. a statement by the nurse aide disputing the findings or conviction that may not exceed 150 words, nor contain information with identifies other persons.

(b) Fees. The New York State RHCF Nurse Aide Registry shall be supported and maintained by charging fees in accordance with Public Health Law Section 2803-j.

(c) Access. The New York State RHCF Nurse Aide Registry shall be accessible by telephone, during the hours established by the Department, or in writing.

(d) Obtaining information by telephone. The New York State RHCF Nurse Aide Registry shall provide the following information upon request to residential health care facilities, nurse aide agencies/employment organizations and nurse aide registries maintained by other states in response to a telephone inquiry:
1. Telephone verification that the individual is a certified nurse aide;
2. an indication of findings of resident abuse, mistreatment or neglect or criminal convictions of resident abuse, mistreatment, neglect or misappropriation of resident property by a nurse aide; and
(3) follow-up documentation as described in subdivision (e) of this section.

(e) Obtaining written information. New York State RHCF Nurse Aide Registry shall provide the following information upon the receipt of a written request, in accordance with the provisions of the Freedom of Information Law:

(1) verification that the individual is a certified nurse aide, the certification number and date of certification/recertification;

(2) copies of final findings of resident abuse, mistreatment or neglect by a nurse aide and a statement from the nurse aide disputing the findings, if any; and

(3) a report of a criminal conviction for resident abuse, mistreatment, neglect or misappropriation of resident property and the date of the conviction.
415.36 Long-term inpatient rehabilitation program for head-injured residents. (a) Definition. A head injury program shall mean a planned combination of services provided in a nursing home unit approved by the commissioner pursuant to Part 710 of this Title as a provider of specialized services for head-injured residents on a designated resident care unit of at least 20 beds. The head-injury program shall be designed specifically to serve medically stable, traumatically brain-injured individuals with an expected length of stay from 3 to 12 months. The program shall provide goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring the individual to the optimal level of physical, cognitive and behavioral functioning. The population served shall consist primarily of individuals with traumatically acquired, nondegenerative, structural brain damage resulting in residual deficits and disability. The program shall not admit or retain individuals who are determined to be a danger to self or others.

(b) General requirements. The nursing home shall ensure:

(1) the development and implementation of a planned and systematic program for monitoring and assessing the quality and appropriateness of resident care to assure care is provided in accordance with current standards of professional practice. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed with written documentation of such reviews. The process shall include but not be limited to reviews of clinical records, resident and family complaints and suggestions, incident reports and the resident's response to discharge plans. There shall be documentation that recommendations are followed up, action is taken to resolve identified problems and results of such action are assessed periodically;

(2) sufficient space, equipment and facilities are available to support the clinical, educational and administrative functions of the program in accordance with standards set forth in Parts 711 and 713 of this title;

(3) transfer agreements are in effect with other facilities, in accordance with section 400.9 of this Title for the acceptance of referrals or the transfer of head-injured residents in need of services not available at the facility;

(4) the development and consistent application of written admission and continued stay criteria for this service which include but are not limited to the use of a generally recognized classification system for measuring each individual's physical, affective, behavioral and cognitive level of functioning and the family's capabilities and functioning, and are consistent with the following requirements:

(ii) a resident admitted for long-term rehabilitation shall be a person who has suffered a traumatic brain injury with structural nondegenerative brain damage, is medically stable, is not in a persistent vegetative state, demonstrates potential for physical, behavioral and cognitive rehabilitation and may evidence moderate to severe behavior abnormalities. The resident must be capable of
exhibiting at least localized responses by reacting specifically but inconsistently to stimuli;

(ii) a resident admitted for coma management shall be a person who has suffered a traumatic brain injury with structural nondegenerative brain damage and is in a coma. The resident may be completely unresponsive to any stimuli or may exhibit a generalized response by reacting inconsistently and nonpurposefully to stimuli in a nonspecific manner; and

(iii) a resident who has diffuse brain damage cause by anoxia, toxic poisoning, cerebral vascular accident, or encephalitis may be admitted to this program if considered appropriate for coma management and long-term rehabilitation.

(5) records are maintained for at least two years identifying persons who were determined by the facility to be ineligible for admission under the head injury program. The records should indicate the reason for ineligibility and any referral action taken;

(6) inservice and continuing education programs which address the medical, physical, cognitive, psychosocial and behavioral needs of head injured residents are conducted on a regular basis for all personnel caring for such residents;

(7) educational programs are conducted for personnel not providing direct care but who come in contact on a regular basis with head-injured residents. The programs should familiarize personnel with the specific needs of these residents; and

(8) education and counseling services are available and offered to the residents and families as needed.

(c) Program management and staffing. There shall be distinct staffing for the direct care services in the head injury program unit.

(1) The program shall be administered by a program director who has at least two years of clinical or administrative experience in head injury rehabilitation programs. The program director has specific responsibilities which include but are not limited to:

(i) administrative direction and oversight of the program;

(ii) ongoing review of the program and implementation of program changes as identified; and

(iii) development and implementation of educational programs on an ongoing basis for staff working with head injured residents.

(2) A physician who has advanced training and experience in the care of the head injured shall be responsible for the medical direction and medical oversight of the head injury program.

(3) A qualified specialist in physical medicine and rehabilitation or a physician who has training and experience in the care and
rehabilitation of head injured patients or residents shall be responsible for the medical management of each resident.

(4) Head injury programs admitting and retaining residents who also require treatment for psychiatric disorders shall have on staff qualified specialists in psychiatry sufficient in number to meet the needs of these residents. A qualified specialist in psychiatry shall be designated to assist in the development and implementation of policies and procedures governing the provision of services for residents with psychiatric disorders, including criteria for transfer of such residents to an appropriate program which is licensed under the Mental Hygiene Law.

(5) A primary interdisciplinary team of health care professionals with special interest, training, experience and expertise in head injury rehabilitation shall be responsible for the assessment, coordinated program and care planning, and direct services for each head injured resident. The interdisciplinary team members shall be specifically assigned to serve head injured resident and the team shall include as a minimum the following types of health care professionals:

(i) physician;
(ii) registered professional nurse;
(iii) physical therapist;
(iv) occupational therapist;
(v) speech-language pathologist;
(vi) social worker;
(vii) dietitian;
(viii) therapeutic recreation specialist; and
(ix) clinical psychologist with at least one year of training in neuropsychology.

(6) Nursing services for the head injury unit shall be under the direction of a registered professional nurse with experience in the provision of rehabilitation nursing for head injured patients or residents.

(7) There shall be at least one registered professional nurse with experience in rehabilitation nursing assigned to each shift on the head injury unit.

(8) Consultative services of qualified specialists shall be available as needed to the head injury program in accordance with resident needs.

(9) Depending upon types of residents being served and individual resident's needs, the program shall provide or make formal arrangements for vocational rehabilitation services and special education services.
(d) Interdisciplinary care planning. (1) A member of the interdisciplinary team managing the resident shall be designated to:

(i) coordinate the overall plan of care and services and identify unmet needs for each resident including discharge and follow-up plans;

(ii) serve as a liaison among resident, family and staff to ensure that resident and family concerns are addressed; and

(iii) serve as a liaison with educational, social and vocational resources in the community which are serving the resident.

(2) A written, comprehensive care plan shall be developed and implemented which establishes rehabilitation goals for each resident. The plan shall be developed on admission by the interdisciplinary team and the attending physician in consultation with the resident, the resident's family and outside agencies, as necessary. The care plan shall be reviewed at least every 14 days and modified according to the resident's needs by the interdisciplinary team. The comprehensive care plan is based upon total and ongoing integrated, interdisciplinary assessments which shall address as a minimum, medical and neurological status, emotional and psychiatric status, nutritional status, the developmental needs of children and adolescents, sensorimotor capacity, cognitive, perceptual and communicative capacity, affect and mood, activities of daily living skills, educational or vocational capacities, sexuality issues and concerns, family counseling and community reintegration needs and recreation and leisure time interests.

(3) A written discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident's family, and as appropriate, any outside agency or resource that will be involved with the resident following discharge.

(4) The family and resident shall receive preparation for discharge through the facility's educational and counseling services.

(5) Provision shall be made by the facility for the follow-up of each resident after discharge to assess the resident's response to the discharge plan.

(e) Utilization review monitoring. The facility shall participate with the commissioner or his designee in a program of resident care and services monitoring which shall include but not be limited to review of admissions, care and services provided, continued stays, and discharge planning. The facility shall furnish such records and reports at such frequency as the commissioner or his designee may require and shall make available members of the interdisciplinary resident care team for case conferences as the commissioner or his designee deems necessary.
415.37 Services for residents with acquired immune deficiency syndrome (AIDS). (a) Applicability. (1) This section applies to a nursing home approved by the commissioner pursuant to Part 710 of this Title as a provider of specialized services for residents with AIDS. Such facility shall provide comprehensive and coordinated health services and programs in accordance with the requirements set forth in this section and this Part, unless a contrary requirement is contained in this section.

(2) For purposes of these regulations, AIDS shall mean acquired immune deficiency syndrome and other human immunodeficiency virus (HIV) related illness.

(3) Freestanding nursing homes of 40 beds or less, approved by the commissioner pursuant to Part 710 of this Title, which are designated solely for the care and management of persons with AIDS, and where such persons are ambulant and would benefit from the support and services provided by a facility providing an intermediate level of care, shall be governed by the provisions of Part 422 and, where Part 422 is silent, this Part. For the purposes of this section, ambulant resident shall mean a person who has the ability to walk on level surfaces and to negotiate stairs and ramps independent of human assistance or supervision, using the following mechanical devices or aids when necessary; prosthesis, brace, cane or handrail.

(b) General requirements. The nursing home shall ensure that:

(1) the facility is staffed and equipped to manage the care and treatment of residents with AIDS requiring nursing home care;

(2) a written agreement exists between the facility and a designated AIDS center for the provision of case management services for each resident. The commissioner may waive the requirement that case management services be provided by a designated AIDS center if the facility presents to the department an alternative plan which adequately meets the case management needs of its residents;

(3) a written transfer agreement exists with a designated AIDS center or other hospital for the transfer of residents in need of emergency or acute inpatient care services;

(4) special services are provided to residents in need thereof. Such special services shall include, as a minimum, substance abuse services, mental health services and pastoral counseling. These special services may be provided directly by the facility or through a formal arrangement;

(5) a written, comprehensive care plan is developed and implemented for each resident by an interdisciplinary team of health-care professionals in coordination with the case manager and in consultation with the resident or the resident's legal representative. The interdisciplinary team shall include health-care professionals as appropriate to the needs of the AIDS resident, but as a minimum shall include the attending physician, a registered professional nurse and a social worker. The resident care plan is reviewed at least every month by the interdisciplinary team and modified as necessary;
(6) in-service and continuing education programs, which address the medical, psychological, social problems and care needs specific to persons with AIDS, are conducted for all nursing home personnel on a regular basis but not less than every three months. A record of the programs attended shall be maintained for each employee;

(7) staff counseling and supportive services are made available to personnel to address problems related to the care of persons with AIDS; and

(8) as part of the facility's infection control program, infection control policies and procedures specific to AIDS are developed and implemented.

(c) Staffing requirements. The nursing home shall ensure that:

(1) specialty oversight of the AIDS program, including the development of policies and procedures, is provided by a physician who has experience in the care and clinical management of persons with AIDS;

(2) the health care of each resident is under the continuing supervision of an attending physician who sees and evaluates the resident whenever necessary;

(i) Physician visits for residents who are assessed as requiring a skilled level of nursing care shall not be less frequent than once per week; and

(ii) Physician visits for residents who are assessed as requiring an intermediate level of nursing care based on their ambulant status and other relevant medical factors, shall not be less frequent than once per month;

(3) the facility makes provision for onsite physician coverage sufficient to meet the medical needs of residents seven days a week. This coverage may be part of the routine physician visits or in addition to such visits;

(4) nursing services for the AIDS program are under the supervision of a registered professional nurse with experience in the care and management of persons with AIDS; and

(5) each resident is evaluated by rehabilitation therapy staff to include, as a minimum, physical therapy and occupational therapy staff. Based on the evaluation, a plan of care is developed which establishes restoration or maintenance rehabilitation goals.
415.38 Long Term Ventilator Dependent Residents. Facilities which admit and care for residents who require nursing home care and continuous or intermittent use of a ventilator shall comply with the following additional requirements pertinent to the care of those residents.

(a) General. The facility shall develop and implement admission, resident care management, transfer and discharge policies and procedures that promote delivery of medical, nursing and respiratory care services consistent with generally accepted standards of professional practice.

(1) Residents shall be congregated within the facility in a single nursing care unit.

(2) Services shall be directed at restoring each resident to his or her optimal level of functioning and assisting each resident to achieve maximum independence from mechanical ventilation.

(3) The facility shall have a transfer agreement with a general hospital which:

(i) is located within twenty minutes travel time of the facility,

(ii) is equipped and staffed for the acute care and management of ventilator dependent patients; and

(iii) has granted privileges to pulmonary care physicians to admit and care for ventilator dependent residents who may require hospital admission.

(4) Laboratory, mental health and diagnostic radiology services appropriate to the needs of the residents shall be readily available either directly or by arrangement.

(5) The facility shall have an effective program of preventive and periodic maintenance of ventilator equipment which meets or exceeds the manufacturer's requirements for the equipment and prevents the spread of infections and communicable disease.

(b) Resident care services:

(1) Physician supervision:

(i) the care of the resident shall be directed by a physician who is a qualified specialist in pulmonology; and

(ii) this physician or other physicians qualified by training and pertinent experience in the care and clinical management of persons requiring respiratory care and requiring use of ventilators shall be available to attend to such residents seven days-a-week, twenty-four hours-a-day. One of these physicians shall see and evaluate the resident as often as necessary but not less than every other week.
(2) All resident care staff shall receive orientation and training appropriate to the care of the ventilator dependent residents to whom they are assigned.

(3) One or more registered professional nurses on each shift shall be assigned to provide care to ventilator dependent residents.

(4) Respiratory therapists shall be available as needed to meet the needs of the residents.

(5) Rehabilitation therapy services shall be available at the facility to meet the needs of the residents.

(6) The facility shall maintain specific supplies appropriate to meeting the care needs of the residents.

(7) Residents shall be assessed as to their ability to be weaned from their ventilatory dependence. Those residents who are assessed as potentially able to be weaned from dependence on support with mechanical ventilation or whose daily use of ventilator support may be reduced shall receive an active program of therapy and other supportive services designed for that resident to reduce or eliminate his or her need for use of a ventilator.

(8) Residents shall be assessed as to their ability to be discharged to home or to a home-like setting with or without supportive services. When such potential is identified, the facility shall initiate an active program of therapy and other supportive services designed to assist the resident in the transition to the new setting. Facility discharge planning staff shall arrange for any home modifications, equipment or assistance expected to be required of the resident in the new setting and document these arrangements in the resident clinical record.
Part 414 Nursing Homes - Continuous Violation Penalties

414.1 Pursuant to Public Health Law section 2803(6), a system of penalties of up to $1,000 per day for continuing for violations of rules and regulations promulgated pursuant to Article 28 of the Public Health Law pertinent to the operation of nursing homes and pertaining to resident care in those nursing homes is established in this Part.

414.2 When the Commissioner elects to impose continuous violation penalties, the amount of those penalties shall be based on a consideration of the consequences of substandard care of the resident(s) associated with each violation and on the harm done to the condition of the resident(s). The daily dollar amount per violation for each specific violation shall be calculated in accordance with the following criteria:

<table>
<thead>
<tr>
<th>Characteristic of the Violation</th>
<th>Daily Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) If the violation continues over time harm is likely to occur harm not requiring professional staff intervention has occurred or there is potential for harm with or without the need for professional staff intervention and the occurrence is one that should be reported to supervisory personnel or facility administration for response.</td>
<td>$ 600</td>
</tr>
<tr>
<td>(b) Harm has occurred which required professional staff intervention.</td>
<td>$ 800</td>
</tr>
<tr>
<td>(c) Physical and life threatening harm has occurred and steps would ordinarily be taken beyond reporting to the facility administrator to prevent recurrence, such as relocation out of the facility or notification of regulatory authorities.</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

414.3 Penalties as established in this Part shall be additional and cumulative to all other penalties or remedies existing for violations of Article 28 of the Public Health Law and of the rules and regulations promulgated pursuant to such article.