72315 Nursing Service-Patient Care

(a)

No patient shall be admitted or accepted for care by a skilled nursing facility except on the order of a physician.

(b)

Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c)

Each patient, upon admission, shall be given orientation to the skilled nursing facility and the facility's services and staff.

(d)

Each patient shall be provided care which shows evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails. The patient shall be free of offensive odors.

(e)

Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active, and out of bed for reasonable periods of time, except when contraindicated by orders of a licensed health care practitioner acting within the scope of his or her professional licensure.

(f)

Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include: (1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient. (2) Encouraging, assisting and training in self-care and activities of daily living. (3) Maintaining proper body alignment and joint movement to prevent contractures and deformities. (4) Using pressure-reducing devices where indicated. (5) Providing care to maintain clean, dry skin free from feces and urine. (6) Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine. (7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician, when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b).

(1)

Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.

(2)

Encouraging, assisting and training in self-care and activities of daily living.

(3)

Maintaining proper body alignment and joint movement to prevent contractures and deformities.

(4)

Using pressure-reducing devices where indicated.

(5)

Providing care to maintain clean, dry skin free from feces and urine.

(6)

Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7)

Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician, when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b).

(g)

Each patient requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(h)

Each patient shall be provided with good nutrition and with necessary fluids for hydration.

(i)

Measures shall be implemented to prevent and reduce incontinence for each patient and shall include: (1) Written assessment by a licensed nurse to determine the patient's ability to participate in a bowel and/or bladder management program. This is to be initiated within two weeks after admission of an incontinent patient. (2) An individualized plan, in addition to the patient care plan, for each patient in a bowel and/or bladder management program. (3) A weekly written evaluation in the progress notes by a licensed nurse of the patient's performance in the bowel and/or bladder management program.

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(j)

Fluid intake and output shall be recorded for each patient as follows: (1) If ordered by the physician. (2) For each patient with an indwelling catheter: (A) Intake and output records shall be evaluated at least weekly and each evaluation shall be included in the licensed nurses' progress notes. (B) After 30 days the patient shall be reevaluated by the licensed nurse to determine further need for the recording of intake and output.

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(2)

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(k)

The weight and length of each patient shall be taken and recorded in the patient's health record upon admission, and the weight shall be taken and recorded once a month thereafter.

(l)

Each patient shall be provided visual privacy during treatments and personal care.

(m)

Patient call signals shall be answered promptly.