Exemption Request - Notice of ADMISSION or RETENTION of a Resident Requiring Exemption

Facility Name: _____ Today's Date: _____

Address: _____

Administrator: _____ Telephone Number: _____

Name of Resident (please print): _____

_____ Admission _____ Retention

Exemption Requested for: _____ (Wounds/ Diabetes/ Oxygen/ Bedfast/Contractures, etc.)

As provided in NAC 449.2736, notice must be given to the Bureau of Health Care Quality and Compliance before admitting a resident with or at the onset of a bedfast or medical condition.

The following information is required and **must** be submitted in order for your request to be processed in a timely manner.

_____ Current medical records and reports concerning the resident's medical condition, which **must** include:

- Assessments or history and physicals from the resident's physician, a nurse practitioner or a physician assistant. This information should be current (within the last 6 months) and should include diagnoses, prognosis and expected duration of condition.
- Plan of Care and/or assessments by the Home Health/Hospice Registered Nurse.

_____ Resident Information (See pg. 2)

_____ A plan for ensuring that the resident's medical needs can be met by the facility

- This written plan must describe the caregiver's abilities to meet the resident's needs, and may include examples of training that has been or will be completed that is unique to the resident requiring an exemption (ie: bedfast exemption should include documentation of how the caregivers have been trained to position a resident properly). (See pg. #3)

_____ A statement signed by the administrator of the facility that the needs of the resident who is the subject of the request will be met by the caregivers employed by the facility (See pg. #3).

_____ A plan for ensuring that the level of care provided to the other residents of the facility will not suffer as a result of the admission of the resident who is the subject of the request

- This written plan must indicate the facility's current census and staffing patterns.
- The plan must also include a statement signed by the administrator that other residents of the facility will not suffer as a result of the admission of this resident and the required care. (See pg. #4)

Upon receipt of a complete packet, the information is reviewed by a Registered Nurse. Past survey history is considered when reviewing the request. You will normally receive notice of approval or denial via mail within 10 business days if all information has been provided.

Completed packet may be submitted by mail, e-mail or fax to:

Division of Public and Behavioral Health-Attention: Crystal Blackeye
727 Fairview Dr. Ste. E
Carson City, NV. 89701
Phone: 775-684-1049
Fax: 775-684-1073
E-mail: cblackeye@health.nv.gov

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

NAME OF YOUR FACILITY: _____

RESIDENT INFORMATION:

Resident Name: _____ **Age:** _____

Diagnosis: _____

Additional medical concerns: (Check all that apply)

_____ Bedfast _____ Gastrostomy Tube _____ MRSA infection or other serious infection

_____ Requires oxygen _____ Requires intermittent positive pressure breathing equipment

_____ Tracheostomy _____ CPAP _____ Nebulizer treatments

_____ Colostomy _____ Ileostomy _____ Foley Catheter _____ Suprapubic Catheter

_____ Bowel incontinence _____ Urinary incontinence

_____ Contractures _____ Diabetic _____ Requires routine Accu-check or Glucose testing

_____ Open wounds _____ Pressure or Stasis Ulcers

_____ Requires regular intramuscular, subcutaneous or intradermal injections

_____ Requires protective supervision

***** Reminder: A copy of a current History and Physical or assessment completed by a physician/PA or NP must also be submitted with your request packet!!**

Name of Hospice Agency providing resident care: _____

Telephone # _____

Name of Home Health Agency providing resident care: _____

Telephone # _____

***** Reminder: You will need to submit the Home Health Agency or Hospice Agency's Plan of Care for the resident with your request packet!**

Signature of Administrator: _____

Print Name of Administrator: _____

NAME OF YOUR FACILITY: _____

FACILITY PLAN FOR ENSURING THE RESIDENT'S NEEDS CAN BE MET

Date: _____

Resident Name: _____

- All medication management will be followed as directed by the Physician and documented accordingly.
- Any and all adverse reactions to any medication or observed changes in the physical and/or mental condition of the resident will be documented and the appropriate individuals will be notified in a timely manner (Physician, Hospice/Home-Health Nurse, Family)
- Resident will be turned or assisted in position change every 2 hours, or as needed, or as directed by the physician &/or hospice/ home health agency.
- Bedside feeding or assistance will be provided by facility staff members as needed
- Diet as prescribed by the resident's physician will be followed
- Facility staff will regularly conduct checks for need of changing or assistance with incontinence care

TRAINING:

Facility staff have received current training for: (check all that apply)

_____ Repositioning a bedfast resident

_____ Incontinence Care

_____ Signs and symptoms of urinary tract infection

_____ Signs and symptoms of other infections

_____ Signs and symptoms of dehydration

_____ Infection control/ prevention – Proper Hand washing procedures

_____ Other: Please describe: _____

_____

_____

_____

Attestation:

By signing this notice, I accept the responsibility to ensure the care and needs of this resident will be met by the caregivers of this facility.

Signature of Administrator: _____

Print Name of Administrator: _____

Date: _____

NAME OF YOUR FACILITY: _____

PLAN FOR ALL RESIDENTS OF THE GROUP HOME UNIMPEDED BY THE CARE PROVIDED FOR:

_____

RESIDENT'S NAME

Our home will continue to provide 24 hour quality care to all residents.

- Our current census is: _____
- Our current staffing pattern is: (Example: 2 caregivers and 1 med-tech at all times)
- All residents will continue to be under constant watch during the day and throughout the night in order to monitor all safety precautions, fall prevention, general precautions and repositioning needs.
- All medication management processes will continue to be followed at the direction of the physician's prescription and logged appropriately on the Medication Administration Record.
- All medication management will continue to be followed as directed by the facility Medication Management Plan and as prescribed by the physician.
- Current assistance given to all residents will continue according to their agreement with the group home and their assessed needs which may include assistance with bathroom visits, incontinence care, bathing, dressing, grooming, feeding, activities and all other general care services as needed.

Attestation:

By signing this notice, I accept the responsibility to ensure the care of this resident will not detract from the care of any other resident. I accept responsibility to ensure the care provided follows the plan of care for all residents in my facility.

Signature of Administrator: _____

Print Name of Administrator: _____

Date _____