A close-up photograph of a hand holding a pen, poised to write on a document. The image is overlaid with a light gray grid pattern. The background is a blurred office setting with a person in a white lab coat.

# 30 Essential Policies and Procedures

**For Long-Term Care**

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Section 1

**Administration**



A facility will 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.

## **Licensure**

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The facility will maintain licensure under applicable state and local law.<sup>1</sup> All applicable licenses, permits, and approvals will be made available to surveyors upon request.

The facility currently holds the following licenses:<sup>2</sup> (Examples of required licenses, permits, and approvals include: facility license, state and local occupancy certificates, public safety certificates, Medicare/Medicaid provider agreements, fire safety certificates, and JCAHO accreditation.)

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Licenses are posted in public areas and are updated as applicable.

## **Compliance with and relationship to other laws, standards, and regulations:**

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### **I. Compliance with federal, state, and local laws and professional standards<sup>3</sup>**

The facility will operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in the facility. Furthermore, the facility will comply with regulations and codes relating to health, safety, and sanitation.

The facility recognizes the problems that can be caused by both deliberate and accidental misconduct. The facility further recognizes that healthcare is an ever-changing and highly regulated industry that requires all staff to conduct themselves ethically, and with the highest level of personal and business standards. This policy has been developed to underscore and enhance the facility's commitment to compliance.

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<sup>1</sup> *Facilities are responsible to review state regulations regarding licensure. Your policy should specify the requirements and be as detailed as possible.*

<sup>2</sup> *List all applicable licenses required according to your state and local laws.*

<sup>3</sup> *Facilities are advised to implement a corporate compliance program. This policy does not replace a compliance program, and this manual is not intended to provide the facility with a fully functional compliance program. Facilities are advised to seek a competent professional for guidance on establishing and maintaining a compliance program. Information is provided as a compliance baseline.*

As such, the facility is committed to compliance with federal, state, and local laws, regulations and codes, and with professional standards. In addition, the facility has developed policies and procedures that govern its operations.

The facility recognizes that there may be situations in which both the federal and the state governments have an established law governing the same issue. In these situations, it is the intent of the facility to adhere to the more stringent law.

To further enhance the facility's commitment to compliance, the facility requires that all staff, including contractors, subcontractors, and affiliates, who become aware of or who otherwise suspect noncompliance report the incident to management or to another high-level individual within the organization. Failure to do so could result in disciplinary action up to and including termination.

The person at the facility who is responsible for oversight of compliance initiatives is \_\_\_\_\_.<sup>4</sup>

If the facility does have a reporting mechanism, specify the details. For example:

E-mail: *complianceofficer@facility.com*

Hotline Voice Mailbox: 555/555-5555

Compliance officer direct dial: Ext. 555

Lockbox: Located behind each nursing station and outside the administrator's office.

## II. Relationship to other Department of Health and Human Services regulations

The facility also will implement policies and procedures in order to address its obligation to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to

- nondiscrimination on the basis of race, color, or national origin (45 CFR part 80)
- nondiscrimination on the basis of handicap (45 CFR part 84)
- nondiscrimination on the basis of age (45 CFR part 91)
- protection of human subjects of research (45 CFR part 46)
- fraud and abuse (42 CFR part 455)

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<sup>4</sup>*This person should, ideally, be a compliance officer. At a minimum, the compliance officer should be a high-level staff member whom the staff trusts and who has excellent communication, interpersonal, and organizational skills.*

The facility recognizes that these regulations are not in themselves considered requirements under the state operations survey. However, violation may result in the termination or suspension of participation in the federal or state payment programs or the refusal to grant or continue payment with federal funds.

## **Governing body**

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Every facility, regardless of ownership or tax status, is operated by a governing body composed of members as determined by its articles of organization or incorporation.

The governing body is the corporate entity or licensee responsible for the overall operation of the facility. The governing body appoints the administrator, approves the facility's policies and procedures, and generally oversees the facility's operation, budgeting, and compliance with applicable state, federal, and corporate rules and regulations.

Strategic planning and goal setting are organized and coordinated through regularly scheduled meetings attended by the board of directors<sup>5</sup> and the administrator.

The responsibilities of the governing body shall be, at a minimum, to

- adopt, review, and revise the bylaws or policies that describe the organizational structure and the bylaws or policies that establish authority or responsibility
- appoint the administrator and ensure his or her professional capabilities
- approve the institutional plan as developed by the administrator, including operating budgets
- adopt effective administrative and resident care policies designed to ensure maintenance of professional standard
- provide a physical plant, equipment, and staff appropriate to the needs of residents
- ensure that the facility develops, and annually reviews, policies and procedures to ensure that resident and family complaints are received, acted upon, and responded to
- ensure proper recordkeeping procedures of clinical and nonclinical material
- ensure compliance with state and federal regulations
- approve appointment of the director of nurses
- approve appointment of the medical director
- establish the facility's operating budget

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<sup>5</sup>*In many multi-chain organizations, it may not be possible for the administrator and governing body to meet on a regular basis. In many of these organizations, the administrator will routinely meet with a regional staff that represents the interests of the governing body.*

- ensure protection of the residents' personal and property rights
- establish policies and procedures ensuring privacy and confidentiality of resident information
- establish a corporate compliance program
- establish a staff development program
- provide facility services and quality resident care in accordance with professional standards of practice and principles
- provide a safe physical environment equipped and staffed to maintain the facility and services
- formulate and document an annual review of all facility policies and procedures
- establish and implement a resident and staff grievance system and provide feedback as to what action was taken and whether an amicable solution was reached
- establish and implement a mechanism for approval of the qualifications, status, and privileges of physicians who may be appointed to the medical staff, including requirements for admission to staff and retention of privileges

***Disclosure of ownership***

The facility will comply with the disclosure requirements set forth herein. The facility will provide written notice to the state agency responsible for licensing the facility at the time of change, if a change occurs in

- persons with an ownership or control interest, as defined herein
- the officers, directors, agents, or managing employees
- the corporation, association, or other company responsible for the management of the facility
- the facility's administrator or director of nursing

The facility will fill out and submit form CMS-1513 as indicated herein. When notifying the state agency of the change, the notice will include the identity of each new individual or company. This form will be filled out as outlined herein by the facility \_\_\_\_\_.<sup>6</sup>

At a minimum, the following information will be disclosed:

- The name and address of each person with an ownership or control interest in the entity or in any subcontractor in which the entity has direct or indirect ownership interest totaling five percent or more. In the case of a Part B supplier that is a joint venture, ownership of five percent or more of any company participating in the joint venture should be reported.<sup>7</sup> Any

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<sup>6</sup>*Title of responsible person.*

<sup>7</sup>*If a Part B supplier exists, include this information. If not, remove it.*

physician who has been issued a Unique Physician Identification Number by the Medicare program must provide this number.

- Whether any of the persons named above is related to another as spouse, parent, child, or sibling.
- The name of any other disclosing entity in which any person with an ownership or control interest, or who is a managing employee in the reporting disclosing entity, has, or has had, in the previous three-year period, an ownership or control interest or position as managing employee, and the nature of the relationship with the other disclosing entity. If any of these other disclosing entities has been convicted of a criminal offense or received a civil monetary or other administrative sanction related to participation in Medicare, Medicaid, Title V (Maternal and Child Health) or Title XX (Social Services) programs, such as penalties assessments and exclusions under sections 1128, 1128A, or 1128B of the Social Security Act, the disclosing entity must also provide that information.

The information will be disclosed according to the following time and manner guidelines:

- If the facility is subject to periodic survey and certification of its compliance with Medicare standards, it must supply the information specified above to the state survey agency at the time it is surveyed. The survey agency will promptly furnish the information to CMS.<sup>8</sup>
- If the facility is not subject to periodic survey and certification, it must supply the information specified above directly to CMS before entering into a contract or agreement with Medicare or before being issued or reissued a billing number as a Part B supplier. Furthermore, if the information specified herein has not been supplied to CMS within the prior 12-month period, the facility must submit the information either directly to CMS or to the state Medicaid agency before entering into a contract or agreement to participate in the program. If providing it to the state Medicaid agency, the Medicaid agency will be responsible for furnishing this information to CMS.
- The facility will furnish updated information to CMS at intervals between recertification, or re-enrollment, or contract renewals, within 35 days of a written request. In the case of a Part B supplier, the supplier must report also within 35 days, on its own initiative, any changes in the information it previously supplied.

The facility recognizes that CMS will not approve an agreement or contract with, or make a determination of eligibility for, or (in the case of a Part B supplier) issue or reissue a billing number to, any facility that fails to comply with these disclosure requirements. Furthermore, CMS will terminate any existing agreement or contract with, or will withdraw a determination of eligibility

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<sup>8</sup>*Pick either the first bullet or the second, depending on the individual facility.*

for or (in the case of a Part B supplier) will revoke the billing number of, a facility that fails to comply with these disclosure requirements.

The facility recognizes that any information furnished to CMS under the provisions of this section will be subject to public disclosure under certain circumstances.

The facility will retain copies of all requests for ownership information and its responses. These records will be made available to CMS or the state agency upon request and the facility will advise the state agency when it is unable to supply this information and include the reason for the failure to do so.

## CMS-1513

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved  
OMB No. 0938-0086

### INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (CMS-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

#### SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related home-maker services must complete parts II and III. Title V providers must complete parts II and III.

#### General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144  
Title XVIII – 42CFR 420.200 – 206  
Title XIX – 42CFR 455.100 – 106  
Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

#### DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I (a)** Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
- (b) For Regional Office Use Only.** If the yes box is checked for item VII, the Regional Office will enter the 5-digit number assigned by CMS to chain organizations.

**Item II** - Self-explanatory.

**Item III** - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

#### Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

**Item IV - (a & b)** If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

**Item V** - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

**Item VI** - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

**Item VII** - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

**Item VIII** - If yes, list the actual number of beds in the facility now and the previous number.

## CMS-1513 (cont.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved  
OMB NO. 0938-0086

### DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

**I. Identifying Information**

(a) Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code
(b) (To be completed by CMS Regional Office)		Chain Affiliate No.		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?  
 Yes  No LB2

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?  
 Yes  No LB3

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)  
 Yes  No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity:  Sole Proprietorship  Partnership  Corporation  Unincorporated Associations  Other (Specify) LB6

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions:  
 (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.  
 Yes  No LB7

Name	Address	Provider Number



## CMS-1513 (cont.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved  
OMB NO. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year? If yes, give date _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB8
(b) Do you anticipate any change of ownership or control within the year? If yes, when? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB9
(c) Do you anticipate filing for bankruptcy within the year? If yes, when? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB10
V. Is this facility operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB11
VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB13
Name _____ EIN # _____		
Address _____		LB14
VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain? (If yes, list Name, Address of Corporation, and EIN)	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB18
Name _____ EIN # _____		
Address _____		LB19
VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB15
If yes, give year of change _____		
Current beds _____ LB16   Prior beds _____ LB17		
WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.		
Name of Authorized Representative (Typed)	Title	
Signature	Date	
Remarks		

## CMS-1513 (cont.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0086. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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## Organizational chart

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### ***Introduction***

An organizational chart touches on many different facets of a facility's operations. Surveys, departmental organization, safety programs, personnel manuals, HIPAA security programs, and many other subsets of a facility rely on an accurate and updated organizational chart. Thus, it is essential that a facility create, maintain, and periodically update its organizational chart.

Developing an organizational chart is not that difficult as long as you have all of the appropriate information from the start. The organizational chart worksheet can be used to develop your own organizational chart. When putting this information together, remember to list departmental reports at the top and all the departments that report to that individual below.

For functions that are in addition to an existing position, list these separately. Consider the example of a compliance officer: A compliance officer may not be a separate and distinct position in your facility. It may be an assistant facility administrator, a director of operations, a human resources director, or a billing manager. In this individual's day-to-day duties, he/she may report to someone else. However, as the compliance officer, this individual needs to report directly to the board of directors. Furthermore, everyone in the organization needs to have the ability to make reports to the compliance officer. Therefore, this position should be listed separately, with a direct reporting line to the board of directors or governing body.

The structure of your facility may not fit exactly into this worksheet. If you have positions that are not addressed in this worksheet, use your professional judgment and write them into the sections marked "other."

### Organizational chart worksheet

#### Facility information:

(1) Owner (or parent company):

---

(2) Chief Executive Officer:

---

(3) Board of Directors (specify chair of audit committee if one exists):

---

---

---

---

---

(4) Facility name:

---

(5) Facility administrator:

---

(6) Medical director:

---

(7) Legal counsel:

---

(8) Other:

---

(9) Other:

---

(10) Other:

---

**Organizational chart worksheet (cont.)****Senior management**

(1) Chief Financial Officer:

---

(2) Chief Operating Officer:

---

(3) Assistant facility administrator:

---

(4) Other:

---

(5) Other:

---

(6) Other:

---

### Organizational chart worksheet (cont.)

#### Nursing services:

(1) Director of nursing:

---

(2) Assistant director of nursing:

---

(3) MDS coordinator:

---

(4) Charge nurse:

a. First shift:

---

b. Second shift:

---

c. Third shift:

---

(5) Unit supervisor:

a. First shift:

---

b. Second shift:

---

c. Third shift:

---

(6) LPNs (if more room is needed, attach a separate sheet):

a. First shift:

---

b. Second shift:

---

c. Third shift:

---

**Organizational chart worksheet (cont.)**

(7) CNAs (if more room is needed, attach a separate sheet):

a. First shift:

---

b. Second shift:

---

c. Third shift:

---

(8) Other:

---

(9) Other:

---

(10) Other:

---

**Organizational chart worksheet (cont.)**

**Medical services:**

(1) Attending physician(s):

---

---

(2) Physician assistants:

---

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---

(3) Nurse practitioners:

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(4) Podiatrist:

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(5) Dentist:

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(6) Ambulance/transportation:

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---

(7) Laboratory services:

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(8) Radiology services:

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**Organizational chart worksheet (cont.)**

(9) Pharmacy services:

---

---

(10) Other:

---

(11) Other:

---

(12) Other:

---

### Organizational chart worksheet (cont.)

#### Rehab department:

(1) If contracted, name of company:

---

(2) Rehab director:

---

(3) Physical therapists:

---

---

---

(4) Occupational therapists:

---

---

---

(5) Speech therapists:

---

---

---

(6) Activities director:

---

**Organizational chart worksheet (cont.)**

**Business department**

(1) Human resources director:

\_\_\_\_\_

a. Human resource staff:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(2) Billing director:

\_\_\_\_\_

a. Billing staff:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(3) Admissions director:

\_\_\_\_\_

a. Admissions staff:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(4) Business office manager/director:

\_\_\_\_\_

a. Business office staff:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(5) Finance director:

\_\_\_\_\_

**Organizational chart worksheet (cont.)**

a. Finance department staff:

---

---

---

(6) Social services director

---

a. Social workers:

---

---

---

(7) Maintenance director:

---

a. Maintenance staff:

---

---

---

(8) Compliance officer:

---

(9) Privacy officer:

---

(10) Security officer:

---

(11) Dietary director:

---

a. Dietary staff:

---

---

---

**Organizational chart worksheet (cont.)**

(12) Housekeeping director:

a. Housekeeping staff:

(13) Administrative director

a. Administrative staff:

(14) Information technology director:

a. Information technology staff:

(15) Medical records director:

a. Medical records staff:

(16) Other:

(17) Other:

(18) Other:

**Organizational chart worksheet (cont.)**

**Other departments (if more are needed, attach a separate sheet):**

(1) Other:

---

(2) Other:

---

(3) Other:

---

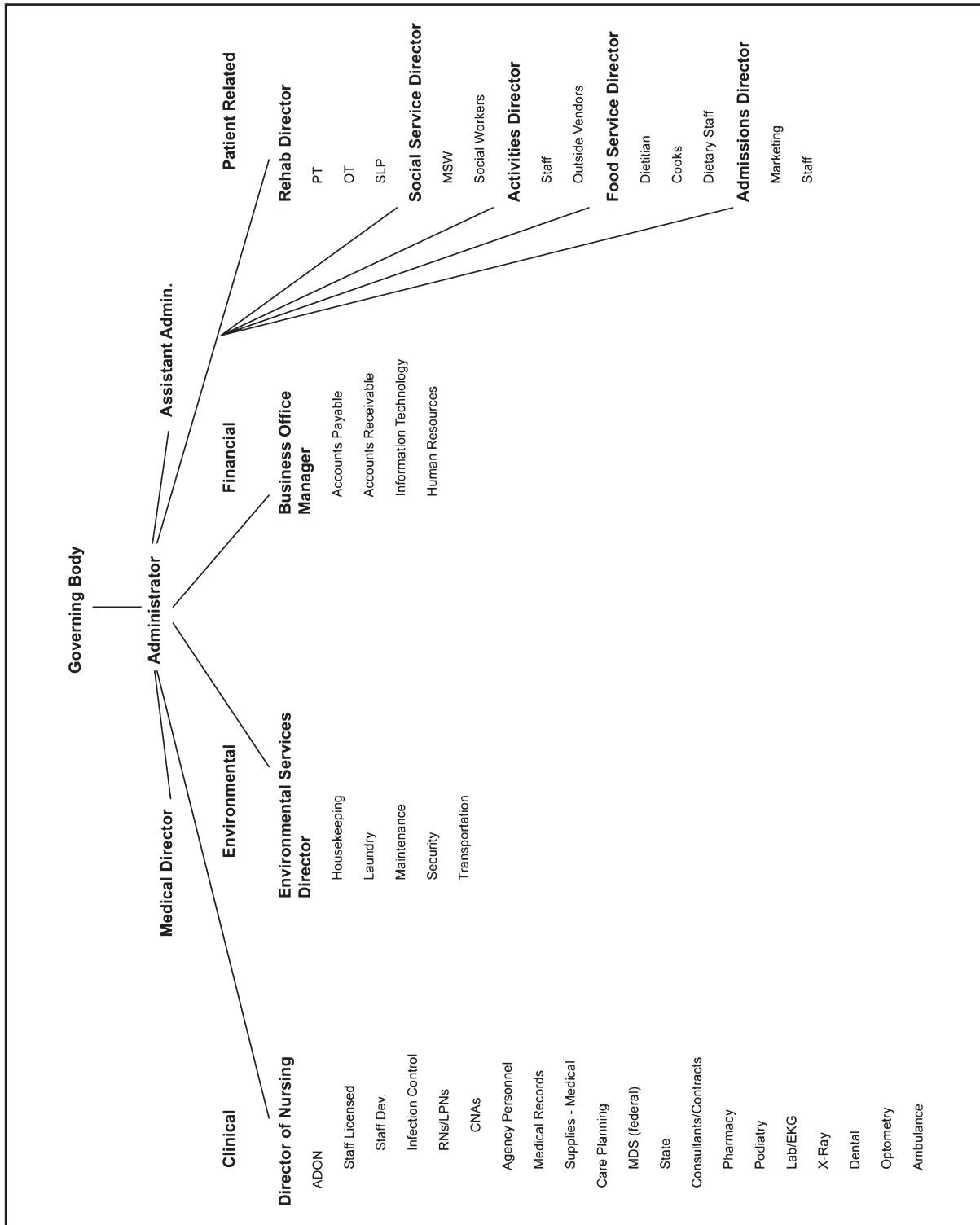
(4) Other:

---

(5) Other:

---

### Sample organization chart



**Using the organizational chart**

If there are any departments that are not listed, make sure you write them down—all departments should be represented on this worksheet. Some facilities will want to drill down into each department, which can be done either by developing a departmental chart or by expanding this organizational chart. If you develop a departmental chart, go into much more detail and outline the department structure down to position level. For example, instead of listing “accounts receivable (A/R),” the chart should list out all the positions within the A/R department (e.g., A/R manager, three A/R clerks, one administrative assistant).

Determine the reporting structure within your facility. Reporting should be represented by a solid line. Dotted lines or different colored lines can be used to indicate alternative reporting.

Remember that different facilities have different organizational structures. The “sample organization chart” is provided as an example only, so use your existing structure to determine levels and reporting lines. For example, the sample shows rehab services as its own department, directly reporting to the facility administrator. In some facilities, however, rehab services may report to the director of nursing or may be subcontracted and listed under consultants/contractors. Use your existing structure to determine how the chart will look. Make the chart realistic, and show how the reporting structure works in your facility.

**Mission statement: Checklist/intro**

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The facility should develop a mission statement for use in policies, procedures, manuals, and programs. Although an official mission statement policy is not required, facilities should have their mission written out and worked into their operations. The mission statement should be clear, concise, and to the point. Sample elements of a long-term care facility mission statement include but are not limited to the following:

- Commitment to serving residents
- Fulfilling the needs of residents
- Providing a safe, comfortable environment
- Environment that treats all residents equally regardless of culture, national origin, religion, gender, and sexual orientation



Sample mission statement: “<Facility> is committed to serving the needs of all residents in a safe, caring, and comfortable environment; to treat all residents equally regardless of culture, national origin, religious affiliation, gender, and sexual orientation; and to serve the needs of the community.”

There should be references to the mission statement in any compliance program, disciplinary policies, and resident care policies. The mission statement also should be printed in the facility’s employee guidebook and posted in the facility. Quite often, elements of a facility’s mission statement are used in marketing and promotional materials.

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