

New Long Term Care Survey Process



What's New and Upcoming

Cindy Deporter Fall 2017

Disclaimer

- The information provided within these slides are current as of October 1, 2017 It provides information related to the CMS' intent to implement the survey process on November 28, 2017 and the policies and procedures based on development to date.
- This presentation will be updated as new information becomes available.

Overview

- Overview of Regulation Reform
- F-Tag Renumbering
- New Interpretive Guidance (IG)
- Current Survey Processes vs. New Survey Process
- New LTC Survey Process



Overview of Regulation Reform

Overview of Regulation Reform

The regulation reform implements a number of pieces of legislation from the Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, including the following:

- Quality Assurance and Performance Improvement (QAPI)
- Reporting suspicion of a crime
- Increased discharge planning requirements
- Staff training section

Implementation Grid

Implementation Date	Type of Change	Details of Change
Phase 1: November 28, 2016 (Implemented)	Nursing Home Requirements for Participation	New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags
Phase 2: November 28, 2017	F Tag numbering Interpretive Guidance (IG) Implement new survey process	New F Tags Updated IG Begin surveying with the new survey process
Phase 3: November 28, 2019	Requirements that need more time to implement	Requirements that need more time to implement

Phase 2 of LTC Regulations

- Implement by November 28, 2017
- Providers must be in compliance with Phase 2 regulations
- All States will use new computer–based survey process for LTC surveys
- All training on new survey process needs to be completed before go live date

Phase 2 of LTC Regulations (continued)

Phase 2 includes:

- Behavioral Health Services
- Quality Assurance and Performance Improvements (QAPI Plan Only)
- Infection Control and Antibiotic Stewardship
- Physical Environment – smoking policies

Phase 2 of LTC Regulations, continued

Phase 2 includes, but is not limited to:

- Resident Rights and Facility Responsibilities – Required Contact Information-
- Freedom from Abuse, Neglect, and Exploitation – 1150B
- Admission, Transfer, and Discharge Rights – Transfer/ Discharge Documentation

Phase 2 of LTC Regulations, continued

Phase 2 includes, but is not limited to:

- Comprehensive Person-Centered Care Planning
- Pharmacy Services – psychotropic medications
- Dental Services – replacing dentures
- Administration – Facility Assessment



F Tag Renumbering

F Tag Renumbering

Notice of Proposed Rulemaking | Long-Term Care Rule CMS

NPRM LTC-Rule | F-Tag Crosswalk Report: Original vs. New Regulation

RecID	Orig Reg Group	Reg Tag	F-Tag #		New Reg Group	Reg Tag	F-Tag #
1	483.05 Definitions	483.05(a) Facility Defined - SNF & NF	F150	N/A	483.05 Definitions	483.05(a) Facility Defined - SNF & NF	F540
2	483.10 Resident Rights 483.15 Quality of Life	(17) of	F151, F240, F241	vs	483.10 Resident Rights 483.15 Quality of Life	Reg Tag	F350

Old F-Tag (points to F150) **New F-Tag** (points to F540)

The image above is the F Tag Crosswalk showing:

- The original regulatory grouping and the new associated grouping
- The original regulation number and the new associated regulation number
- The original F Tag and the associated new F Tag

F Tag Renumbering, continued

Notice of Proposed Rulemaking | Long-Term Care Rule



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RecID	Orig Reg Group	Reg Tag	FTag #		New Reg Group	Reg Tag	F-Tag #
1	483.05 Definitions	483.05(a) Facility Defined - SNF & NF	F150	N/A	483.05 Definitions	483.05(a) Facility Defined - SNF & NF	F540
2	483.10; Resident Rights; 483.15 Quality of Life	483.10 Resident Rights; 483.10(a)(1)-(2): Right to Exercise Rights-Free of Reprisal; 483.15: Care and Environment Promotes Quality of Life; 483.15(a): Dignity and Respect of Individuality	F151, F240, F241	Y1	483.10 Resident Rights	483.10; Resident Rights and Dignity 483.10(a)(1) -(2); 483.10(b)(1) -(2)	F550
3	483.10 Resident Rights	483.10(a)(3)-(4): Rights Exercised by Representative	F152	Y2	483.10 Resident Rights	483.10(b)(3) Rights Exercised by -(7) Representative	F551
4	483.10 483.10 Resident Rights	483.10(b)(3): Informed of Health Status, Care & Treatments; 483.10(b)(4): Right to Refuse; Formulate Advance Directives	F154, F155	Y3	483.10 Resident Rights	483.10(c)(1) Right to be Informed/Make (4),(5) Treatment Decisions	F552
5	483.10; Resident Rights 483.20 Resident Assessment	483.10(b)(3): Informed of Health Status, Care & Treatments; 483.10(d)(3): Right to Participate Planning Care- Revise CP	F154, F280	Y4	483.10 Resident Rights	483.10(c)(2) Right to Participate Planning -(3) Care	F553
6	483.10 Resident Rights	483.10(n): Resident Self-Administer Drugs if Deemed Safe	F176	Y5	483.10 Resident Rights	483.10(c)(7) Resident Self-Administer Drugs if Deemed Safe	F554
7	483.10 Resident Rights	483.10(b)(9): Notice of Rights, Rules, Services, Charges; 483.10(d)(1): Right to Choose a Personal Physician	F156, F163	Y6	483.10 Resident Rights	483.10(d)(1) Right to Choose/Be Informed of -(5) Personal Phys	F555
8	483.10 Resident Rights	483.10(l)	None	Y8	483.10 Resident Rights	483.10(e)(2) Right to Have Personal Property	F557
9	483.10 Resident Rights	483.10(m)(1): Reasonable	F242	Y9	483.10 Resident Rights	483.10(e)(3) Reasonable Accommodation	F558



New Interpretive Guidance (IG)

New Interpretive Guidance (IG)

- New Guidance is released and we will be discussing this later in the presentation.



Current Survey Processes
vs.
New Survey Process

Why is CMS Changing the LTC Survey Process?

- Two different survey processes existed to review for the Requirements of Participation (Traditional and QIS)
- Surveyors identified opportunities to improve the efficiency and effectiveness of both survey processes.
- The two processes appeared to identify slightly different quality of care/quality of life issues.
- CMS set out to build on the best of both the Traditional and QIS processes to establish a single nationwide survey process.

Goals of New Process

- Same survey for entire country
- Strengths from Traditional & QIS
- New innovative approaches
- Effective and efficient
- Resident-centered
- Balance between structure and surveyor autonomy



Sample Selection

Traditional	QIS	New Survey Process
<ul style="list-style-type: none"> • Sample size determined by facility census • Residents are pre-selected based on QM/QI percentiles (total sample) • Sample may be adjusted based on issues identified on tour • Maximum sample size is 30 residents • Includes complaints 	<p>The ASE-Q provides a randomly selected sample of residents for the following:</p> <ul style="list-style-type: none"> • Admission sample is a review of up to 30 current or discharged resident records • Census sample includes up to 40 current residents for observation, interview, and record review • With QIS 4.04, complaints can be included in census sample 	<ul style="list-style-type: none"> • Sample size is determined by the facility census • 70% of the total sample is MDS pre-selected residents and 30% of the total sample is surveyor-selected residents. Surveyors finalize the sample based on observations, interviews, and a limited record review. • Maximum sample size is 35 residents

Offsite

Traditional	QIS	New Survey Process
<ul style="list-style-type: none">• Review Casper 3 and 4 reports• Survey team uses QM/QIs report offsite to identify preliminary sample of residents areas of concern	<ul style="list-style-type: none">• Review the Casper 3 report and current complaints• Download the MDS data to PCs• ASE-Q selects a random sample of residents for Stage 1 from residents with MDS assessments in past 180 days	<ul style="list-style-type: none">• Each team member independently reviews the Casper 3 report and other facility history information• Review offsite selected residents and their indicators and the facility rates.

Information Needed Upon Entrance

Traditional	QIS	New Survey Process
<ul style="list-style-type: none">Roster Sample Matrix Form (CMS-802)	<ul style="list-style-type: none">Obtain census number and alphabetical resident census with room numbers and unitsList of new admissions over last 30 days	<ul style="list-style-type: none"><i>Completed matrix for new admissions over the last 30 days</i><i>Facility census number</i><i>Alphabetical list of residents</i><i>List of residents who smoke and designated smoking times</i>

Initial Entry to Facility

Traditional	QIS	New Survey Process
<ul style="list-style-type: none"> • Gather information about pre-selected residents and new concerns • Determine whether pre-selected residents are still appropriate • 1 – 3 hours on average 	<ul style="list-style-type: none"> • No sample selection • Initial overview of facility, resident population and staff/resident interactions. • 30 – 45 minutes on average for initial overview 	<ul style="list-style-type: none"> • No formal tour process • Surveyors complete a full observation, interview all interviewable residents, and complete a limited record review for initial pool residents: <ul style="list-style-type: none"> • Offsite selected residents • New admissions • Vulnerable residents • Identified Concern that doesn't fall into one of the above subgroups • 8 hours on average for interviews, observations, and screening.

Survey Structure

Traditional	QIS	New Survey Process
<ul style="list-style-type: none"> Resident sample is about 20% of facility census for resident observations, interviews, and record reviews Phase I: Focused and comprehensive reviews based on QM/QI report and issues identified from offsite information and facility tour Phase II: Focused record reviews Facility and environmental tasks completed during the survey 	<ul style="list-style-type: none"> Stage 1: Preliminary investigation of regulatory areas in the admission and census samples and mandatory facility tasks started Stage 2: Completion of in-depth investigation of triggered care areas and/or facility tasks based on concerns identified during Stage 1 	<ul style="list-style-type: none"> Resident sample size is about 20% of facility census Interview, observation and limited record review care areas are provided for the initial pool process; surveyors can ask the questions as they would like Surveyors meet to discuss and select sample, may have more concerns than can be added to the sample; may need to prioritize concerns

Survey Structure, continued

Traditional	QIS	New Survey Process
		<ul style="list-style-type: none">• Investigations are then completed during the remainder of the survey for each sample resident using CE pathways• Facility tasks and closed record reviews are completed during the survey

Group Interviews

Traditional	QIS	New Survey Process
<ul style="list-style-type: none">• Meet with Resident Group/ Council• Includes Resident Council minutes review to identify concerns	<ul style="list-style-type: none">• Interview with Resident Council President or Representative• Includes Resident Council minutes review to identify concerns	<ul style="list-style-type: none">• Resident Council Meeting with active members• Includes Resident Council minutes review to identify concerns



New LTC Survey Process Overview

New Survey Process (continued)

Three parts to new Survey Process:

1. Initial pool process
2. Sample Selection
3. Investigation

Overview

- Initial Pool Process
 - Sample size based on census:
 - 70% offsite selected
 - 30% selected onsite by team:
 - Vulnerable
 - New Admission
 - Complaint
 - FRI (Facility Reported Incidents- federal only)
 - Identified concern

Overview, continued

- Select Sample
 - Survey team selects sample
- Investigations
 - All concerns for sample residents requiring further investigation
 - Closed records
 - Facility tasks



Section I. Offsite Prep

Offsite Preparation

- Team Coordinator (TC) completes offsite preparation
 - Repeat deficiencies
 - Results of last Standard survey
 - Complaints
 - FRIs (Facility Reported Incidences- federal only)
 - Variances/waivers
- Necessary documents are printed

Offsite Preparation, continued

- Unit and mandatory facility task assignments
 - Dining
 - Infection Control
 - Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review
 - Resident Council Meeting



Offsite Preparation, continued

- Unit and facility task assignments, continued
 - Kitchen
 - Medication administration and storage
 - Sufficient and competent nurse staffing
 - QAA/QAPI
- No offsite preparation meeting



Section II. Facility Entrance

Facility Entrance

- Team Coordinator (TC) conducts an Entrance Conference
 - Updated Entrance Conference Worksheet
 - Updated facility matrix
- Brief visit to the kitchen
- Surveyors go to assigned areas
- Facilities should provide a copy of the Facility Assessment during the Entrance Conference



New Facility Expectations

- Surveyors need the following as soon as possible after we enter:
 - The facility should provide us with the facility census
 - A list of the number of residents who smoke
 - An Alpha list of all residents with the room number
 - A completed New Admission Facility Matrix
 - Once this is completed it should be delivered to the surveyors
 - There are some updates from the old 802
 - The form uses abbreviations and some different care areas.

Within the first Hour to the team

- Schedule of meal times
 - Locations of the Dining Rooms
 - All current menus including therapeutic menus served for the duration of the survey
 - Policy for Food brought in from visitors
- The schedule of Medication Administration Times
 - Locations and number of med storage rooms
 - Locations of medication carts.

Within the first Hour to the team

- A list of key personnel, location and phone numbers, this includes contract staff, and rehabilitation staff
- If the facility employs paid feeding assistants you will need to collect the following:
 - Does the paid feeding assistant have 8 hours of training through a state approved program
 - Names of the staff (including agency staff) who completed the training and are assisting residents.

Within the First Hour

- A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.

Within 4 Hours

- Complete Matrix for all other residents
- Admission Packet
- Dialysis Contract, Agreements, Arrangements and Policy and Procedures if applicable
- List of Qualified Staff providing hemodialysis or assistance for peritoneal dialysis treatments if applicable.
- Agreements or Policies and Procedures for transport to and from dialysis treatments if applicable

Within 4 Hours

- Does the facility have an onsite separately certified ESRD unit?
- Hospice Agreement and Policies and Procedures for each hospice used (name of facility designees(s) who coordinate(s) services with hospice providers
- Infection Prevention and Control Program Standards, Policies and Procedures and Antibiotic Stewardship Program

Within 4 hours

- Influenza/Pneumococcal Immunization Policy and Procedures
- QAA committee information (name of contact, names of members and frequency of meetings)
- QAPI Plan
- Abuse Prohibition Policy and procedures
- Description of any experimental research occurring in the facility

Within 4 Hours

- Facility Assessment
- Nurse Staffing Waivers (NC has none of these)
- List of rooms meeting any one of the following conditions that require a variance:
 - Less than required square footage
 - More than 4 residents
 - Below ground level
 - No window to the outside
 - No direct access to the corridor

Information within the First Day of the Survey

- Provide each surveyor with access to all resident electronic health records. Do not exclude an information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the HER's outside the conference room. Team will give you the form once on site.(Electronic Health Record Information)

Within 24 Hours of Entrance

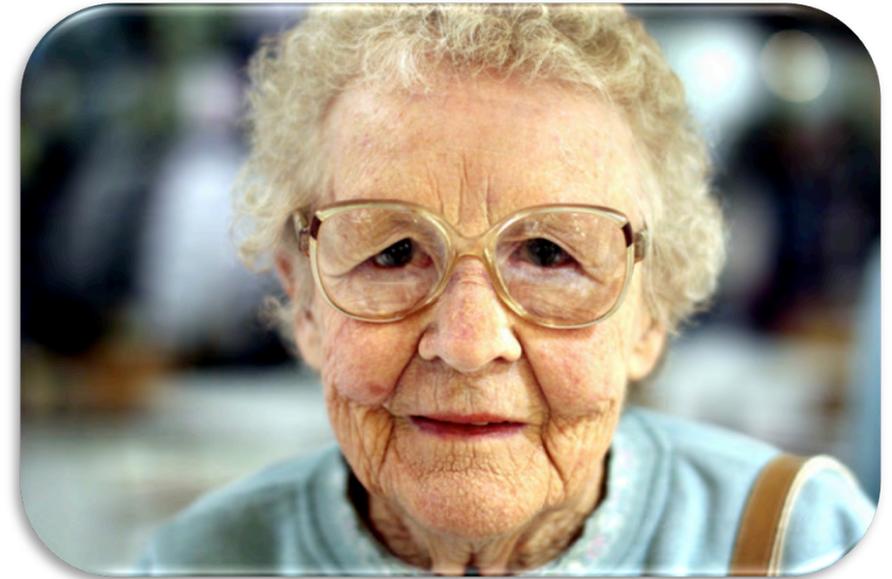
- Completed Medicare/Medicaid Application (CMS -671)
- Completed Census and Condition Information (CMS-672)
- Please complete the attached form on page 3 which is titled “Beneficiary Notice – Residents Discharged Within the Last Six Months”



Section III. Initial Pool Process

Initial Pool Process

- Surveyor request names of new admissions
- Identify initial pool—about eight residents
 - Offsite selected
 - Vulnerable
 - New admissions
 - Complaints or FRIs (Facility Reported Incidences- federal only)
 - Identified concern



Resident Interviews

- Screen every resident
- Suggested questions—but not a specific surveyor script
- Must cover all care areas
- Includes Rights, QOL, QOC
- Investigate further or no issue

Resident Representative/Family Interviews

- Non-interviewable residents
- Familiar with the resident's care
- Complete at least three during initial pool process or early enough to follow up on concerns
- Sampled residents if possible
- Investigate further or no issue

Limited Record Review

- Conduct limited record review after interviews and observations are completed prior to sample selection.
- All initial pool residents: advance directives and confirm specific information
- If interview not conducted: review certain care areas in record
- Confirm insulin, anticoagulant, and antipsychotic with a diagnosis of Alzheimer's or dementia, and PASARR (Pre-Admission Screening and Resident Review)

Limited Record Review, continued

- New admissions – broad range of high-risk medications
- Extenuating circumstances, interview staff
- Investigate further or no issue

Dining – First Full Meal

- Dining – observe first full meal
 - Cover all dining rooms and room trays
 - Observe enough to adequately identify concerns
 - If feasible, observe initial pool residents with weight loss
 - If concerns identified, observe another meal

Team Meetings

- Brief meeting at the end of each day
 - Workload
 - Coverage
 - Concern
 - Synchronize/share data (if needed)



Section IV. Sample Selection

Sample Selection

- Select sample
- Prioritize using sampling considerations:
 - Replace discharged residents selected offsite with those selected onsite
 - Can replace residents selected offsite with rationale
 - Harm, SQC if suspected, IJ if identified
 - Abuse Concern
 - Transmission based precautions
 - All MDS indicator areas if not already included

Sample Selection – Unnecessary Medication Review

- System selects five residents for full medication review
- Based on observation, interview, record review, and MDS
- Broad range of high-risk medications and adverse consequences
- Residents may or may not be in sample





Section V. Investigation

Resident Investigation – General Guidelines

- Conduct investigations for all concerns that warrant further investigation for sampled residents
- Continuous observations, if required
- Interview representative, if appropriate, when concerns are identified

Investigations

- Majority of time spent observing and interviewing with relevant review of record to complete investigation
- Use Appendix PP and critical elements (CE) pathways





Section VI. Ongoing and Other Survey Activities

Closed Record Reviews

- Complete timely during the investigation portion of survey
- Unexpected death, hospitalization, and community discharge last 90 days
- System selected or discharged resident
- Use Appendix PP and CE pathways

Infection Control

- Throughout survey, all surveyors should observe for infection control
- Assigned surveyor coordinates a review of influenza and pneumococcal vaccinations
- Assigned surveyor reviews infection prevention and control, and antibiotic stewardship program

SNF Beneficiary Protection Notification Review

- A new pathway has been developed
- List of residents (home and in-facility)
- Randomly select three residents
- Facility completes new worksheet
- Review worksheet and notices

Kitchen Observation

- In addition to the brief kitchen observation upon entrance, conduct full kitchen investigation
- Follow Appendix PP and Facility Task Pathway to complete kitchen investigation



Medication Administration

Medication Administration

- Recommend nurse or pharmacist
- Include sample residents, if opportunity presents itself
- Reconcile controlled medications if observed during medication administration
- Observe different routes, units, and shifts
- Observe 25 medication opportunities
- Non nurses will now be observing the medication pass.

Medication Storage

Medication Storage

- Observe half of medication storage rooms and half of medication carts
- If issues, expand medication room/cart

Resident Council Meeting

- Group interview with active members of the council
- Complete early to ensure investigation if concerns identified
- Refer to updated Pathway



Resident Council Interview

- Completed Early as possible in the Survey
- Surveyors will ask the president of the resident council to review at least three months of resident council minutes prior to the meeting
- Surveyors will review the grievance policy to assure prompt resolution and that grievances are maintained for at least three years.

Sufficient and Competent Nurse Staffing Review

- Is a mandatory task, refer to revised Facility Task Pathway
- Sufficient and competent staff
- Throughout the survey, consider if staffing concerns can be linked to QOL and QOC concerns

Environment

- Investigate specific concerns
- Eliminate redundancy with LSC
 - Disaster and Emergency Preparedness
 - O2 storage
 - Generator



Section VII. Potential Citations

Potential Citations

- Team makes compliance determination.
 - Compliance decisions reviewed by team
 - Scope and severity (S/S)
- Conduct exit conference and relay potential areas of deficient practice



S&C Letter 17-34

New Format for Plans of Corrections and Allegations of Compliance

Plans of Correction

- S&C: 17-34-All
- Format for Plans of Corrections/Allegations of Compliance
- An acceptable plan of correction must contain the following elements:

Plans of Corrections

- **The plan of correcting the specific deficiency. The plan address the processes that lead to the deficiency cited.**
 - We need specific information for how the facility will correct the deficiency including a evaluation of what led to the deficiency being cited and how the facility was going to fix it.
 - What are the facts of the situation that led to the deficiency.
- **The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**
 - Be specific in the steps that are being taken to fix the problem.

Plans of Correction

- **The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.**
- **The title of the person responsible for implementing the acceptable plan of correction.**

Past Non Compliance

- *Past noncompliance occurs when noncompliance has occurred in the past, but the facility corrects the deficiency and is in substantial compliance at the time of the current survey. More specifically, a deficiency citation at past noncompliance meets the following three criteria:*
- *1. The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;*
- *2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and*
- *3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.*
- *The surveyors must document the facility's corrective actions in the CMS-2567; the facility is not required to submit a plan of correction. Refer to Appendix P of the State Operations Manual (SOM) for more specific information on determining and documenting past noncompliance. Refer to SOM Section 7510.1 for information on the imposition of a civil monetary penalty related to a finding of past noncompliance.*



11/27/17

LTC Regulations

F 540: Definitions

- Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.

It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

F 550: Residents

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, *including those specified in this section.*

- §483.10(a)(1) A facility must *treat each resident with respect and dignity and care for each resident* in a manner and in an environment that promotes maintenance or enhancement of *his or her* quality of life, *recognizing each resident's individuality. The facility must protect and promote the rights of the resident.*

F 550

- *483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.*

§483.10(b) Exercise of Rights.

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

- *§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*
- *§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.*

Intent

- *All residents have rights guaranteed to them under Federal and State laws and regulations. This regulation is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.*

Justice Involved Individuals

- *Justice involved individuals are entitled to the same rights described in 42 CFR Part 483, Subpart B as all other residents residing in the facility. The facility shall not establish policies or impose conditions on the justice involved resident that result in restrictions which violate the resident's rights. Some Department of Corrections or law enforcement terms of release or placement may conflict with CMS requirements. If the facility accepts responsibility for enforcing restrictive law enforcement terms applied to a resident that are contrary to the Requirements for LTC Facilities, the facility would not be in compliance with federal long term care requirements. In addition, law enforcement jurisdictions may not be integrated with the operations of the facility.*

F 551

§483.10(b)(3) In the case of a resident who has not been adjudged incompetent *by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. *The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.**

§ 483.10 Resident Rights - New

§ 483.10(c) Planning and Implementing Care (F552/F553)

- Right to be informed in advance of risks and benefits of proposed care/treatment, treatment alternatives, and choose the alternative of his or her choice
- Right to identify individuals to be included in care planning;
- Right to request meetings or revisions to the care plan;
- Right to establish expected goals and outcomes
- Right to see the care plan and sign after any significant changes

§ 483.10 Resident Rights - New

§ 483.10(c) Planning and Implementing Care (F552/F553)

The facility must inform the resident of the right to participate in his/her treatment and support the resident in that right by:

- Facilitating the inclusion of the resident or representative;
- Include an assessment of the resident's strengths and needs; and
- Incorporate the resident's personal and cultural preferences in developing goals of care;

F 559: Room Changes/Roommates

- **§483.10(e)(4)** The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
- **§483.10(e)(5)** *The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.*
- **§483.10(e)(6)** *The right to receive written notice, including the reason for the change,* before the resident's room or roommate in the facility is changed.

Guidance

- Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.*
- There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents are not able to share a room if one of the residents has a different payment source for which the facility is not certified (if the room is in a distinct part of the facility, unless one of the residents elects to pay privately for his or her care) or one of the individuals is not eligible to reside in a nursing home.*

Room Changes

- *Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an **explanation in writing** of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.*

Room changes/Room Mates

- **A resident receiving a new roommate should *be given as much advance notice as possible*. The resident should *be supported when a roommate passes away* by providing time to adjust before moving another person into the room. The length of time needed to adjust may differ depending upon the resident. *Facility staff* should provide necessary social services for a resident who is grieving over the death of a roommate.**

F 560

§483.10(e)(7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:

- **(i) *to relocate* a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or**
- **(ii) *to relocate* a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.**
- ***(iii) solely for the convenience of staff.***

Refuse to Transfer

- *A resident also has the right to refuse transfer if that transfer is solely for the convenience of staff. For example, a resident may experience a change in condition that requires additional care. Facility staff may wish to move the resident to another room with other residents who require a similar level of services, because it is easier for staff to care for residents with similar needs. The resident would have the right to stay in his or her room and refuse this transfer.*

F 585 Grievances

- *Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, **issuing written grievance decisions to the resident**; and coordinating with state and federal agencies as necessary in light of specific allegations;*

F585 Grievances.

- **§483.10(j)(1)** The resident has the right to voice grievances *to the facility or other agency or entity that hears grievances* without discrimination or reprisal *and without fear of discrimination or reprisal*. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, *the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.*

F 585 Grievances

- **§483.10(j)(2)** The resident has the right to *and the facility must make* prompt efforts by the facility to resolve grievances *the resident may have, in accordance with this paragraph.*
- **§483.10(j)(3)** *The facility must make information on how to file a grievance or complaint available to the resident.*
- **§483.10(j)(4)** *The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:*

Policy must include:

- *i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;*

Policy must include:

- *(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;*
- *(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;*

Policy must include:

- *(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;*
- *(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;*

Policy must include:

- *(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and*
- *(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.*

F 585: Interpretative Guidance

- *Review facility grievance policy to see if compliant with necessary requirements as listed above.*
- *Determine how information on how to file a grievance is made available to the resident.*
- ***Review grievance decisions to determine if required information was provided to residents and facility documentation was maintained for at least 3 years.***



Freedom from Abuse, Neglect, and Exploitation



Abuse and Neglect were placed together as they are so similar

Starts with F 600

Overview of 42 CFR 483.12

- F600 – Abuse and Neglect
- F602 -Misappropriation of Resident Property and Exploitation
- F603 –Involuntary Seclusion
- F604 – Physical Restraints
- F605 – Chemical Restraints

Overview of 42 CFR 483.12

- F606 – Prohibit Employment for Individuals with Adverse Actions
- F607 – Policies and Procedures
- F608 – Reporting of Suspected Crimes
- F609 – Reporting of Alleged Violations
- F610 – Response to Alleged Violations

Definition

- “**Abuse**,” “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. *Abuse* also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. *Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.*”

Definitions

- “Neglect,” as defined at §483.5, means *“the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.”*
- *Willful,* as defined at §483.5 and as used in the definition of “abuse,” *“means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.”*

Staff to Resident Abuse of Any Type

- *Nursing homes have diverse populations including, among others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences, speech/language challenges, and generational differences. When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population. A facility cannot disown the acts of staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. CMS does not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for an employee to claim his/her action was "reflexive" or a "knee-jerk reaction" and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited.*

Staff to Resident Abuse

- ***NOTE:** It should not be assumed that every accident or disagreement that occurs between an employee and a resident should be considered to be abuse. Accidents that may not be considered to be abuse include instances such as a staff member tripping and falling onto a resident; or a staff member quickly turning around or backing into a resident that they did not know was there.*

Abuse

Determination of Findings and Potential to Foresee Abuse

- It has been reported that some facilities have identified that they are in compliance with F600- Free from Abuse and Neglect because that they could not foresee that abuse would occur and they have “done everything to prevent abuse,” such as conducted screening of potential employees, assessed residents for behavioral symptoms, monitored visitors, provided training on abuse prevention, suspended or terminated employment of the perpetrator, developed and implemented policies and procedures to prohibit abuse, and met reporting requirements. However, this interpretation would not be consistent with the regulation, which states that “the resident has the right to be free from verbal, sexual, physical, and mental abuse...” Therefore, if the survey team has investigated and collected evidence that abuse has occurred, it is appropriate for the survey team to cite the current or past noncompliance at F600-Free from Abuse and Neglect.

Past Non Compliance

Past noncompliance occurs when noncompliance has occurred in the past, but the facility corrects the deficiency and is in substantial compliance at the time of the current survey. More specifically, a deficiency citation at past noncompliance meets the following three criteria:

- 1. The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;*
- 2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and*
- 3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.*
- 4. The surveyors must document the facility's corrective actions in the CMS-2567; the facility is not required to submit a plan of correction. Refer to Appendix P of the State Operations Manual (SOM) for more specific information on determining and documenting past noncompliance. Refer to SOM Section 7510.1 for information on the imposition of a civil monetary penalty related to a finding of past noncompliance.*

Staff to Resident Abuse of Any Type

- CMS does not consider striking a combative resident an appropriate response in any situation. *It is also not acceptable for an employee to claim his/her action was “reflexive” or a “knee-jerk reaction” and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited.*

Resident to Resident Abuse

- *A resident to resident altercation should be reviewed as a potential situation of abuse. When investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term “willful”.*

Resident to Resident Abuse

- *The word “willful” means that the individual’s action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (“willful”) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. If it is determined that the action was not willful (a deliberate action), the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible, and that each resident receives adequate supervision (See F689)*

Resident to Resident Abuse

- *The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse. For example, redirection alone is not a sufficiently protective response who will not be deterred after being redirected away from a resident.*

Resident to Resident Abuse

- *Staff should monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to:*
- *Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;*
- *Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;*
- *Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;*
- *Taking, touching, or rummaging through other's property; and*
- *Wandering into other's rooms/space.*

Definition of Sexual Abuse

- “**Sexual abuse,**” is defined at §483.5 as “non-consensual sexual contact of any type with a resident.”

Some Examples of Sexual Abuse:

- Unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, and coerced nudity;
- Forced observation of masturbation and/or pornography; and
- Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident.

Visitor to Resident Abuse of Any Type

- *Allegations of abuse have been reported between spouses, or residents and their parents or children, in addition to visitors who are not members of a resident's immediate family.*
- *Based on the circumstances we can cite this under several different tags.*
- *If there is any abuse of residents from anyone outside the facility the facility has the obligation to call the police and also report to the State.*

Capacity to Consent

- *Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity*
- *The facility's policies, procedures and protocols, should identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded.*

- *NOTE: See F551 at 42 CFR 483.10(b)(6)- If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.*
- *This means notifying entities such as the Department of Social Services for say Financial Exploitation*

F 602 and F 603

- F602/603
- **The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.**

DEFINITIONS

- *“Exploitation,” as defined at §483.5, means “taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.”*

Guidance to surveyors

GUIDANCE

- *Residents' property includes all residents' possessions, regardless of their apparent value to others since they may hold intrinsic value to the resident. Residents are permitted to keep personal clothing and possessions for their use while in the facility, as long as it does not infringe upon the rights of other residents (See F557). Examples of resident property include jewelry, clothing, furniture, money, and electronic devices, the resident's personal information such as name and identifying information, credit cards, bank accounts, driver's licenses, and social security cards. **CALL THE POLICE notify the state if it is THEFT***

F 604 §483.10(e) *Respect and Dignity*

- The resident has a right to be treated with respect and dignity, including:
- **§483.10(e)(1)** The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, *consistent with §483.12(a)(2)*.

F 604 Restraints

§483.12(a) The facility must—

- Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.*

Definition

- *“Physical restraint” is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:*
- *Is attached or adjacent to the resident’s body;*
- *Cannot be removed easily by the resident; and*
- *Restricts the resident’s freedom of movement or normal access to his/her body.*

GUIDANCE: Definition

- *A physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to remove it. For example, a bed rail is considered to be a restraint if the resident is not able to put the side rail down in the same manner as the staff. Similarly, a lap belt is considered to be a restraint if the resident cannot intentionally release the belt buckle.*

Bed Rails

- *Facilities must use a person-centered approach when determining the use of bed rails, which would include conducting a comprehensive assessment, and identifying the medical symptom being treated by using bed rails. Bed rails may have the effect of restraining one individual but not another, depending on the individual resident's conditions and circumstances.*

Bed Rails

- *Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. Residents in a bed with bed rails have attempted to exit through, between, under, over, or around bed rails or have attempted to crawl over the foot board, which places them at risk of serious injury or death.*
 - *Serious injury from a fall is more likely from a bed with raised bed rails than from a bed where bed rails are not used. In many cases, the risk of using the bed rails may be greater than the risk of not using them as the risk of restraint-related injury and death is significant. For example, a resident who has no voluntary movement may still exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed, increasing the risk for entrapment, when bed rails are used.*

Bed Rails

- *The use of partial bed rails may assist an independent resident to enter and exit the bed independently and would not be considered a physical restraint. To determine if a bed rail is being used as a restraint, the resident must be able to easily and voluntarily get in and out of bed when the equipment is in use. If the resident cannot easily and voluntarily release the bed rails, the use of the bed rails may be considered a restraint.*

Position Change Alarms

- *Position change alarms are any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors. Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.*
- *While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement. For example, a resident may be afraid to move to avoid setting off the alarm and creating noise that is a nuisance to the resident(s) and staff, or is embarrassing to the resident. For this resident, a position change alarm may have the potential effect of a physical restraint.*

Guidance

- *The resident or resident representative may request the use of a physical restraint; however, the nursing home is responsible for evaluating the appropriateness of the request, and must determine if the resident has a medical symptom that must be treated and must include the practitioner in the review and discussion. If there are no medical symptoms identified that require treatment, the use of the restraint is prohibited. Also, a resident, or the resident representative, has the right to refuse treatment; however, he/she does not have the right to demand a restraint be used when it is not necessary to treat a medical symptom.*

- Wander guards are not considered restraints. Do not code them as restraints.
- You can not put wander guards on alert and oriented residents.
- You would code the Wander Guards under P 200 on the MDS where it asks about types of alarms.

Separated Tags

- F606 *Not Employ/Engage Staff with Adverse Actions
- F607 *Develop/Implement Abuse/Neglect, Policies and Procedures
- F608 *Reporting of Reasonable Suspicion of a Crime
- F609 *Reporting of Alleged Violations
- F610 *Investigate/Prevent/Correct Alleged

F 606: Not Employ....

§483.12(a)(3) Not employ or otherwise engage individuals who—

- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;**
- (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or**
- (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.**

F 607 Policies and Procedures

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,

§483.12(b)(4) Establish coordination with the QAPI program required under §483.75. [§483.12(b)(4) will be implemented beginning November 28, 2019 (Phase 3)]

F 608 Reporting Reasonable Suspicion of a Crime

The facility must develop and implement written policies and procedures:

(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

F 609 In response to allegations of abuse, neglect, exploitation, or mistreatment:

- ***Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.***

Serious Bodily Injury

- *“Serious bodily injury” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse*

Definition

- *“Immediately” means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.*

F 610

- ***§483.12(c)*** *In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:*
- ***§483.12(c)(2)*** *Have evidence that all alleged violations are thoroughly investigated.*
- ***§483.12(c)(3)*** *Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.*
- ***§483.12(c)(4)*** *Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.*

F620 Admissions policy

- **Not *request* or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and**
- ***(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.***

Guidance : F 620

§483.15(a)(1) and (2) Admissions Policy/Preconditions of Admission

- *All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the admissions policy must comply with the provisions at §483.15(c)(1) which stipulate the limited conditions for transfer or discharge. The provisions at §§483.15 (a)(2) –(5), further prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, under §§483.15(a)(6) – (7), the admissions policy must identify information that must be disclosed to residents and potential residents, such as notice of special facility characteristics, any service limitations of the facility, if applicable. Additionally, it requires that the facility's admission agreement disclose its physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part (see additional guidance below). The facility must also have a process for how it will disclose required information to residents and potential residents.*

Admissions Policy

- *Lastly, residents must not be asked to waive facility responsibility for the loss of their personal property or be unable to use personal property because it is only permitted in the facility if safeguarded by the facility in a manner that makes the property essentially inaccessible to the resident. These waivers effectively take away the residents' right to use personal possessions and relieve facilities from their responsibility to exercise due care with respect to residents' personal property. Compliance requires facilities to develop policies and procedures to safeguard residents' personal possessions without effectively prohibiting a resident's use of personal possessions.*

Admission Policy

- This provision is not intended to make facilities automatically liable for every loss regardless of whether or not the facility is aware of the extent of personal property brought into the facility . Examples of reasonable facility policies may include
- 1) establishing a process to document high value personal property (particularly cash, valuables, and medical/ assistive devices) brought in by residents.

Admission Policy

- 3) establishing a process to work with residents and their representatives/family to ensure safety as well as availability to the resident of cash and/or items over a certain dollar value, including medical/assistive devices.

F 622 Transfer and Discharge

- **§483.15(c) Transfer and discharge-**
- **(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—**
- **(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
- **(B) 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;**

F 622 Transfer and Discharge

- (C) The safety of individuals in the facility is endangered *due to the clinical or behavioral status of the resident*;**
- (D) The health of individuals in the facility would otherwise be endangered;**
- (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. *Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.* For a resident who becomes eligible for Medicaid after admission to a *facility*, the facility may charge a resident only allowable charges under Medicaid; or**

F 622 Transfer and Discharge

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

F622: Transfer and discharge

- *The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.*

F622: Transfer and discharge

- *The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.*

F 622

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, *the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.*

(i) Documentation in the resident's medical record must include:

- (A) The basis for the transfer per paragraph (c)(1)(i) of this section.*
- (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).*

F 622 Required Documentation

(iii) Information provided to the receiving provider must include a minimum of the following:

- (A) Contact information of the practitioner responsible for the care of the resident.*
- (B) Resident representative information including contact information*
- (C) Advance Directive information*
- (D) All special instructions or precautions for ongoing care, as appropriate.*
- (E) Comprehensive care plan goals;*
- (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.*

Interpretative Guidelines

- *A resident-initiated transfer or discharge is one in which the resident has provided written or verbal notice of their intent to leave the facility, which is documented in the resident's record. A resident's expression of a general desire to return home or to the community or elopement of a resident who is cognitively impaired should not be taken as a notice of intent to leave.*
- *When a resident initiates his or her transfer or discharge, the medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or if appropriate his/her representative, containing details of discharge planning, and arrangements for post-discharge care (See F660, Discharge Planning Process). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident initiated. Therapeutic leave is a type of resident-initiated transfer. However, if the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge.*

F 660: Discharge Planning Process

- *The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and— (many areas under this please review)*

Discharge: Intent

- *This requirement intends to ensure that the facility has a discharge planning process in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.*

Required Documentation

- *To demonstrate that any of the circumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge.*
- *For circumstances 1 and 2 above for permissible facility-initiated transfer or discharge, the resident's physician must document information about the basis for the transfer or discharge. Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the resident's physician must include:*
 - *The specific resident needs the facility could not meet;*
 - *The facility efforts to meet those needs; and*
 - *The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.*

Required Documentation

- *In circumstances 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.*

Information Conveyed to Receiving Provider (if not expected to return)

The regulations at §483.15(c)(2)(iii) address information that must be conveyed to the receiving provider when a resident is transferred or discharged. The specific information which must be conveyed depends upon whether the resident is transferred (expected to return), or is discharged (not expected to return). If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider:

- Contact information of the practitioner who was responsible for the care of the resident;*
- Resident representative information, including contact information;*
- Advance directive information;*
- Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:
 - Treatments and devices (oxygen, implants, IVs, tubes/catheters);*
 - Precautions such as isolation or contact;*
 - Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;**

Information Conveyed to Receiving Provider (if not expected to return)

- *The resident's comprehensive care plan goals; and*
- *All information necessary to meet the resident's needs, which includes, but may not be limited to:*
 - *Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;*
 - *Diagnoses and allergies;*
 - *Medications (including when last received); and*
 - *Most recent relevant labs, other diagnostic tests, and recent immunizations.*

Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information).

F623 (c)(3) Notice before transfer

- Before a facility transfers or discharges a resident, the facility must—
- (i) Notify the resident and the *resident's* representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. *The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.*
- (ii) Record the reasons *for the transfer or discharge* in the resident's *medical* record *in accordance with paragraph (c)(2) of this section*; and
- (iii) Include in the notice the items described in paragraph (c) (5) of this section.

F 623 (c) (4) Timing of Notice

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when

- **(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;**
- **(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;**
- **(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;**
- **(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or**
- **(E) A resident has not resided in the facility for 30 days.**

483.15(c)(5) Contents of the notice.

- (i) The reason for transfer or discharge;
- (ii) The effective date of transfer or discharge;
- (iii) The location to which the resident is transferred or discharged;
- (iv) A statement of the resident's *appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;*
- (v) The name, address (*mailing and email*) and telephone number of *the Office of the State Long-Term Care Ombudsman;*
- (vi) For nursing facility residents with *intellectual and developmental disabilities or related disabilities*, the mailing *and email* address and telephone number of the agency responsible for the protection and advocacy of individuals *with developmental disabilities* established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (*Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.*); and
- (vii) For nursing facility residents *with a mental disorder or related disabilities*, the mailing *and email* address and telephone number of the agency responsible for the protection and advocacy of individuals *with a mental disorder* established under the Protection and Advocacy for Mentally Ill Individuals Act

§483.15(c)(6) Contents of the Notice

- *If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.*
- *§483.15(c)(8) Notice in advance of facility closure*
- *In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).*

GUIDANCE

- *The requirements at 483.15(c)(3)-(6) only apply to facility-initiated transfers and discharges, not resident-initiated transfers and discharges. This guidance will address the requirement to send a notice in situations where the facility initiates a transfer or discharge, including discharges that occur while the resident remains in the hospital after emergency transfer.*
- *Facility-initiated transfers and discharges generally occur when the facility determines it should not, or cannot provide needed care or services to a resident in accordance with F622, Transfer and Discharge Requirements. Whether or not a resident agrees with the facility's decision, the requirements at 483.15(c)(3)-(6) apply whenever a facility initiates the transfer or discharge.*

Transfers

- *Emergency Transfers--When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii) (D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.*

F 624 Orientation for transfer or discharge

- A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. *This orientation must be provided in a form and manner that the resident can understand.*

GUIDANCE

- *The guidance at this tag generally addresses the immediate orientation and preparation necessary for a transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate discharge where a complete discharge planning process is not practicable.*

F 625: Notice of *bed-hold* policy and *return*

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or *the resident goes on therapeutic leave*, the nursing facility must provide written information to the resident or *resident representative* that specifies—

- (i) The duration of the *state* bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
- (ii) *The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;*
- (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; *and*
- (iv) *The information specified in paragraph (e)(1) of this section.*

Bed Hold

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and *the resident representative* written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

INTENT

- *To ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility.*

F626 Permitting residents to return

A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

- (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, *returns to the facility to their previous room if available or* 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 *Medicare skilled nursing facility services or Medicaid nursing facility services.*
- (ii) *If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.*

F 626 Permitting Return

A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on his or her condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:

- Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.*
- Ascertain an accurate status of the resident's condition—this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.*
- Find out what treatments,*

F 626 Permitting Return

Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.

- Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to: Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;

- Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

F 626 Permitting Return

- *If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.*

F 635 Admissions Orders

§483.20(a) Admission orders

- **At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.**
- **INTENT §483.20(a)**
- *To ensure each resident receives necessary care and services upon admission.*



Comprehensive Person Centered Care Planning

Baseline Care Plans

Requirements

F655

Comprehensive Person-Centered Care

§483.21(a) Baseline Care Plans

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

- (i) Be developed within 48 hours of a resident's admission.*
- (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—*
 - (A) Initial goals based on admission orders.*
 - (B) Physician orders.*
 - (C) Dietary orders.*
 - (D) Therapy services.*
 - (E) Social services.*
 - (F) PASARR recommendation, if applicable.*

Baseline Care Plans

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

- (i) The initial goals of the resident.*
- (ii) A summary of the resident's medications and dietary instructions.*
- (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.*
- (iv) Any updated information based on the details of the comprehensive care plan, as necessary.*

Baseline Care Plan Summary

The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:

- Initial goals for the resident;*
 - A list of current medications and dietary instructions, and*
 - Services and treatments to be administered by the facility and personnel acting on behalf of the facility;*
- The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.*

F656

§483.21(b) Comprehensive Care Plans

- **§483.21(b)(1)** The facility must develop *and implement* a comprehensive *person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3)*, that includes measurable objectives and *timeframes* to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —

New Language

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

F657

§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must be—

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

(ii) Prepared by an interdisciplinary team, that includes *but is not limited to*--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) *A member of food and nutrition services staff.*

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) *Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.*

F 660 Discharge Planning Process

- *F660*
- *§483.21(c)(1) Discharge Planning Process*
- *The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—*

F 660 Discharge Planning Process

- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.*
- (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.*
- (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.*
- (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.*
- (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.*
- (vi) Address the resident's goals of care and treatment preferences.*
- (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.*

F 660 Discharge Planning

- *(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.*
- *(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.*
- *(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.*

F 660 Discharge Planning

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

F661

§483.21(c)(2) Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes, *but is not limited to, the following:*

- (i) A recapitulation of the resident's *stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.*
- (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
- (iii) *Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).*
- (iv) A post-discharge plan of care that is developed with the participation of the resident and, *with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.*

Quality of Life



F675

§ 483.24 Quality of life

- *Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.*

Intent

- *The intent of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:*
- *Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and*
- *Ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.*

F 676 & 677

- **F676(a)** *Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:*
- **F677 §483.24(a)(2)** 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; and

F 678

§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

INTENT §483.24(a)(3)

- To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs, and the resident's advance directives.*

F 689: Accidents

Accidents.

- **The facility must ensure that –**
- **§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and**
- **§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.**

Interpretative Guidance

- *Verbal consent or signed consent/waiver forms do not eliminate a facility's responsibility to protect a resident from an avoidable accident, nor does it relieve the provider of its responsibility to assure the health, safety, and welfare of its residents. **While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. The regulations hold the facility ultimately accountable for the resident's care and safety.***

Interps cont.....

Position Change Alarms:

- *Facilities often implement position change alarms as a fall prevention strategy or in response to a resident fall. The alarms are designed to alert staff that the resident has changed position, increasing the risk for falling. However, the efficacy of alarms to prevent falls has not been proven and a study of hospitalized patients concluded these devices may only alert staff that a fall has already occurred. The same study also noted false alarms are a common problem leading to “alarm fatigue,” where staff no longer respond to the sound of an alarm.¹² A study on bed-exit alarms concluded the alarms are not a substitute for staff assisting residents and bed-exit alarms may not always function reliably for residents who weigh less than 100 pounds or who are restless.¹³ Individual facility efforts to reduce use of alarms have shown falls actually decrease when alarms are eliminated and replaced with other interventions such as purposeful checks to proactively address resident needs, adjusting staff to cover times of day when most falls occur, assessing resident routines, and making individualized environmental or care changes that suit each resident.¹⁴*

Interps: Position Change Alarms

- *Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. While position change alarms are not prohibited from being included as part of a plan, they should not be the primary or sole intervention to prevent falls. If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident. Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis.*

F 697: *Pain Management.*

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

INTENT §483.25 (k)

- *Based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management.*

§483.25(l) Dialysis

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

INTENT: §483.25(l)

- *The intent of this requirement is that the facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including the:*
- *• Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility;*
- *• Safe administration of hemodialysis at the bedside and/or peritoneal dialysis in the nursing home provided by qualified trained staff/caregivers, in accordance with State and Federal laws and regulations;*
- *• Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments, monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices; and*
- *• Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.*

F 700 Bed Rails

The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

- (1) Assess the resident for risk of entrapment from bed rails prior to installation.*
- (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation*
- (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.*
- (4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.*

Bed Rails

- *INTENT 483.25(n)*
- *The intent of this requirement is to ensure that prior to the installation of bed rails, the facility has attempted to use alternatives; if the alternatives that were attempted were not adequate to meet the resident's needs, the resident is assessed for the use of bed rails, which includes a review of risks including entrapment; and informed consent is obtained from the resident or if applicable, the resident representative. The facility must ensure the bed is appropriate for the resident and that bed rails are properly installed and maintained.*

Bed Rails

- *"Entrapment" is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.*
- *"Bed rails" are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed.*
- *Examples of bed rails include, but are not limited to:
Side rails, bed side rails, and safety rails; and
Grab bars and assist bars.*

Interps.....

Resident Assessment

- *After a facility has attempted alternatives to bed rails and determined that these alternatives do not meet the resident's needs, the facility must assess the resident for the risks of entrapment and possible benefits of bed rails. In determining whether to use bed rails to meet the needs of a resident, the following components of the resident assessment should be considered*

Informed Consent

After alternatives have been attempted and prior to installation, the facility must obtain informed consent from the resident or if applicable, the resident representative for the use of bed rails. The facility should maintain evidence that it has provided sufficient information so that the resident or resident representative could make an informed decision. Information that the facility must provide to the resident, or resident representative include, but are not limited to:

- What assessed medical needs would be addressed by the use of bed rails;*
- The resident's benefits from the use of bed rails and the likelihood of these benefits;*
- The resident's risks from the use of bed rails and how these risks will be mitigated; and*
- Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.*

Informed Consent

- *The information should be presented to the resident, or if applicable, the resident representative, so that it could be understood and that consent can be given voluntarily, free from coercion.*

Installation & Maintenance

- *Assuring the correct installation and maintenance of bed rails is an essential component in reducing the risk of injury resulting from entrapment or falls. The FDA and the United States Consumer Product Safety Commission (CPSC) has recommended the following initial and ongoing actions to prevent deaths and injuries from entrapment and/or falls from bed rails:*
- *Before bed rails are installed, the facility should:*
 - *Check with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible, since most bed rails and mattresses are purchased separately from the bed frame.*

Physician Regulations

*Dietary
Therapy*

New Language



F715 *A resident's attending physician may delegate ...*

..the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who—

- (i) Is acting within the scope of practice as defined by State law; and*
- (ii) Is under the supervision of the physician.*

(3) A resident's attending physician may delegate the task of writing therapy orders, consistent with §483.65, to a qualified therapist who—

- (i) Is acting within the scope of practice as defined by State law; and*
- (ii) Is under the supervision of the physician*

INTENT §483.30(e)(2)-(3)

- To provide physicians with the flexibility to delegate to a qualified dietitian/other clinically qualified nutrition professional the task of writing dietary orders, and to delegate to a qualified therapist the task of writing therapy orders. This flexibility is beneficial to the physician and the resident, allowing the physician to determine how to best use his or her time and allowing the*
- resident to have more frequent adjustments to nutritional needs and therapy as his or her condition or abilities change.*

F 725: Nursing Services

Nursing Services

- **The facility must have sufficient nursing staff *with the appropriate competencies and skills sets* to provide nursing and related services *to assure resident safety and* 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 *and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).***

This helps my behavioral health!



F 740 Behavioral Health Services

- *Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.*

Guidance

- *Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.*

The facility must provide necessary behavioral health care and services which include:

- Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;*
- Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.*
- Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;*
- Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;*
- Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.*

F 741: Sufficient Staff

The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

- (1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3).*
- (2) Implementing non-pharmacological interventions.*

INTENT

- The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.70(e). This includes residents with mental disorders, psychosocial disorders, or substance use disorders. Facility staff members must implement person-centered, care approaches designed to meet the individual needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.*

Skill and Competency of Staff

- *The facility must identify the skills and competencies needed by staff to work effectively with residents (both with and without mental disorders and psychosocial disorders). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through an evidence-based process that could include the following: an analysis of Minimum Data Set (MDS) data, review of quality improvement data, resident-specific and population needs, review of literature, applicable regulations, etc. Once identified, staff must be aware of those disease processes that are relevant to enhance psychological and emotional well-being.*

Interps.....

Determination of Staff Competencies

- *As required under §483.70(e) (F838), the facility's assessment must include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. The facility must have a process for evaluating these competencies.*

F 742

- *A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;*

Intent

- *The intent of this regulation is to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being. Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.*

GUIDANCE

- *Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (PTSD) require specialized care and services to meet their individual needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.*

New Dementia Tag

- **F744**

A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Guidance

- *Providing care for residents living with dementia is an integral part of the person-centered environment, which is necessary to support a high quality of life with meaningful relationships and engagement. Fundamental principles of care for persons living with dementia involve an interdisciplinary approach that focuses holistically on the needs of the resident living with dementia, as well as the needs of the other residents in the nursing home. Additionally, it includes qualified staff that demonstrate the competencies and skills to support residents through the implementation of individualized approaches to care (including direct care and activities) that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.*



SHANNON BRINKMAN PHOTO

F756: Drug Regimen Review.

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

2) *This review must include a review of the resident's medical chart.*

4) *The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.*

- *(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.*
- *(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.*
- *(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.*

F 757: Unnecessary Drugs

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—

- (1) In excessive dose (including duplicate *drug* therapy); or**
- (2) For excessive duration; or**
- (3) Without adequate monitoring; or**
- (4) Without adequate indications for its use; or**
- (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or**
- (6) Any combinations of the reasons stated *in paragraphs (d)(1) through (5) of this section.***

F 758: Psychotropic Drugs

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

- **(i) Anti-psychotic;**
- **(ii) Anti-depressant;**
- **(iii) Anti-anxiety; and**
- **(iv) Hypnotic**

Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

- **§483.45(e)(1) Residents who have not used *psychotropic* drugs are not given these drugs unless *the medication* is necessary to treat a specific condition as diagnosed and documented in the clinical record;**
- **§483.45(e)(2) Residents who use *psychotropic* drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;**

Psychotropic continued..

- *(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and*
- *(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.*
- *(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.*

Intent

- *Each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being;*
- *The facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and*
- *PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.*

Duration

- *Regarding PRN medications, it is important that the medical record include documentation related to the attending physician's or other prescriber's evaluation of the resident and of indication(s), specific circumstance(s) for use, and the desired frequency of administration for each medication. As part of the evaluation, gathering and analyzing information helps define clinical indications and provide baseline data for subsequent monitoring.*

PRN Orders for Psychotropic and Antipsychotic Meds

- *In certain situations, psychotropic medications may be prescribed on a PRN basis, such as while the dose is adjusted, to address acute or intermittent symptoms, or in an emergency. However, residents must not have PRN orders for psychotropic medications unless the medication is necessary to treat a diagnosed specific condition. The attending physician or prescribing practitioner must document the diagnosed specific condition and indication for the PRN medication in the medical record.*

PRN table

- *Type: PRN orders for psychotropic medications, excluding antipsychotics*
- *Duration: 14 days*
- *Exception: Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order.*
- *Required Actions: Attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration.*

PRN Table

- **Type:** PRN orders for antipsychotic medications only
- **Duration:** 14 days
- **Exception:** None
- **Required Actions:** If the attending physician or prescribing practitioner wishes to write a new order for the PRN antipsychotic, the attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

Note

The required evaluation of a resident before writing a new PRN order for an antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record:

- Is the antipsychotic medication still needed on a PRN basis?*
- What is the benefit of the medication to the resident?*
- Have the resident's expressions or indications of distress improved as a result of the PRN medication?*

Medication Errors

- **F759 Medication Errors.**
- **The facility must ensure that *its*—**
 - 1) Medication error rates *are not* 5 percent or greater; and**

F760: The facility must ensure that *its*—

 - 2) Residents are free of any significant medication errors.**

Crushing Medications and Administering Medications via Feeding Tube

The crushing of tablets or capsules for which the manufacturer instructs to “do not crush” requires further investigation *by the surveyor*. Some exceptions to the “Do Not Crush” instruction include:

- If the prescriber orders a medication to be crushed which the manufacturer states should not be crushed, the prescriber or the pharmacist must explain, in the clinical record, why crushing the medication will not adversely affect the resident. Additionally, the pharmacist should inform the facility staff to observe for pertinent adverse effects.
- If the facility can provide literature from the medication manufacturer or from a *peer-reviewed* health journal to justify why modification of the dosage form will not compromise resident care.

Crushing Medications

- *CMS has clarified that the crushing of other types of medications for ease of dosage is up to the facility as it is considered that the facility best knows the resident and their needs. It is acceptable to do.*
- *If crushing of medications is done for these types of medications the facility should document in the residents chart the reason for the crushing of the medications.*

Crushing Medications

- *If the surveyor observes medications being crushed and combined, then the number of errors would be equal to the number of medications crushed whether the medications are to be administered orally or via feeding tube. For example, if four medications were crushed and added altogether to applesauce or combined to be administered all at once via feeding tube, then four errors have occurred before the medications have been administered.*

Dental Services



F790

Dental services.

- *§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;*
- *§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.*

F 790 Dental Services

- *§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and*
- *§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.*

Intent

- To ensure that residents obtain needed dental services, including routine dental services; *to ensure the facility provides the assistance needed or requested to obtain these services; to ensure the resident is not inappropriately charged for these services; and if a referral does not occur within three business days, documentation of the facility's to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.*

Dietary



F801

Dietary Staffing

The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)

- 1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who—**
 - (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.*
 - (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.*
 - (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.*
 - (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.*

Dietary Staffing and Qualifications

(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who—

(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:

- (A) A certified dietary manager; or*
- (B) A certified food service manager; or*
- (C) Has similar national certification for food service management and safety from a national certifying body; or*
- (D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and*

(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and



September 2016

Facility Assessment

Three Components

November 28, 2019 it goes live



How is it used on survey?

How is it used in the survey process?

To verify if the facility conducted and documented a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.

Process

- Recertification Survey
- Complaint Survey

F 838: Facility Assessment

- *The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:*

Facility Assessment

- *§483.70(e)(1) The facility's resident population, including, but not limited to, (see regulations)*
- *§483.70(e)(2) The facility's resources, including but not limited to, (see regulations)*
- *§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
– (see regulations)*

Resident Population:

- 1) *The facility's resident population, including, but not limited to,*
 - (i) *Both the number of residents and the facility's resident capacity;*
 - (ii) *The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;*
 - (iii) *The staff competencies that are necessary to provide the level and types of care needed for the resident population;*
 - (iv) *The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and*
 - (v) *Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.*

Facility Assessment: Resident Population

- The regulation outlines that the individualized approach of the facility assessment is the foundation to determine staffing levels and competencies.
 - Therefore, the facility assessment must include an evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs.
 - Furthermore, the assessment must include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. This also includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care identified.
 - Finally, the assessment should consider a review of individual staff assignments and systems for coordination and continuity of care for residents within and across these staff assignments. Also refer to F553, §483.10 Resident Rights for more information and guidance on cultural competence.

Facility Resources:

- (2) The facility's resources, including but not limited to,*
- (i) All buildings and/or other physical structures and vehicles;*
 - (ii) Equipment (medical and non-medical);*
 - (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;*
 - (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;*
 - (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and*
 - (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.*

Resources

- The assessment must include or address the facility's resources which include but are not limited to a facility's operating budget, supplies, equipment or other services necessary to provide for the needs of residents.
- The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. If there are any concerns regarding training refer to §483.95 Training.

Resources

- *The facility assessment must include an evaluation of any contracts, memorandums of understanding including third party agreements for the provision of goods, services or equipment to the facility during both normal operations and emergencies. The facility assessment must address their process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements. For example, if the facility contracts for language translation, the assessment must address how those contractors will ensure services are provided both during normal operational hours and during emergencies.*

Resources

- *The facility assessment must consider health information technology resources, such as managing resident records and electronically sharing information with other organizations. For example, the assessment should address how the facility will securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility.*
- *The facility assessment must include an evaluation of the physical environment necessary to meet the needs of the residents. This must include an evaluation of how the facility needs to be equipped and maintained to protect and promote the health and safety of residents. This should also include an evaluation of building maintenance capital improvements, or structures, vehicles, or medical and non-medical equipment and supplies.*

Facility Based Risk Assessment:

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

INTENT §483.70(e)

- The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.*

Risk Based Assessment

- *Risk Assessment is general terminology that is within the emergency preparedness regulations and preamble to the Final Rule (81 Fed. Reg. 63860, Sept. 16, 2016) which describes a process facilities are to use to assess and document potential hazards within their areas and the vulnerabilities and challenges which may impact the facility. Additional terms currently used by the industry are all-hazards risk assessments, also referred to as Hazard Vulnerability Assessments (HVAs), or all-hazards self-assessments. For the purposes of these guidelines, we are using the term “risk assessment,” which may include a variety of current industry practices used to assess and document potential hazards and their impacts.*
- *Hazard Vulnerability Assessments (HVAs) are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. The HVA describes the process by which a provider or supplier will assess and identify potential gaps in its emergency plan(s).*

Facility Assessment

- *The facility must review and update this assessment annually or whenever there is, or the facility plans for, any change that would require a modification to any part of this assessment.*
 - *For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.*

Risk Based Assessment

- *The facility based and community-based risk assessment, utilizing an all-hazards approach must evaluate the facility's ability to maintain continuity of operations and its ability to secure required supplies and resources during an emergency or natural disaster. For example, if the facility is located in a flood zone, the risk assessment must include an evaluation of how residents will be kept safe and needs met during a flood affecting the facility. Facility staff should consider involving their local/county Office of Emergency Preparedness when conducting this community based risk assessment. The facility's emergency preparedness plans as required under §483.73 should be integrated and compatible with the facility assessment. As one is updated, so should the other.*

Hospice Services



F849

Hospice services

1) A long-term care (LTC) facility may do either of the following:

- (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.*
- (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility*
- that will arrange for the provision of hospice services when a resident requests a transfer.*

F 849: Hospice Services

(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

- (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.*
- (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:*

F 849 Hospice Services

- *A) The services the hospice will provide.*
- *(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.*
- *(C) The services the LTC facility will continue to provide based on each resident's plan of care.*
- *(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.*

F 849

- *(E) A provision that the LTC facility immediately notifies the hospice about the following:*
 - *(1) A significant change in the resident's physical, mental, social, or emotional status.*
 - *(2) Clinical complications that suggest a need to alter the plan of care.*
 - *(3) A need to transfer the resident from the facility for any condition.*
 - *(4) The resident's death.*
- *(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.*

F 849

- *(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.*
- *(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.*

F 849

- *(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.*
- *(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.*
- *(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.*

F 849

- *3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.*
- *The designated interdisciplinary team member is responsible for the following:*

F 849

- *(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.*
- *(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.*
- *(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.*

Hospice

(iv) Obtaining the following information from the hospice:

- (A) The most recent hospice plan of care specific to each patient.*
- (B) Hospice election form.*
- (C) Physician certification and recertification of the terminal illness specific to each patient.*
- (D) Names and contact information for hospice personnel involved in hospice care of each patient.*
- (E) Instructions on how to access the hospice's 24-hour on-call system.*
- (F) Hospice medication information specific to each patient.*
- (G) Hospice physician and attending physician (if any) orders specific to each patient.*
- (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.*

F 849

- *(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.*

Staffing



F 851: Payroll Based Journal

- *F851 (q) Mandatory submission of staffing information based on payroll data in a uniform format.*
- *Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.*

F 851

- *§483.70(q)(1) Direct Care Staff.*
- *Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).*

F 851

2) *Submission requirements.*

- *The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:*
- *(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);*
- *(ii) Resident census data; and*
- *(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).*

F 851

- 3) *Distinguishing employee from agency and contract staff.*
 - *When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.*
- 4) *Data format.*
 - *The facility must submit direct care staffing information in the uniform format specified by CMS.*
- 5) *Submission schedule.*
 - *The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.*

Guidance

- *The facility is responsible for ensuring all staffing data entered in the Payroll-Based Journal (PBJ) system is auditable and able to be verified through either payroll, invoices, and/or tied back to a contract.*
- *Refer to the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual for submission guidelines. Please see the following link for more information: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>*
- *For questions related to F851, surveyors, providers, or other stakeholders should email NHStaffing@cms.hhs.gov.*

- PBJ: 800 839 9290

NH Compare

Email questions: bettercare@cms.hhs.gov

Payroll Based Journal Reports:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>

QAPI



F 865: QAPI [*§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified*]

Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

F 865

- (2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)]*
- (3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and*
- (4)(a) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.*

F 865

b) Program design and scope.

- (1) Address all systems of care and management practices;*
- (2) Include clinical care, quality of life, and resident choice;*
- (3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.*
- (4) Reflect the complexities, unique care, and services that the facility provides.*

F 865

(f) Governance and leadership.: The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

- (1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.*
- (2) The QAPI program is sustained during transitions in leadership and staffing;*
- (3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;*
- (4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.*

F 865

- *(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and*
- *(6) Clear expectations are set around safety, quality, rights, choice, and respect.*
- *(h) Disclosure of information.*

F 865

(g) Quality assessment and assurance.

2) The quality assessment and assurance committee *reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:*

- (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;**
- (iii) *Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.***

F 868

(g) Quality assessment and assurance.

- **(1) A facility must maintain a quality assessment and assurance committee *consisting at a minimum of:***
 - **(i) The director of nursing services;**
 - **(ii) *The Medical Director or his/her designee;***
 - **(iii) *At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and***
 - **(iv) *The infection Preventionist. (not until 11/28/19)***

F 868

(2) The quality assessment and assurance committee *reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:*

- (i) Meet at least quarterly *and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.***

Infection Control



F 880 Infection Control

The facility must establish and maintain an infection *prevention and control* program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of *communicable* diseases and infections.

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

F 880

2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

– (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

F 880

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

(f) Annual review.

- The facility will conduct an annual review of its IPCP and update their program, as necessary.*

F 881 Antibiotic Stewardship

- a) Infection prevention and control program.***
 - The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:***
 - 3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.***

F 881: Antibiotic Stewardship

3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

INTENT

The intent of this regulation is to ensure that the facility:

- Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic;*
- Reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use; and*
- Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics.*

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- *• Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic;*
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- *• Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics.*

Bed Rails



F 909: Bed Rails

(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.

- For concerns related to the inspection or compatibility of bed frames, mattresses and bed rails, cite those here. For additional guidance on the assessment of individual's needs, including the potential risks and benefits of the use of bed rails, refer to F700 Bed Rails located in Quality of Care at §483.25(n).*

PROCEDURES

- *When investigating F909, surveyors may reference Food and Drug Administration (FDA) documents entitled “Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment” dated March 10, 2006, “Practice Hospital Bed Safety” dated February 2013, and “Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care: The Facts” as to the proper dimensions and distances apart of various parts of the bed such as distance between bed frames and mattresses, bed rails and mattress etc. to prevent entrapment by users of the bed.*

F 926 Smoking

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety, including but limited to non-smoking residents.

GUIDANCE

The use of oxygen in smoking areas and while smoking is forbidden.

PROCEDURES

- *Review F689 guidance concerning smoking in the facility.*

F 926 Smoking

5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety, including but limited to non-smoking residents:

- The use of oxygen in smoking areas and while smoking is forbidden.*
- Review F689 guidance concerning smoking in the facility.*
- As part of the overall review of the facility, look for signs of smoking by residents, staff, visitors, guests, and non-staff.*
- Look for smoking areas both inside and outside of the facility. **Smoking inside health care facilities in NC is prohibited.***

F 926

- **The facility must assess their smokers as to whether the resident is capable of smoking safely alone.**
- **If the resident is unable to smoke safely the facility may require that the resident smoke during supervised times.**
- **If the facility assesses the resident as safe to smoke independently then the resident has to be allowed to smoke in designated smoking areas any time they chose to smoke.**

F 926

- *The facility is allowed to keep a resident's smoking materials and to manage these. If a resident asks for them then they have to provide them to the resident upon request.*
- *If you are a smoking facility you must give the surveyors a list of residents that smoke when they enter.*

Emergency Preparedness



Emergency Preparedness

- **E 001: The SNF must comply with all applicable Federal, State and local emergency preparedness requirements. The *[facility]* must establish and maintain a *[comprehensive]* emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:**

E-0002 - E-0006

- (a) **Emergency Plan.** The [*facility*] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. The plan must do all of the following:
- Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*
 - Including missing residents.
 - Include strategies for addressing emergency events identified by the risk assessment.
 - Address patient/client population, including, but not limited to, persons at-risk; the type of services the [*facility*] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

E-0009 - 0022 Emergency Plan must:

- **Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. ****

Plan must include:

- (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
 - (i) Food, water, medical and pharmaceutical supplies
 - (ii) Alternate sources of energy to maintain the following:
 - (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (B) Emergency lighting.
 - (C) Fire detection, extinguishing, and alarm systems.
 - (D) Sewage and waste disposal.

Policies and Procedures

- A system to track the location of on-duty staff and sheltered patients in the [*facility's*] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [*facility*] must document the specific name and location of the receiving facility or other location.

Policies and procedures

- **Safe evacuation from the [*facility*], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.**

Policy and Procedures

- A means to shelter in place for patients, staff, and volunteers who remain in the [*facility*].
- A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
- The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

Policies and Procedures

- The development of arrangements with other [*facilities*] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.
- The role of the [*facility*] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

Communication Plan

- **Must be reviewed and updated at least annually] The communication plan must include all of the following:**
 - (2) Contact information for the following:**
 - (i) Federal, State, tribal, regional, or local emergency preparedness staff.**
 - (ii) The State Licensing and Certification Agency.**
 - (iii) The Office of the State Long-Term Care Ombudsman.**
 - (iv) Other sources of assistance.**

Communication Plan must:

- (4) A method for sharing information and medical documentation for patients under the [*facility's*] care, as necessary, with other health providers to maintain the continuity of care.
- (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).
- (6) A means of providing information about the general condition and location of patients under the [*facility's*] care as permitted under 45 CFR 164.510(b)(4).

Communication Plan must:

- (7) A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.
- (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.

Training and Testing Required:

Training and testing. The [*facility*] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

Training must include:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of all emergency preparedness training.
- (iv) Demonstrate staff knowledge of emergency procedures.

Testing required:

Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

- (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

Testing required:

- (ii) Conduct an additional exercise that may include, but is not limited to the following:**
- **(A) A second full-scale exercise that is community-based or individual, facility-based.**
 - **(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.**
 - **(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.**

Emergency and Standby power systems:

- (e) *Emergency and standby power systems.*** The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.
- ***Emergency generator location.*** The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.
 - ***Emergency generator inspection and testing.*** The [LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.
 - ***Emergency generator fuel.*** [LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

E-0042

- **Integrated healthcare systems.** If a [*facility*] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [*facility*] may choose to participate in the healthcare system's coordinated emergency preparedness program.

Emergency Preparedness

- **Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually.**

F895

§483.85 Compliance and ethics program.

[§483.85 and all subparts will be implemented beginning November 28, 2019]

§483.85(a) Definitions.

- *For purposes of this section, the following definitions apply:*
- *Compliance and ethics program means, with respect to a facility, a program of the operating organization that—*

§483.85(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and

§483.85(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.

- *High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.*
- *Operating organization means the individual(s) or entity that operates a facility.*

F 943: Training Requirements

Facilities must train their staff on;

(c) Abuse, neglect, and exploitation.

In addition to the freedom from abuse, neglect, and exploitation requirements in § facilities must also provide training to their staff that at a minimum educates staff on—

- (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.*
- (2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property*
- (3) Dementia management and resident abuse prevention.*

DEFINITION

- Staff includes for the purposes of the training guidance, all facility staff, (direct and indirect care and auxiliary functions) contractors, and volunteers. F 943*

Questions?

