Survey Management

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

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Survey Management

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Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Staffing Data Submission	CMS is **waiving** 42 CFR **§483.70(q)** to provide **relief** to long-term care facilities on the **requirements** for **submitting staffing data through the Payroll-Based Journal system**.	483.70(q)	F851	Mandatory Submission of Based on Payroll Data.
		483.70(q)(1)		Direct Care Staff.
		483.70(q)(2)		Submission Requirements.
		483.70(q)(3)		Distinguishing Employee from Agency and Contract Staff.
		483.70(q)(4)		Data Format.
		483.70(q)(5)		Submission Schedule.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the reporting of staffing data. It only waives the **timeframe** for which the data is to be submitted (e.g., quarterly).
- During the Public Health Emergency (PHE) staffing data will **not** impact the **5-Star** staffing calculations.
- Reported **staffing data** is **released** by CMS that shows the facility's average number of nursing staff and total staff onsite each day. CMS indicated in QSO 20-28 the data will be used for supporting its response to the COVID-19 pandemic (e.g., use of PPE supplies, staffing shortages, etc.)
- It is also important to **maintain** accurate staffing records in light of the COVID-19 and OSHA Focused Surveys.
- In accordance with OSHA Inspection Guidelines (April 13, 2020), OSHA **will investigate** employee COVID-19 complaints, hospitalizations, and deaths which must be recorded on the OSHA 300/300A logs.
- CMS, CDC, and OSHA will request **employee information** such as work assignments, status of infection, contacts with other staff, etc.

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Minimum Data Set Assessments and Transmission	CMS is **waiving** 42 CFR **§483.20** to provide **relief** to SNFs on the **timeframe requirements** for Minimum Data Set assessments and transmission.	483.20(b)(2)(i)	F636	Timeframe – Assessment within 14 days after admission.
		483.20(b(2)(iii)	F636	Timeframe – Annual Assessment.
		483.20(b)(2)(ii)	F637	Timeframe –Assessment within 14 days after significant change.
		483.20(c)	F638	Timeframe - Quarterly Assessment at Least Every 3 Months.
		483.20(f)(1)	F640	Encoding RAI Data (7-days).
		483.20(f)(2)		Transmittal Capability (7-days).
		483.20(f)(3)		Transmittal of RAI (14-days).
		483.20(f)(4)		Data Format.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the completion of the MDS assessment. It only waives the timeframes for submission of the completed assessment.
- During the PHE, submitted MDS data will **not** be used in calculating the QM 5-Star Ratings.
- You must still complete the MDS Assessment in a timely manner as it is necessary to complete the care plan. Care plan tags are **not** waived **EXCEPT** for COVID-19 transfers and discharges. These exceptions are outlined in the **Resident Transfer and Discharge Waivers** *(see pages 10 and 11)*
- Waiver does **NOT** affect MDS assessment requirements at:
  - ✓ **F641** – Accuracy of Assessments.
  - ✓ **F642** – Coordination/Certification of Assessments

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Pre-Admission Screening and Annual Resident Review (PASARR)	CMS is **waiving** 42 CFR **§483.20(k)**, allowing nursing homes to **admit new** residents who have **not received Level 1 or Level 2 Preadmission Screening**. **Level 1** assessments **may** be performed post-admission. **On or before** the 30th day of admission, **new** patients **admitted** to nursing homes **with** a mental illness **(MI)** or intellectual disability **(ID) should** be **referred promptly by** the nursing home **to** State PASARR program **for Level 2** Resident Review.	483.20(k)	F645	PASARR Screening for MI or ID.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the **completion** of a PASARR Level 1 or Level 2 screening process.
- The waiver **ONLY** **modifies** the requirement that **new admission** PASARR screening be completed **PRIOR** to admission.
- **Level 1** PASARR assessment may be **performed** post-admission.
- **On or before** the **30th** day of admission, **new** residents admitted with a **MI** or **ID should** be **referred promptly** to the State PASARR program **for Level 2** Resident Review.
- This waiver does **NOT** affect the PASARR requirements at:
  - ✓ **F644** – Coordination of PASARR and Assessments.
  - ✓ **F646** – MD/ID Significant Change Notification.

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Resident Groups	CMS is **waiving** the requirements at 42 CFR **§483.10(f)(5)**, which **ensure** residents **can** participate in-person in resident groups. **This waiver would only permit the facility to restrict in-person meetings during the national emergency** given the recommendations of **social distancing** and **limiting** gatherings of more than **ten people**. Refraining from in-person gatherings will help prevent the spread of COVID-19.	483.10(f)(5) 483.10(f)(5)(i) 483.10(f)(5)(ii)	**F565 *** ** SQC Tag*	Right to Organize and Participate in Resident Groups in the Facility. Providing Resident/Family Group with Space for Meetings. Attendance at Meetings.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the residents' right to **participate** in family/group meetings. It only **waives in-person** meeting requirements. Request for resident/family groups must still be honored if such meetings can be held in other formats (e.g., teleconference, GTM, Zoom, Skype, etc.)
- **Issue to Consider**: Does this waiver apply **IF** there are **no** COVID-19 cases in the facility and participants show no signs or symptoms of COVID-19?
- This waiver does **NOT** affect the Family/Group Meeting requirements at:
  - ✓ §483.10(f)(5)(iii) – Providing a staff person to provide assistance.
  - ✓ §483.10(f)(5)(iv) – Consider the views of resident/family group and act promptly upon grievances and recommendations.
  - ✓ §483.10(f)(6) – The resident's right to participate in family groups.
  - ✓ §483.10(f)(7) – The resident's right to have family members or representative to meet with the group.

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Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
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Resident Roommates and Grouping	CMS is **waiving** the requirements in 42 CFR **§483.10(e)(5), (6),** and **(7)** **solely for the purposes** of **grouping** or **cohorting** residents **with** respiratory illness symptoms and/or residents **with** a **confirmed** diagnosis of COVID-19, and **separating** them from residents who **are** asymptomatic or tested negative for COVID-19. This action **waives a facility's requirements**, under 42 CFR **§483.10(e)(7)**, to **provide** for a resident to **share a room with** his or her **roommate** of **choice** in certain circumstances, to provide **notice** and **rationale** for **changing** a resident's room, and to provide for a resident's **refusal** of a transfer to another room in the facility. This **aligns** with CDC guidance to **preferably** place residents in locations **designed** to care for **COVID-19** residents, to **prevent** the transmission of COVID-19 to other residents.	483.10(e)(5) 483.10(e)(6) 483.10(e)(7)	**F559 *** **F559 *** F560 * SQC Tag	Right to Share a Room with his/her Roommate of Choice. Right to Receive Written Notice Before Room / Roommate is Changed. Right to Refuse Transfer to Another Room in the Facility.

Compliance Discussion Points:

- This waiver **ONLY** applies to **certain** residents and only allows the facility to waive the **ADVANCE** notice of the change of room or roommate and the right to refuse the transfer to another room in the facility.
- The waiver did not eliminate the requirement to **INFORM** residents of the move. It only waived the advance notice requirement. Residents and family members should be informed of the **necessity** of the move as soon as practicable.
- **Note**: This waiver did **NOT** include **§483.10(e)(4)**-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.
- **Issue to Consider**: Does this waiver apply to residents who do **not** meet the **criteria** for grouping or cohorting or if there are **no** COVID-19 cases in the facility? Can they still request a room or roommate change?

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		Affected CFR Reference	Affected Survey Tag #	
Clinical Records	CMS is **modifying** the requirement at 42 CFR **§483.10(g)(2)(ii)** which **requires** long-term care (LTC) facilities to **provide** a resident a **copy** of their **records** within **two** working days (when requested by the resident). **Specifically**, CMS is modifying the **timeframe** requirements to **allow** LTC facilities **ten working days** to provide a resident's record **rather** than **two** working days.	483.10(g)(2)(ii)	F573	Right to Access/Purchase Copies of Records.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the requirement to **provide** copies of the medical record to the resident. It only waives the **timeframe** from **two (2)** days to **ten (10)** days.
- This waiver does **NOT** affect requirements at:
  - ✓ §483.10(g)(2)(i) – Providing resident access to personal and medical records within 24-hours.
  - ✓ §483.10(g)(3) – Format and manner in which records are provided to the resident.

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Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
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Quality Assurance and Performance Improvement (QAPI	CMS is <u>modifying</u> **certain requirements** in 42 CFR **§483.75**, which **requires** long-term care facilities to develop, implement, evaluate, and maintain an **effective**, comprehensive, data driven **QAPI** program. **Specifically**, CMS is <u>modifying</u> **§483.75(b)(c)(d)** and **(e)(3)** to the extent necessary **to narrow the scope of the QAPI program to focus on adverse events <u>and</u> infection control**. This will **help** ensure facilities **focus** on aspects of care delivery most **closely associated** with COVID-19 <u>during</u> the **PHE**.	483.75(b)(1)-(4) 483.75(c)(1)-(4) 483.75(d)(1)(2) 483.75(e)(3)	F865 F866 F867	Program Design and Scope. Program Feedback, Data Systems and Monitoring. Program Systematic Analysis & Systemic Action. Performance Improvement Projects.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the **QAPI** requirements at **F865**, **F866**, and **F867**. It **only modifies** the requirements to narrow the scope of the QAPI program to **focus** on **adverse events** <u>and</u> **infection control**.
- This waiver does **NOT** eliminate the QAPI program from **functioning** when other areas are identified. **For example**, if during the course of investigating an adverse event or infection control issue, the QAA Committee determines that staff competency may have contributed to the event, then the QAPI program would still be required to implement tags F865, F866, and F867 to investigate the staff competency issue.
- The waiver does **NOT** affect QAPI requirements at:
  - ✓ **F868** – Maintaining a QAA Committee.

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Inservice Training	CMS is **modifying** the nurse aide training requirements at **§483.95(g)(1)** for SNFs and NFs, which requires the nursing assistant to **receive at least 12 hours** of in-service training **annually**. In accordance with section 1135(b)(5) of the Act, CMS is **postponing** the deadline for completing this requirement throughout the COVID-19 PHE **until** the **end** of the first full quarter **after** the declaration of the **PHE concludes**.	483.95(g)(1)	F947	Required Inservice Training for Nurse Aides.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the **requirement** for nurse aide training. It **only extends** the **12 hours** of required in-service training **annually** until the end of the 1st full quarter AFTER the declaration of the PHE concludes.
- In-Service training must still be **provided** to nurse aides when **competency** issues are **identified**, or upon **employment** of **new** nurse aides. (See **Training and Certification of Nurse Aides Waiver** on next page.)
- This waiver does **NOT** affect training requirements at:
  - ✓ §483.95(g)(2) – Dementia Management Training and Resident Abuse Prevention Training.
  - ✓ §483.95(g)(3) – Performance Reviews. (See also §483.35(d)(7) F730-Nurse Aide Performance Review.)
  - ✓ §483.95(g)(4) – Care of the Cognitively Impaired.

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Training and Certification of Nurse Aides	CMS is **waiving** the requirements at 42 CFR **§483.35(d)** (with the **exception** of 42 CFR **§483.35(d)(1)(i)**), which require that a SNF and NF may **not** employ **anyone** for longer than **four** months **unless** they met the training and certification requirements under §483.35(d). CMS is waiving these requirements to **assist** in potential staffing shortages seen with the COVID-19 pandemic. To ensure the health and safety of nursing home residents, **CMS is not waiving** 42 CFR **§483.35(d)(1)(i)** which requires facilities to **not use** any individual working as a nurse aide for more than four months, on a full-time basis, **unless** that individual is **competent** to **provide** nursing and nursing related services. CMS further notes that they are **not waiving §483.35(c)**, which **requires** facilities to **ensure** that nurse aides are able to **demonstrate competency** in skills and techniques **necessary** to care for residents' needs, as **identified** through resident **assessments**, and described in the **plan of care**.	483.35(d)(1)(ii) 483.35(d)(2) 483.35(d)(3) 483.35(d)(6) 483.35(d)(7)	F728 F729 F730	Completion of a NATCEP. Use of Individuals. Minimum Competency. Required Retraining. Performance Review.

Compliance Discussion Points:

- This waiver **ONLY** permits the **continued** use of individuals (current or new employees) who have **not** met **certification** requirements **AFTER** four months as long as they are **competent** to provide nursing and nursing related services.
- **Issue to Consider**: There is nothing in the waiver that **exempts** the facility from **conducting** a background check (§483.12(a)(3)(4)-Not Employ or Engage Staff with Adverse Actions [**F606**]) or registry verification (§483.35(d)(4(5) [**F729**]. It appears the waiver **only** concerns **training requirements**.
- This waiver does **NOT** affect requirements at:
  - ✓ §483.35(c) – Proficiency of nurse aides **(F726).**
  - ✓ §483.35(d)(1)(i) – Competent to provide nursing and nursing related services **(F728)**.

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Resident Transfer and Discharge	CMS is **waiving** requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and §483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) (with some exceptions) to allow a long term care (LTC) facility to **transfer or discharge** residents to another LTC facility **solely for the following cohorting purposes**: 1. **Transferring** residents with **symptoms** of a respiratory infection or **confirmed** diagnosis of COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents; 2. **Transferring** residents **without** symptoms of a respiratory infection or confirmed to **not** have COVID-19 to another facility that **agrees** to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19, as well as providing treatment or therapy for other conditions as required by the resident's plan of care, or 3. **Transferring** residents **without** symptoms of a respiratory infection to another facility that **agrees** to accept each **specific** resident to **observe** for any signs or symptoms of a respiratory infection over 14 days. **Exceptions to Resident Transfer and Discharge Notices** These requirements are **only** waived in cases where the **transferring** facility receives **confirmation** that the **receiving** facility **agrees** to **accept** the resident to be transferred or discharged. Confirmation may be in **writing** or **verbal**. If verbal, the transferring facility needs to **document** the date, time, and person that the **receiving** facility communicated agreement. **EXCEPTIONS Continued on NEXT Page**			

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Resident Transfer and Discharge	**Exceptions to Resident Transfer and Discharge Notices** In §483.10, CMS is **only waiving** the requirement, under **§483.10(c)(5),** that a facility provide **advance notification** of **options relating** to the transfer or discharge to **another** facility. **Otherwise**, **all requirements related to §483.10 are not waived**. **Similarly**, in §483.15, CMS is **only waiving** the requirement, under **§483.15(c)(3), (c)(4)(ii), (c)(5)(i)** and **(iv),** and **(d),** for the **written notice** of transfer or discharge to be provided **before** the transfer or discharge. This notice must be provided as soon as practicable. In §483.21, CMS is **only waiving** the **timeframes** for **certain care planning** requirements for residents who are transferred or discharged for the purposes **explained in 1–3 above** (see page 10). **Receiving** facilities should **complete** the required care plans as soon as practicable, and CMS expects **receiving** facilities to **review** and **use** the **care plans** for residents **from** the **transferring** facility, and **adjust** as **necessary** to protect the health and safety of the residents they apply to. **These** requirements are **also waived when transferring** residents to **another** facility, such as a COVID-19 isolation and treatment location, with the provision of services "**under arrangements**," as long as it is **not inconsistent** with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department. **In these cases**, the **transferring** LTC facility need **not** issue a formal discharge, as it is still considered the provider and should bill Medicare normally for each day of care. The **transferring** LTC facility is then **responsible** for **reimbursing** the other provider that accepted its resident(s) **during** the emergency period. CMS **reminds** LTC facilities that they are **responsible** for ensuring that **any** transfers (either within a facility, or to another facility) are **conducted** in a safe and orderly manner, and that each resident's health and safety is protected.	483.10(c)(5)	F552	Right to be Informed in Advance.
		483.15(c)(3)(i)-(iii)	F623	Notice Before Transfer.
		483.15(c)(4)(ii)	F623	Timing of the Notice.
		483.15(c)(5)(i)	F623	Reason for Transfer or Discharge.
		483.15(c)(5)(iv)	F623	Name/Address/Phone-Ombudsman
		483.15(c)(5)(d)	F625	Notice of Bed Hold Policy.
		483.21(a)(1)(i)	F655	Baseline Care Plans – 48 Hours.
		483.21(a)(2)(i)	F655	Comp CP in Place of Baseline.
		483.21(b)(2)(i)	F657	Comp CP within 7 Days-Completion of Comp. Assessment.
	If the facility does **not** intend to provide services **under arrangement**, the COVID-19 isolation and treatment facility is the **responsible entity** for Medicare billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to **submit** a discharge bill to Medicare. The COVID-19 isolation and treatment facility **should** then **bill Medicare** appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is **not yet an enrolled provider**, the facility should **enroll** through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.			

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Discharge Planning	CMS is **waiving** the **discharge planning** requirement **§483.21(c)(1)(viii)**, which requires LTC facilities to **assist** residents and their representatives in **selecting** a post-acute care provider **using** data, such as **standardized** patient assessment data, **quality measures** and **resource** use. This **temporary** waiver is to provide facilities the **ability** to **expedite** discharge and **movement** of residents among care settings. **CMS is maintaining all other discharge planning requirements,** such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii) [Care Plan Timing and Revision **F657**], in the ongoing process of **developing** the discharge plan address the resident's goals of care and treatment preferences.	483.21(c)(1)(viii)	F660	Assisting residents in selecting a Post-Acute Care Provider by using data that includes, but is not limited to, assessment data, quality measures, available resources.

Compliance Discussion Points:

- This waiver **ONLY** applies to resident's being **discharged** to another **SNF**, or who is being **discharged** to a **HHA**, **IRF**, or **LTCH**. The waiver **only** applies to the facility's requirement to **provide** the resident with **information** about the **receiving facility's** MDS assessment data as it relates to the resident's goals of care and treatment preferences, quality measures and resource use data such as discharges to the community, preventable hospital readmissions, etc which is housed on the Nursing Home, HHA, IRF, or LTCH Compare Websites.
- This waiver does **NOT** affect the following discharge planning requirements:
  - ✓ §483.21(c)(1)(i) – Discharge needs are identified and result in the development of a discharge plan for each resident.
  - ✓ §483.21(c)(1)(ii) – Regularly re-evaluated to identify changes that require modification of the discharge plan.
  - ✓ §483.21(c)(1)(iii) – Involved the interdisciplinary team.
  - ✓ §483.21(c)(1)(iv) – Consider caregiver/support person/resident's capacity and capability to perform required care.
  - ✓ §483.21(c)(1)(v) – Involved the resident/representative in the development of the discharge plan.
  - ✓ §483.21(c)(1)(vi) – Address the resident's goals of care and treatment preferences.
  - ✓ §483.21(c)(1)(vii) – Document that the resident has been asked about their interest in receiving information regarding return to the community (MDS – Section Q)
  - ✓ §483.21(c)(1)(ix) – Document and include in the clinical record the evaluation of the resident's discharge needs and discharge plan.
  - ✓ §483.21(c)(2) – Discharge Summary **(F661)**

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Physician Visits	CMS is **waiving** the requirement at **§483.30(c)(3)** that all required **physician visits** (not already exempted in §483.30(c)(4) and (f)) must be made by the physician personally. CMS is **modifying** this provision to **permit** physicians to **delegate any required physician visit** to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is **not** an **employee** of the **facility**, who is **working** in **collaboration** with a physician, and who is **licensed** by the State and performing within the state's scope of practice laws. CMS is **not waiving** the **requirements** for the **frequency** of required physician visits at **§483.30(c)(1)**. As set out above, CMS has **only** modified the requirement to **allow** for the requirement to be **met** by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate. In addition, CMS notes that they are **not waiving** the requirements for **physician supervision** in **§483.30(a)(1),** and the requirement at **§483.30(d)** for the facility to provide or arrange for the provision of physician services **24 hours a day**, in case of an **emergency**. It is important that the physician be **available** for consultation regarding a resident's care.	483.30(c)(3) 483.30(c)(4) 483.30(f)	F712 F712 F714	Physician Visits must be made by the Physician Personally. Alternating Physician Visits. Performance of Physician Tasks in NFs.

Compliance Discussion Points:

- This waiver is **only modifying** the requirements that **physician visits** be made **personally** by the **physician**. It does **not** waive the physician visit requirement. The waiver **permits** the physician to **delegate** required physician visits to a nurse practitioner, physician assistant, or clinical nurse specialist in accordance with state law.
- This waiver does **NOT** apply to:
  - ✓ §483.30(a)(1)(2) – Admission/treatment orders, care supervised by a physician. (**F710**)
  - ✓ §483.30(b)(1)-(3) – Physician must review resident's total program of care, write, sign, date, progress notes at each visit, sign and date orders. (**F711**)
  - ✓ §483.30(c)(1) – Resident must be seen by a physician at least once every 30 days for the first 90 days, and at least once every 60 days thereafter. (**F712**)
  - ✓ §483.30(c)(2) – A physician visit is considered timely if it occurs not later than 10 days after the date the visit is required. (**F712**)
  - ✓ §483.30(d) – Availability of physicians for emergency care 24-hours a day. (**F713**)

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Physician Delegation of Tasks in SNFs	CMS is **waiving** the requirement in **§483.30(e)(4)** that **prevents** a physician from **delegating** a task when the regulations **specify** that the physician must perform it personally.	483.30(e)(4)	F714	Delegation of a Task when the Regulations Specify the Physician must Perform it Personally.
	This waiver gives physicians the **ability** to **delegate any tasks** to a physician assistant, nurse practitioner, or clinical nurse specialist who **meets** the applicable definition in 42 CFR 491.2 or, in the case of a clinical nurse specialist, is **licensed** as such by the State and is acting **within** the scope of practice laws as defined by State law.	483.30(f)	F714	Performance of Physician Tasks in NFs.
	CMS is **temporarily modifying** this regulation to specify that **any task** delegated under this waiver must **continue** to be under the **supervision** of the physician.	483.30(e)(1)(iii)	F714	Under the Supervision of a Physician.
	This waiver **does not include** the provision of §483.30(e)(4) that **prohibits** a physician from delegating a task **when** the **delegation is prohibited** under State law or by the facility's own policy.			

Compliance Discussion Points:

- This waiver does **NOT** apply if the delegation of tasks is **prohibited** under State law or by the facility's own policies.
- This waiver does **NOT** eliminate or modify the services that must be provided to the resident regardless of who is permitted to perform the service on behalf of the physician.

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Physical Environment	CMS is **waiving** requirements related at 42 CFR §**483.90**, specifically the following: 42 CFR §483.90 **require facilities** and their **equipment** to be maintained to ensure an **acceptable** level of safety and quality. CMS is **temporarily modifying** these requirements to the extent necessary to **permit** these facilities to **adjust scheduled inspection**, testing, and maintenance (ITM) frequencies and activities for facility and medical equipment.	483.90(d)(2)	F908	Maintain all mechanical, electrical, and patient care equipment in safe operating condition.
	§483.90(a)(1)(i) and **(b)** requires facilities to be in compliance with the Life Safety Code **(LSC)** and Health Care Facilities Code **(HCFC)**. CMS is **temporarily modifying** these provisions to the extent necessary to **permit** facilities to **adjust** scheduled ITM frequencies and activities required by the LSC and HCFC.	483.90(a)(1)(i) 483.90(b)		Life Safety from Fire (Life Safety Code). Building Safety (Health Care Facilities Code NFPA 99).
	The following LSC and HCFC ITM are considered critical are not included in this waiver: • Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing. (**K353**) • Portable fire extinguisher monthly inspection. (**K355**) • Elevators with firefighters' emergency operations monthly testing. (**K531**) • Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing. (**K918**) (**F906**) • Means of egress daily inspection in areas that have undergone construction, repair, alterations or additions to ensure its ability to be used instantly in case of emergency. (**K211**)			
	§483.90(a)(7) require facilities to have an **outside window** or **outside door** in every sleeping room. CMS will **permit a waiver** of these **outside window** and **outside door** requirements to permit these providers to **utilize** facility and **non-facility** space that is **not normally** used for patient care to be **utilized** for **temporary** patient care or quarantine.	483.90(a)(7) 483.90(e)(1)(vi)	F915 K381	Resident Rooms-Windows to the Outside. Sleeping Room Outside Windows and Doors.

Compliance Discussion Points:

- This waiver does **NOT** eliminate the scheduled maintenance program, it only **permits** the facility to **temporarily** modify its inspection, testing, and maintenance program for **non-critical** items and to **permit** the use of **rooms** that do **not** have an outside window or outside door.

CMS Emergency Blanket Waivers Mapped to Survey Tag Numbers

Waiver Topic	Description of CMS Waiver	Click on CFR # / Tag to View Regs		Survey Tag Description
		Affected CFR Reference	Affected Survey Tag #	
Paid Feeding Assistants	CMS is **modifying** the requirements at 42 CFR **§483.60(h)(1)(i)** and **§483.160(a)** regarding required training of paid feeding assistants. **Specifically**, CMS is **modifying** the **minimum timeframe** requirements in these sections, which **require** this training to be a minimum of 8 hours. CMS is **modifying** to allow that the training can be a **minimum of 1 hour in length**. CMS is **not** waiving **any other requirements** under 42 CFR **§483.60(h)** related to paid feeding assistants or the required training content at 42 CFR §483.160(a)(1)-(8), which **contains** infection control training and other elements. **Additionally**, CMS is also **not waiving** or **modifying** the requirements at 42 CFR **§483.60(h)(2)(i)** **[F811],** which **requires** that a feeding assistant must **work under the supervision** of a registered nurse (RN) or licensed practical nurse (LPN).	483.60(h)(1) 483.160(a)	F811	Use of Paid Feeding Assistants. Minimum Training Requirements.

Compliance Discussion Points:

- This waiver **ONLY** applies to the **reduction** of the minimum training requirements **from 8 hours to 1 hour**.
- This waiver does **NOT** apply to following requirements:
- §483.60(h)(1)(ii) – The use of feeding assistants is consistent with State law.
- §483.60(h)(2)(i) – A feeding assistant must work under the supervision of an RN or LPN.
- §483.60(h)(2)(ii) – In an emergency, a feeding assistant must call a supervisory nurse for help.
- §483.60(h)(3)(i) – A facility must ensure that a feeding assistant provides dining assistance only for resident who have no complicated feeding problems.
- §483.60(h)(3)(ii) – Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
- §483.60(h)(3)(iii) – The facility must base resident selection on the IDT assessment and the resident's latest assessment and plan of care.
- §483.160(a)(1)-(8) – Minimum training course requirements.

Effective November 28, 2017

F552 - Right To Be Informed/Make Treatment Decisions

Old Tag Number: F154

§483.10(c) **Planning and Implementing Care.**

The resident has the right to be informed of, and participate in, his or her treatment*, including:*

§483.10(c)(1) **The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.**

§483.10(c)(4) **The right to be informed, in advance, *of the* care *to be furnished and the type of care giver or professional that will furnish care.***

§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

DEFINITIONS §483.10(c)(1), (4)-(5)

"Total health status" *includes functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.*

"Treatment" *refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.*

GUIDANCE §§483.10(c)(1), (4)-(5)

*Health i*nformation *and services* must be *provided* in *ways* that *are easy for* the resident and/or the resident's representative *to* understand. This includes, *but is not limited to, communicating in*

plain language, explaining technical and medical terminology in a way that makes sense to the resident, offering language assistance services to residents who have limited English proficiency, and providing qualified sign language interpreters or auxiliary aids if hearing is impaired. This does not mean that a facility is required to supply and pay for hearing aids.

The physician or other practitioner or professional must inform the resident *or their representative in advance of treatment risks and benefits, options, and alternatives. The* information *should be* communicated at times it would be most useful to them, such as when they are expressing concerns, raising questions, *or when a change in treatment is being proposed*. *The resident or resident representative has the right to choose the option he or she prefers.*

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Discussion and documentation of the resident's choices regarding future health care may take place during the development of the initial comprehensive assessment and care plan and periodically thereafter.

NOTE: *While surveyors must only cite F552 when deficient practice is found related to applicable program requirements as reflected in the CFR, the following information may inform surveyors about important considerations in making compliance decisions.* The Federal Patient Self - Determination Act contained in Public Law 101-508 is the authority on an individual's rights and facility responsibilities related to *a*dvance *d*irectives. This includes, the right of an individual to direct his or her own medical treatment, including withholding or withdrawing life-sustaining treatment. *If there are concerns with advance directives, refer to §483.10(g)(12), F578.*

See §483.21(a), F655 (Baseline Care Plans), Comprehensive Person-Centered Care Planning, for additional guidance.

Effective November 28, 2017

F559 - Choose/Be Notified of Room/Roommate Change

Old Tag Numbers: F175; F247

Note: Deficiencies cited at S/S Levels of F, H, I, J, K, or L for this tag = Substandard Quality of Care Citation

§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 §483.10(e)(4)-(6)

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*.

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* explana*tion 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.

A resident receiving a new roommate should *be* give*n* as much *advance* notice *as possible. The resident* should *be* support*ed when a* roommate passe*s* 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. *F*acility *staff* should provide necessary social services for a resident who is grieving over the death of a roommate.

If the survey team identifies potential compliance issues related to social services, refer to §483.*40(d), F745,* Social Services.

Effective November 28, 2017

F560 - Right to Refuse Certain Transfers

Old Tag Number: F177

§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.

§483.10(e)(8) **A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.**

DEFINITIONS §483.10(e)(7)-(8)

"Campus": *Under §413.65(a)(2), "Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus."*

"Composite distinct part": *Under §483.5, a composite distinct part is a type of distinct part SNF or NF consisting of two or more noncontiguous components that are not located within the same campus, as that term is defined in §413.65(a)(2).*

"Distinct Part": *A distinct part SNF or NF is part of a larger institution or institutional complex. The distinct part SNF or NF is physically distinguishable from the larger institution or complex and may be comprised of one or more buildings or parts of buildings (such as wings, wards, or floors). Distinct part SNFs or NFs must be immediately adjacent or in close proximity to the institution's main buildings. CMS may determine, on an individual basis that other areas are part of the institution's campus and considered to be a distinct part SNF or NF. A distinct part SNF or NF must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes composite distinct part SNFs or NFs. Additional requirements specific to distinct part SNFs or NFs are found at §483.5.*

GUIDANCE §483.10(e)(7)-(8)

A resident can decline relocation from a room in one *institution's* distinct part *SNF or NF* to a room in another *institution's* distinct part *SNF or NF* for purposes of obtaining Medicare or Medicaid eligibility. *Facility staff are responsible for notifying the resident or resident representative of changes in eligibility for Medicare or Medicaid covered services and of what the resident's financial responsibility may be.* If the resident is unable to pay for those services, then after giving the resident a *discharge* notice, *the resident may be* transferr*ed* or discharge*d* under the provisions of §483.*15(b), F621, Equal Access to Quality Care.*

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When a resident occupies a bed in a distinct part NF that *is certified to* participate in Medicaid *only* and not in Medicare, he or she may not be moved involuntarily *(or required to be moved by the State) from that distinct part NF* to another part of the *larger* institution *(e.g., hospital or intermediate care facility for individuals with intellectual disabilities) that houses the distinct part* solely for the purpose of assuring *eligibility for* Medicare payments. Such moves are only appropriate *only* when they occur at the request of a resident.

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.

PROBES §483.10(e)(7)-(8)

For residents moved between Medicare or Medicaid approved distinct parts:

- Was the resident moved to a different room because of a change in payment source *or staff convenience*?
- Did facility *staff* give the resident the opportunity to refuse the transfer?

POTENTIAL TAGS FOR ADDITIONAL CONSIDERATION

- *42 CFR §483.10(e)(6), F559, Notification of Roommate Change.*
  - *Determine if the resident received prior notification of a room change.*
- *42 CFR §483.10(g)(17), F582, Medicare/Medicaid Coverage.*
  - *Determine if the resident was notified of changes in eligibility for Medicare or Medicaid covered services, what the resident's financial responsibility may be, and their appeal rights.*
- *For additional guidance regarding admission to, discharges, or transfers from a SNF or NF, including bed-hold policies and therapeutic leave, see §483.15, F620 Admission, Transfer, and Discharge Rights.*

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F565 - Resident/Family Group and Response

Old Tag Numbers: F243; F244

Note: Deficiencies cited at S/S Levels of F, H, I, J, K, for L for this tag = Substandard Quality of Care Citation

§483.10(f)(5) **The resident has a right to organize and participate in resident groups in the facility.**

- ***(i)*** **The facility must provide a resident or family group, if one exists, with private space;** ***and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.***
- ***(ii)*** **Staff, visitors,** ***or other guests*** **may attend** ***resident group or family group*** **meetings** ***only*** **at the** ***respective*** **group's invitation.**
- ***(iii)*** **The facility must provide a designated staff person** ***who is approved by the resident or family group and the facility and who is*** **responsible for providing assistance and responding to written requests that result from group meetings.**
- ***(iv) The facility*** **must** ***consider*** **the views** ***of a resident or family group*** **and act** ***promptly*** **upon the grievances and recommendations** ***of such groups*** **concerning** ***issues of*** **resident care and life in the facility.**
  - ***(A) The facility must be able to demonstrate their response and rationale for such response.***
  - ***(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.***

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have **family** ***member(s) or other resident representative(s)*** **meet in the facility with the families** ***or resident representative(s)*** **of other residents in the facility.**

DEFINITIONS ***§483.10(f)(5)-(7)***

"A resident or family group" is defined as a group of residents or residents' family members that meets regularly to:

- Discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life;
- Support each other;
- Plan resident and family activities;
- Participate in educational activities; or
- For any other purpose.

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GUIDANCE §483.10(f)(5)-(7)

This requirement does not require that residents organize a resident or family group. However, whenever residents or their families wish to organize, *they* must *be able* to do so without interference. *Additionally, they* must *be* provided space, privacy for meetings, and staff support. *T*he designated staff person responsible for assistance and liaison between the group and the facility's administration and any other staff members *may* attend the meeting only if *invited by the resident or family group. The resident or family group may meet without staff present*. *The groups should determine how frequently they meet.*

*F*acility *staff are* required to *consider* resident and family group *views* and *act upon* grievances and recommendations. *F*acility *staff* must consider *these* recommendations and attempt to accommodate *them*, to the extent practicable. *This may include* developing *or* changing policies affecting resident care and life. *F*acility *staff should discuss* its decisions *with* the resident and/or family group *and document in writing its response and rationale as required under 42 CFR §483.10(j), F585, Grievances.*

PROCEDURES §483.10(f)(5)-(7)

During the entrance interview, determine:

- *If there is a resident or family group;*
- *Who the resident or family representative is for each of these groups; and,*
- *Who the designated staff person is for assisting and working with each of these groups.*

If residents or their families attempted to organize a group and were unsuccessful, why?

Through interviews with the representatives for the resident and family groups and staff designated for assisting and working with these groups, determine:

- *Are groups able to meet without staff present unless desired?*
- *If a resident wants a family member present during a resident group meeting, how is this handled? Facility staff should not require said family member to leave the group meeting, without the permission of the group.*
- *How views, grievances or recommendations from these groups are considered, addressed and acted upon; and,*
- *How facility staff provide responses, actions, and rationale to the groups.*

Examples of noncompliance may include, but are not limited to:

- *Facility staff impede or prevent residents or family members ability to meet or organize a resident or family group;*
- *Resident and/or families were not always informed in advance of upcoming meetings.*
- *Facility staff impede with meetings and/or operations of family or resident council by mandating that they have a staff person in the room during meetings or assigning a staff person to liaise with the council that is not agreeable to the council;*
- *Private meeting space for these groups is not provided;*

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- *The views, grievances or recommendations from these groups have not been considered or acted upon by facility staff;*
- *Facility staff does not provide these groups with responses, actions, and rationale taken regarding their concerns;*
- *Facility staff are not able to demonstrate their response and rationale to grievances;*
- *Facility staff prevent family members or representatives from meeting with those of another resident.*

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

For concerns regarding the handling of individual grievances, refer to §483.10(j), F585, Grievances.

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F573 - Right to Access/Purchase Copies of Records

Old Tag Number: F153

§483.10(g)**(2) The resident has the right to access personal and medical records pertaining to him or herself.**

- **(i)** ***The facility must provide the resident*** **with access to personal and medical records pertaining to him or herself, upon an oral or written request,** ***in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual,*** **within 24 hours (excluding weekends and holidays); and**
- **(ii)** ***The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically)*** **upon request and 2 working days advance notice to the facility. T*he facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:***
  - ***(A) Labor for copying the records requested by the individual, whether in paper or electronic form;***
  - ***(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and***
  - ***(C)Postage, when the individual has requested the copy be mailed.***

§483.10***(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.***

DEFINITIONS §483.10(g)(2)-(3)

"Records," *includes all records, in addition to clinical records, pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility.*

GUIDANCE §483.10(g)(2)-(3)

An oral request is sufficient to produce *the resident's personal and medical* record for review.

The facility may charge a reasonable, cost-based fee for providing a copy of the requested records, whether in paper or electronic form. This may only include the cost of labor for copying the records, supplies for creating the paper copy or electronic media, and postage, if applicable. Additional fees for locating the records or typing forms/envelopes may not be assessed.

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KEY ELEMENTS OF NONCOMPLIANCE §483.10(g)(2)-(3)

To cite deficient practice at F573, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- *Support the resident's right to access his or her own personal and medical records;* ***or***
- *Provide the resident access to his or her personal and medical records within 24 hours (excluding weekends and holidays) of a written request;* ***or***
- *Allow the resident to purchase a copy of his or her personal and medical records upon request and with 2 working days advanced notice;* ***or***
- *Charge a reasonable, cost-based fee, including only the cost of labor, supplies, and postage involved in providing or sending the personal and medical records requested;* ***or***

- *Ensure the information is provided:*
  - *In a form the resident can access and understand ;****or***
  - *In a form and format agreed upon by the facility and the resident.*

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F623 - Notice Requirements Before Transfer/Discharge

Old Tag Number: F203

***§483.15*(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.

***§483.15*(c)(4) Timing of the 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. The written notice specified in paragraph *(c)(3)* of this section must include the following:**

(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 *L*ong-*T*erm *C*are *O*mbudsman;

(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

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(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) Changes to 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).

DEFINITIONS

"Facility-initiated transfer or discharge": *A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.*

"Resident-initiated transfer or discharge": *Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).*

"Transfer and Discharge": *Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

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.

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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.

Notice of Transfer or Discharge and Ombudsman Notification

For facility-initiated transfer or discharge of a resident, the facility must 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. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state.

Facility-Initiated Transfers and Discharges

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the ***transfer*** *notice to the ombudsman only needed to occur as soon as practicable as described below.*

For any other types of facility-initiated discharges, the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the ombudsman must be sent at the same time notice is provided to the resident and resident representative.

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***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.*

Resident-Initiated Transfers and Discharges

A resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. The medical record must contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility. While a resident's expression of a general desire or goal to return home or to the community or the elopement of a resident who is cognitively impaired should be taken into consideration for the purposes of discharge planning and community placement, it should not be taken as notice of intent to leave the facility and does not constitute a resident-initiated transfer or discharge. For resident-initiated transfers or discharges, sending a copy of the notice to the ombudsman is not required because the notice requirement does not apply to resident-initiated transfers or discharges.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. 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, and F661, Discharge Summary). 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. If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

Contents of the Notice

The facility's notice must include *the following:*

- The *specific* reason for the *transfer or* discharge, *including the basis per §§483.15(c)(1)(i)(A)-(F)*;
- The effective date of the *transfer or* discharge;
- The location to which the resident is to be *transferred or* discharged;
- An explanation of the right to appeal to the State;
- *The name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests;*
- *Information on how to request an appeal hearing;*
- *Information on obtaining assistance in completing and submitting the appeal hearing request; and*
- The name, address, and phone number of the *representative of the Office of the* State Long-Term Care ombudsman.

Effective November 28, 2017

For residents with intellectual and developmental *disabilities and/or mental illness*, *the notice must include* the name, *mail and e-mail* address*es* and phone number of the *state protection and advocacy* agency responsible for advocating for these *populations.*

Timing of the Notice

Generally, this notice must be provided at least 30 days prior to the *transfer or discharge*. Exceptions to the 30-day requirement apply when the *transfer or discharge* is effected because:

- *The resident's welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or*
- *The health or safety of others in the facility is e*ndangered.

In these cases, the notice must be provided as soon as practicable *and* ***notice to the ombudsman*** *in these situations can be sent when practicable, such as a list of residents on a monthly basis.*

Changes to the Notice

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents *and their representatives* are aware of and can respond appropriately. *For significant changes, such as a change in the destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date, in order to provide 30 day advance notification.*

Notice in Advance of Facility Closure:

Refer to 483.70(l), F845 for guidance related to evaluating Notice in Advance of Facility Closure.

Effective November 28, 2017

F625 - Notice of Bed Hold Policy Before/Upon Transfer

Old Tag Number: F205

***§483.15(*d) Notice of *b*ed-*h*old 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.

***§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.

DEFINITIONS

"Bed-hold": *Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.*

"Reserve Bed Payment": *Payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility.*

"Therapeutic Leave": *Absences for purposes other than required hospitalization.*

Effective November 28, 2017

GUIDANCE

Notice of Bed-Hold Policy

All facilities must have policies that address holding a resident's bed during periods of absence, such as during hospitalization or therapeutic leave. Additionally, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source.

These *provisions* require *facilities to issue* two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, *i.e., information provided in the admission packet.* Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change.

The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative.
The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed.

When a resident residing in a skilled nursing facility under Medicare is hospitalized or takes therapeutic leave, Medicare will not pay to hold the bed. Facility policies may allow the resident to pay privately to hold his or her bed. While the provisions of this requirement specifically address bed-hold under Medicaid law, facilities must make all residents aware in writing of their policies related to holding beds during absences from the facility.

***NOTE**: Residents not covered by Medicare or Medicaid, may be permitted to privately provide reserve bed payments.*

Medicaid law requires each state Medicaid plan to address bed-hold policies for hospitalization and periods of therapeutic leave. State plans vary in payment for and duration of bed-holds. However, federal regulations do not require states to pay nursing facilities for holding beds while the resident is away from the facility. In general, the State plan sets the length of time, if any, that the state will pay the facility for holding a bed for a Medicaid-eligible resident. It is the responsibility of the survey team to know the bed-hold policies of their State Medicaid plan.

Additionally, §483.15 (e)(1) and F626 require facilities to permit residents to return to the facility immediately to the first available bed in a semi-private room.

Effective November 28, 2017

As stated above, a participating facility *must* provide notice to its residents *and if applicable, their representatives,* of the facility's bed-hold policies*, as stipulated in each State's plan. This notice must be provided* prior to *and upon* transfer *and must include information on how long a facility will hold the bed, how reserve bed payments will be made (if applicable), and the conditions upon which the resident would return to the facility. These conditions are:*

- *The resident requires the services which the facility provides; and*
- *The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.*

Bed-hold for days of absence in excess of the State's bed-hold limit *is* considered *a* non-covered service which means that the resident could use his/her own income to pay for the bed-hold. However, if a resident does not elect to pay to hold *his or her* bed, *the resident will be permitted to return* to the next available bed, *consistent with the requirements at §483.15(e).*

The provision at §483.15(d)(1)(ii) references regulations for Medicaid Payments for Reserving Beds in Institutions (§447.40), which state "Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient's plan of care." This means that therapeutic leave of absence must be consistent with the resident's goals for care, be assessed by the comprehensive assessment, and incorporated into the comprehensive care plan, and cannot be a means of involuntarily discharging the resident.

INVESTIGATIVE PROTOCOL

Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility requirements for bed-hold.

Summary of Investigative Procedure

If concerns arise regarding notice of bed-hold, review the medical record for evidence of whether a notice of bed-hold was provided both (1) prior to and (2) upon transfer. Look for documentation such as a copy of the dated notice(s), progress notes, transfer checklist(s), or other evidence that the notice was given. Additionally, ask to review facility policies on bed-hold. Review the facility's admission packet to determine if notice of bed-hold is given at admission. If not, determine how the facility notifies residents prior to transfer.

Ask the resident, or if applicable, the resident's representative(s), whether they received the bed-hold notice and understand the facility's bed-hold policy. If not, determine how the facility notifies residents of this information prior to transfer.

Effective November 28, 2017

F636 - Comprehensive Assessments and Timing

Old Tag Numbers: F272, F273, F275

§483.20 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, *strengths, goals, life history and preferences,* using the resident assessment instrument (RAI) specified by *CMS*. The assessment must include at least the following:

- **(i) Identification and demographic information**
- **(ii) Customary routine.**
- **(iii) Cognitive patterns.**
- **(iv) Communication.**
- **(v) Vision.**
- **(vi) Mood and behavior patterns.**
- **(vii) Psychological well-being.**
- **(viii) Physical functioning and structural problems.**
- **(ix) Continence.**
- **(x) Disease diagnosis and health conditions.**
- **(xi) Dental and nutritional status.**
- **(xii) Skin Conditions.**
- **(xiii) Activity pursuit.**
- **(xiv) Medications.**
- **(xv) Special treatments and procedures.**
- **(xvi) Discharge *planning.***
- **(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).**
- ***(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.***

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

- **(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)**

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- **(iii)Not less than once every 12 months.**

Effective November 28, 2017

INTENT §483.20(b)(1)-(2)(i)&(iii)

To ensure that the *Resident Assessment Instrument* (RAI) is used*, in accordance with specified format and timeframes,* in conducting comprehensive assessments as part of anongoing process through which the facility identifies each resident's *preferences and goals of care,* functional *and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.*

DEFINITIONS §483.20(b)(1)-(2)(i)&(iii)

"Minimum Data Set": *The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.*

"Care Area Assessment (CAA) Process" *is a process outlined in Chapter 4 of the MDS manual designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. This process has three components:*

- ***Care Area Triggers (CATs)*** *are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.*
- ***Care Area Assessment (CAA)*** *is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning.*
- ***CAA Summary*** *(Section V of the MDS) provides a location for documentation of the care area(s) that have triggered from the MDS, the decisions made during the CAA process regarding whether or not to proceed to care planning, and the location and date of the CAA documentation.*

"Comprehensive Assessment" *includes the completion of the MDS as well as the CAA process, followed by the development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment.*

"Resident Assessment Instrument (RAI)" *consists of three basic components: the Minimum Data Set (MDS) version 3.0, the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of these components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.*

"Utilization Guidelines" *provide instructions for when and how to use the RAI. The Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.*

Effective November 28, 2017

GUIDANCE **§483.20(b)(1)-(2(i)&(iii)**

Each facility must use *the* RAI *specified by CMS* (which includes the MDS, utilization guidelines and the CAAs) to assess *each* resident. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.

The information required in §483.20(b)*(1)*(i-xvi*ii*) is incorporated into the MDS, which forms the core *of the RAI process*. Additional assessment information is also gathered using triggered *Care Area Assessments* (CAAs) *after the completion of the comprehensive MDS*.

The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to *record review,* direct observation and communication with the resident, the facility *must* use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, *the resident's representative,* family members, or outside consultants.

At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.

For additional requirements regarding a Significant Change in Status Assessment, see §483.20(b)(2)(ii).

If a comprehensive assessment was completed, any time prior to a temporary absence for hospitalization or a leave of absence, and upon return to the facility, the resident does not meet the criteria for a Significant Change in Status Assessment (SCSA), as defined in §483.20(b)(2)(ii), a comprehensive assessment is not required. For example, a resident had a comprehensive assessment completed within 14 days of admission, four months later was hospitalized, then returned to the facility. Upon return to the facility, the resident's status does not meet the criteria for a SCSA, therefore a comprehensive assessment is not required.

For additional information on assessment scheduling and completion requirements, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html.

The facility *must* use *the RAI process* to develop a *comprehensive* care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

Effective November 28, 2017

PROBES §483.20(b)(1)-(2)(i)&(iii)

- *Did the facility complete a comprehensive assessment,* using the *CMS*-specified RAI process, within the regulatory timeframes (i.e. within 14 days after admission and at least annually) *for each resident in the sample*?
- *Is there evidence in the clinical record that* the facility gathered *and analyzed* supplemental information based on the triggered CAAs *prior to developing the comprehensive* care plan? *For reference a list of CAAs is found in Section V of the MDS (Care Area Assessment Summary).*
- *Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews, providing information about preferences or discharge goals.*
- *Ask licensed and non-licensed direct-care staff if they participate in the resident assessment process.*
- *Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?*

Effective November 28, 2017

F637 - Comprehensive Assessment After Significant Change

Old Tag Number: F274

§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

INTENT §483.20(b)(2)(ii)

To ensure that each resident who experiences a significant change in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process.

DEFINITIONS §483.20(b)(2)(ii)

"Significant Change" *is a major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered "self-limiting" (**NOTE**: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a resident's physician of changes as required under 42 CFR 483.10(i)(14), F580.*

"Significant Change in Status Assessment (SCSA)" *is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline.*

"Assessment Reference Date (ARD)" *is the specific end point for the look-back periods in the Minimum Data Set (MDS) assessment process. This look-back period is also called the observation or assessment period.*

GUIDANCE **§483.20(b)(2)(ii)**

A SCSA including Care Area Assessments (CAAs) must be completed within 14 days after a determination has been made that a significant change in the resident's status from baseline occurred. This may be determined by comparison of the resident's current status to the most recent comprehensive assessment and most recent Quarterly assessment, and the resident's condition is not expected to return to baseline within 2 weeks. A SCSA is appropriate if there are either two or more MDS areas of decline or two or more MDS areas of improvement or if the IDT determines that the resident would benefit from the SCSA assessment and subsequent care plan revision. The facility should document in the medical record when the determination is made that the resident meets the criteria for a Significant Change in Status Assessment.

Effective November 28, 2017

A *Significant Change in Status MDS* is *required* when:

- *A* resident *enrolls in a hospice program; or*
- *A resident changes hospice providers and remains in the facility; or*
- *A resident receiving hospice services discontinues those services; or*
- *A resident experiences a consistent pattern of changes, with* either **two or *more*** *areas of decline or* ***two or more*** *areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS).*

Examples of Decline include, but are not limited to:

- *Resident's decision-making ability has changed;*
- *Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E Behavior;*
- *Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment;*
- *Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning;*
- *Resident's incontinence pattern changes or there was placement of an indwelling catheter;*
- *Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days).*
- *Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;*
- *Resident begins to use a restraint of any type, when it was not used before;*
- *Emergence of a condition/disease in which a resident is judged to be unstable.*

Examples of Improvement include, but are not limited to:

- *Any improvement in ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;*
- *Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;*
- *Resident's decision making ability improves;*
- *Resident's incontinence pattern improves;*

If there is only one change, *the* resident may still benefit from a SCSA as determined by the IDT or as initiated by the resident based on changes in the care plan. It is important to remember that each resident's situation is unique. The facility must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.

The facility may not complete a SCSA until after a Comprehensive Admission assessment has been completed.

Effective November 28, 2017

A Significant Change in Status MDS is considered timely when:

- *The RN Assessment Coordinator signs the MDS as complete at section Z0500B & V0200B2 by the 14th calendar day **after the determination** that a significant change has occurred (determination date + 14 calendar days).*

If a *SCSA MDS is completed*, the next annual assessment is not due until 366 days after the *ARD* of the significant *change in status* assessment.

NOTE: For information on assessment scheduling for the MDS, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument *3.0* User's Manual. *Link to the LTCF RAI User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html.*

*Circumstances when a change in resident status is **not** significant include, but are not limited to:*

- *Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.*
- *Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).*
- *Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.*
- *Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.*

PROBES §483.20(b)(2)(ii)

- *Did* the facility identify, in a timely manner, those residents who experienced a *significant* change *in status*?
- *Is there documentation in the medical record when the determination was made that the resident met the criteria for a Significant Change in Status Assessment?*
- *Did* the facility reassess residents who had a significant change in status, using the *CMS*-specified RAI, within 14 days after determining the change was significant?

Effective November 28, 2017

F638 - Quarterly Assessment At Least Every 3 Months

Old Tag Number: F276

§483.20(c) Quarterly Review Assessment

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

INTENT §483.20(c)

To assure *each* resident *is assessed using the standardized Quarterly Review assessment tool no less than once every 3 months between comprehensive assessments*.

DEFINITIONS §483.20(c)

"Quarterly Review Assessment" *is an OBRA '87-required, non-comprehensive assessment that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all Minimum Data Set (MDS) items appear on the Quarterly assessment.*

GUIDANCE §483.20(c)

At least *every 92 day*s, the facility shall review each resident with respect to those MDSitems specified *in the CMS* quarterly assessment *(MDS)*.

A Quarterly assessment is considered timely if:

- *The Assessment Reference Date (ARD) of the Quarterly MDS is **within 92 days** (ARD of most recent OBRA assessment +92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment) **AND***
- *The MDS completion date (Item Z0500B) must be **no later than** 14 days after the ARD (ARD + 14 calendar days).*

If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the *S*ignificant Change *in Status* Assessment.

For information on assessment scheduling for the MDS, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument *3.0* User's Manual.

Link to the LTCF RAI User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html.

***NOTE**: The Quarterly MDS does not require the completion of Care Area Assessments (CAAs). However, the resident's care plan must be reviewed and revised by the interdisciplinary team after each assessment as required at §483.21(b)(2)(iii).*

Effective November 28, 2017

PROBES §483.20(c)

- *Does* the facility assess *residents, using the CMS-specified quarterly review assessment,* no less than once every 3 months, *between comprehensive assessments*?
- *Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews and providing information about preferences or discharge goals.*

Effective November 28, 2017

F640 - Encoding/Transmitting Resident Assessment

Old Tag Number: F287

§483.20(f) Automated data processing requirement-

§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

INTENT §483.20(f)(1-*4*)

To ensure that facilities have provided resident specific information for payment and quality measure purposes.

To enable a facility to better monitor *each* resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data.

Effective November 28, 2017

DEFINITIONS §483.20(f)(1-4)

"Accurate" means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at §483.20(g), and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).

"Background (face-sheet) information" refers to the MDS Entry tracking record

"Capable of transmitting" means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission.

"Complete" means that all items required according to the record type, and in accordance with CMS' record specifications and State required edits are in effect at the time the record is completed.

"Discharge subset of items" refers to the MDS Discharge assessment.

"Encoding" means entering information into *the facility MDS software in the* computer.

"Passing standard edits" means that the encoded responses to MDS items are consistent and within range, in accordance with CMS-specified standards. In general, inconsistent responses are either not plausible or ignore a skip pattern on the MDS. An example of inconsistency would be if one or more MDS items on a list were checked as present, and the "None of the Above" response was also checked for the same list. Out of range responses are invalid responses, such as using a response code of 2 for an MDS item for which the valid responses are zero or 1.

"Transmitted" means electronically transmitting to the *Quality Improvement Evaluation System (*QIES*) Assessment Submission and Processing (*ASAP*)* System, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record.

"Transmitting data" refers to electronically sending encoded MDS information, from the facility to the QIES ASAP System.

GUIDANCE §483.20(f)(1-*4*)

Facilities are required to encode MDS data for each resident in the facility.

Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the QIES ASAP System.

Effective November 28, 2017

Facilities are responsible to edit the encoded MDS data to ensure that it meets the standard edit specifications.

For §483.20(f)(1)(v), the subset of items required upon a resident's entry, transfer, discharge and death are contained in the Entry and Death in Facility Tracking records and Discharge assessments. Refer to Chapter 2 of *the Long-Term Care Resident Assessment Instrument User's Manual* for further information about these records.

All nursing homes must computerize MDS information. The facility must edit MDS information using standard CMS-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the QIES ASAP system within 7 days:

- *For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).*
- *For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).*
- *For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).*

Submission must be according to State and Federal time frames. Therefore the facility must:

- Encode the MDS and CAAs Summary (where applicable) in machine readable format; and
  - Edit the MDS and CAA Summary (where applicable) according to edits specified by CMS. Within the 7 day time period specified above for editing, the facility must revise any information on the encoded MDS and CAA Summary (if applicable) that does not pass CMS-specified edits, revise any otherwise inaccurate information, and make the information ready for submission. The MDS Vendor software used at the facility should have an automated editing process that alerts the user to entries in an MDS record that do not conform to the CMS-specified edits and that prompts the facility to complete revisions within the 7-day editing and revision period. After editing and revision, MDS information and CAA summary information (if applicable) must always accurately reflect the resident's overall clinical status as of the original ARD for an assessment or the original event date for a discharge or entry.

Electronically submit MDS information to the QIES ASAP system within 14 days:

- ***Assessment Transmission:*** *Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).*
- ***Tracking Information Transmission:*** *For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).*

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*Only CMS-required MDS assessments (e.g., OBRA and Medicare Part A PPS) are permitted to be transmitted into the QIES ASAP System. Assessments completed to meet third party payer (i.e. private insurance or managed care) requirements **cannot** be transmitted to CMS. OBRA MDS assessments completed anytime a facility is NOT certified to participate in Medicare/Medicaid cannot be transmitted.*

PROCEDURES **§483.20(f)(1-*4*)**

If the surveyor suspects the facility is not encoding and submitting assessments as required, the surveyor should review the facility's MDS 3.0 NH Final Validation Report to verify assessment submission into the QIES ASAP System.

Effective November 28, 2017

F645 - PASARR Screening for MD & ID

Old Tag Number: F285

§483.20(*k*) Preadmission Screening for individuals *with a mental disorder* and individuals with *intellectual disability*.

§483.20(*k*)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental *disorder* as defined in paragraph *(k)(3)(i)* of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) *Intellectual disability*, as defined in paragraph *(k)(3)(ii)* of this section, unless the State *intellectual disability* or developmental disability authority has determined prior to admission—

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(*k*)*(2) Exceptions. For purposes of this section-*

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(*k*)(*3*) Definition. For purposes of this section-

(i) An individual is considered to have *a* mental *disorder* if the individual has a serious mental *disorder* defined in 483.102(b)(1).

(ii) An individual is considered to *have an intellectual disability* if the individual *has an intellectual disability* as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

Effective November 28, 2017

INTENT §483.20(*k*)(1)-(3)

To ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive *care and services in the most integrated setting appropriate to their needs*.

DEFINITIONS §483.20(*k*)(1)-(3)

"Intellectual Disability (ID)" *is defined in 42 CFR 483.102(b)(3) as follows:*

An individual is considered to have intellectual disability (ID) if he or she has—

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual's Disability Manual on Classification in Intellectual Disability (1983);or

(ii) A related condition as defined by §435.1010 of this chapter.

"Mental Disorder (MD)" *For purposes of this section, the term "mental disorder" is the equivalent of "mental illness" used in the definition of serious mental illness in 42 CFR 483.102(b)(1), which states:*

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

(i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987.
This mental disorder is—
(A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but
(B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(ii) Level of impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:
(A) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;
(B) Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

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(C) Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

(iii) Recent treatment. The treatment history indicates that the individual has experienced at least one of the following:

(A) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

"Persons with Related Conditions" *is defined in 42 CFR 435.1010 as follows:*
Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to—

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than a mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

"Preadmission Screening and Resident Review (PASARR)" *is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. Regulations governing PASARR are found at 42 CFR §483.100-483.138.*

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"Specialized Services for MD or ID" *means the services specified by the State that exceed the services ordinarily provided by the nursing facility (NF) under its per diem rate. These services must be provided or arranged by the state and could include hiring additional staff or contractors such as qualified mental health/intellectual disability professionals. When specialized services are combined with services provided by the nursing facility, the result is a continuous and aggressive implementation of an individualized plan of care for individuals with MD or ID. The resident's Level II PASARR identifies the specialized services required by the resident.*

"Rehabilitative services for MD or ID" *refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff that come into contact with any resident who has as mental disorder or who has intellectual disability. These services are necessary regardless of whether or not they are specified in the PASARR Level II documents and whether or not the resident requires additional services to be provided or arranged for by the State.*

GUIDANCE §483.20(k)(1)-(3)

*The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening is referred to as Level I Identification of individuals with MD or ID (§483.128**)** and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identity individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility.*
A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II PASARR, which must be conducted prior to admission to the facility.

Failure to pre-screen residents prior to admission to the facility may result in the failure to identify residents who have or may have MD, ID or a related condition. A record of the pre-screening should be retained in the resident's medical record.

Individuals who have or are suspected to have MD, ID or a related condition (as indicated by a positive Level 1 screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASARR evaluation and determination. Exceptions to this requirement are specified in §483.20(k)(2) and may be exercised at the discretion of the State, as specified in the State's PASARR process.

Level II PASARR is a comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has MD, ID or a related condition as defined above, determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs. The Level II PASARR cannot be conducted by the nursing facility.

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Each State Medicaid Agency has specific processes for conducting Level I screens and Level II PASARR evaluations and determinations. Exceptions to the pre-screening requirements are specified in §483.20(k)(2) and may be exercised at the discretion of the State, as specified in the State's PASARR process. Facility staff and surveyors should be acquainted with their States' requirements.

If the State program permits the use of the exceptions specified in §483.20(k)(2), and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. ***NOTE****: under 42 CFR 483.106(b)(2)(ii), If an individual who enters a NF as an exception (an exempted hospital discharge) is later found to require more than 30 days of NF care, the State mental health or intellectual disability authority must conduct a Level II resident review within 40 calendar days of admission.*

The State is responsible for providing *or arranging for* specialized services *for* residents with M*D or* ID residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition. Therefore, if a facility has residents with M*D or* ID, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

PROCEDURES AND PROBES §483.20(k)(1)-(3)

- *If the resident's Level II PASSR report indicates that he or she needs specialized services but the resident is not receiving them, the State Survey Agency would notify the State-designated mental health or intellectual disability authority that evaluated the resident prior to admission. NF services alone are not ordinarily of the intensity to meet the needs of residents with MD or ID.*
- *Is there evidence of Level I pre-screening of residents prior to admission to the nursing facility to identify residents who have or may have MD, ID or a related condition, who requires Level II PASARR evaluation?*
- *Are residents with a positive Level I PASARR screen evaluated by the designated state-authority, through the Level II PASARR process, and approved for admission* ***prior*** *to admission to the nursing facility?*
- *If pre-admission screening of residents expected to be in the facility 30 days or less is not performed, in accordance with the State PASARR process, does the facility screen residents who have or may have MD, ID or a related condition, if the resident remains in the facility longer than 30 days? Are residents who have a positive screen then referred to the appropriate state-authority for Level II evaluation and determination?*

If *the resident has a* M*D* or ID, did the State Mental Health or Intellectual Disabilities Authority determine:

- Whether the residents needed the services of a nursing facility
- Whether the residents need specialized services for their M*D* or ID?

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DEFICIENCY CATEGORIZATIONS

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety
An example of Level 4, immediate jeopardy to resident health and safety, include, but is not limited to:

- *A resident with bipolar disorder was newly admitted to the facility prior to Level II PASARR evaluation and determination. The facility's failure to ensure the Level II PASARR process was completed prior to admission resulted in the resident no longer receiving needed psychotherapy 4 times per week. The interruption in receiving needed psychotherapy services caused the resident to relapse into a depressive state, during which the resident engaged in social withdrawal and self-cutting behaviors resulting in hospitalization of the resident.*

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
An example of Level 3, actual harm that is not immediate jeopardy includes but is not limited to:

- *The facility failed to ensure Level 1 pre-screening of a new resident for MD/ID or a related condition prior to admission to the facility. The resident had cerebral palsy, which is a related condition. The lack of pre-screening resulted in the resident's condition not being identified prior to admission and the resident not being evaluated through the Level II PASARR process. The resident did not receive the specialized rehabilitation services she needed which resulted in a decline in her function.*

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy
An example of Level 2, no actual harm, with potential for more than minimal harm, that is not immediate jeopardy, includes, but is not limited to:

- *The facility failed to ensure Level 1 pre-screening of new residents for MD/ID or a related condition, prior to admission to the facility. While the residents did not have MD/ID or a related condition, the facility admitted the residents without knowing if the residents had one of these conditions. The failure to determine whether the residents had MD/ID or a related condition had the potential to cause more than minimal harm to new and/or current residents.*

Severity Level 1: No Actual Harm with Potential for Minimal Harm
Failure to ensure residents are pre-screened for MD/ID or a related condition, prior to admission to the facility, could prevent the resident from attaining or maintaining his/her highest practicable level or result in a decline in the resident's physical, mental or psychosocial well-being. Therefore, Severity Level 1 does not apply for this regulatory requirement.

Effective November 28, 2017

F655 - Baseline Care Plan

Old Tag Number: No Associated Tag

§483.21 Comprehensive Person-Centered Care Planning

§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.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§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.

INTENT §483.21(a)

Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

Effective November 28, 2017

GUIDANCE §483.21(a)

Nursing homes are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. This means that the baseline care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.

Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Baseline care plans are required to address, at a minimum, the following:

- *Initial goals based on admission orders.*
- *Physician orders.*
- *Dietary orders.*
- *Therapy services.*
- *Social services.*
- *PASARR recommendation, if applicable.*

The baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her current needs. It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan. Facility staff must implement the interventions to assist the resident to achieve care plan goals and objectives.

Facilities may complete a comprehensive care plan instead of the baseline care plan. In this circumstance, the completion of the comprehensive care plan will not override the RAI process, and must be completed and implemented within 48 hours of admission and comply with the requirements for a comprehensive care plan at §483.21(b), with the exception of the requirement at (b)(2)(i) requiring the completion of the comprehensive care plan within 7 days of completion of the comprehensive assessment. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand.

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If the facility completes a comprehensive care plan instead of the baseline care plan, review the requirements of the comprehensive care plan at §483.21(b). If the care plan does not meet the requirements of §483.21(b), cite at the appropriate corresponding tag(s):

- *F656 Develop Comprehensive Care Plan*
- *F657 Care Plan Timing and Revision*
- *F658 Services Provided Meet Professional Standards*
- *F659 Qualified Persons*

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.

Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.

As the resident remains in the nursing home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident, however, these subsequent changes will not need to be reflected in the summary of the baseline care plan. Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes. Refer to §483.10(c) for guidance related to Resident Rights and Facility Responsibilities regarding Planning and Implementing Care.

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INVESTIGATIVE SUMMARY AND PROBES §483.21(a)

- *Use the Critical Element (CE) Pathway associated with the issue under investigation, or if there is no specific CE Pathway, use the General CE Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement develop and implement a Baseline Care Plan. If systemic concerns are identified with Baseline Care Plans, use the probes below to assist in your investigation.*
- *Was the baseline care plan developed and implemented within 48 hours of admission to the facility?*
- *Does the resident's baseline care plan include:*
  - *The resident's initial goals for care;*
  - *The instructions needed to provide effective and person-centered care that meets professional standards of quality care;*
  - *The resident's immediate health and safety needs;*
  - *Physician and dietary orders;*
  - *PASARR recommendations, if applicable; and*
  - *Therapy and social services.*
- *Was the baseline care plan revised and updated as needed to meet the resident's needs until the comprehensive care plan was developed?*
- *If the resident experienced an injury or adverse event prior to the development of the comprehensive care plan, should the baseline care plan have identified the risk for the injury/event (i.e., if risk factors were known or obvious)?*
- *Did the facility provide the resident and his or her representative, if applicable, with a written summary of the baseline care plan that contained at least, without limitation:*
  - *Initial goals of the resident;*
  - *A summary of current medications and dietary instructions;*
  - *Services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility; and*
  - *Any updated information based on details of the admission comprehensive assessment.*

Effective November 28, 2017

F657 - Care Plan Timing and Revision

Old Tag Number: F280

§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.

INTENT of §483.21(b)(2)

To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.

DEFINITIONS

"Non-physician practitioner (NPP)" *is a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).*

GUIDANCE §483.*21(b)(2)*

*Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment. "**After each assessment**" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS) as required by §483.20, except discharge assessments. For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.*

Effective November 28, 2017

As used in this requirement, "Interdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team *(IDT)* meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. *In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.*

The IDT must, at a minimum, consist of the resident's attending physician, a registered nurse and nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and to the extent possible, the resident and resident representative, if applicable. If the *attending* physician *is unable to participate in the development of the care plan,, he/she* may *delegate participation to an NPP who is involved in the resident's care, to the extent permitted by state law, or* arrange *alternative methods of* providing input in the development and revision of the care plan, such as one-on-one discussions*, videoconferencing* and conference calls with the IDT.

The determination of other appropriate staff or professionals participation in the IDT should be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, social workers, and other professionals, such as developmental disabilities specialists or spiritual advisor. Involvement of other individuals is dependent upon resident request and/or needs.

Each resident *has the* right to participate in choosing treatment options and must be *given* the opportunity to participate *in the development, review and revision of his/her care plan*. *Residents also have* the right to refuse treatment.

Facility *staff have* a responsibility to assist residents to *engage in the care planning process*, e.g., helping residents and *resident* representatives, *if applicable* understand the assessment and care planning process; holding care planning meetings at the time of day when the resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's *representative to participate in care planning and* attend *care planning conferences*.

The facility must provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing.

Effective November 28, 2017

Facilities are expected to facilitate the residents' and if applicable, the resident representatives' participation in the care planning process. There are limited circumstances in which the inclusion of the resident and/or resident representative may not be practicable (or feasible). An example may be the case of a severely cognitively impaired resident who is unable to understand or participate in care plan development, and the resident's representative does not respond to facility attempts to make contact. If the facility determines that the inclusion of the resident and/or resident representative is not practicable, documentation of the reasons, including the steps the facility took to include the resident and/or resident representative, must be included in the medical record.

While Federal regulations at §483.10(c) affirm the resident's right to participate in care planning, request and/or refuse treatment, the regulations do not create the right for a resident or *resident* representative*, if applicable*, to demand that the facility use specific medical intervention*s* or treatment*s* that the facility deems *not medically necessary and/or reasonable.*

The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

NOTE: *Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing. The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident's needs between required RAI assessments should be addressed at 483.35 Nursing Services, F726 (competency and skills to identify and address a change in condition), and the relevant outcome tag, such as 483.12 Abuse, 483.24 Quality of Life, 483.25 Quality of Care, and/or 483.40 Behavioral Health.*

For concerns related to the resident's rights to participate in planning and implementing his or her care, see requirements at §483.10(c).

INVESTIGATIVE SUMMARY AND PROBES §483.*21(b)(2)*

Use the Critical Element (CE) Pathway associated with the issue under investigation, or if there is no specific CE Pathway, use the General Critical Element Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement for timely completion and IDT and resident involvement in the development of the Comprehensive Care Plan. If systemic concerns are identified with timeliness and IDT/resident involvement in the development of Comprehensive Care Plans, use the probes below to assist in your investigation.

- *Was a comprehensive plan of care developed within seven days of completion of the resident's comprehensive assessment?*
- Is *there evidence of participation in the care planning process by required IDT members?*
- *Ask required members of the IDT how they participate in the development, review and revision of care plans.*

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- *Based on the resident's goals and needs, were other appropriate staff or professionals'* expertise utilized to develop a plan to improve the resident's functional abilities?

For example:

a. Did an occupational therapist *recommend* needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?
b. D*id* the dietitian and speech therapist determine the optimum textures and consistency for the resident's food that is nutritionally adequate and *compatible* with the resident's oropharyngeal capabilities *and food preferences*?

- Is there evidence of *attending* physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls, written communication)?
- How do staff make an effort to schedule care plan meetings at the best time of the day for residents and *if applicable, the resident representatives?*
- How do staff make the *care plan* process understandable to the resident *and resident representative, if applicable*?
- *Ask the resident and resident representative, if applicable if he or she actively participates in the care planning process? If not, what have been the barriers to participation?*
- *Ask the resident and if applicable, the resident representative if he or she has requested the participation of additional individuals care planning process. If so, was the request respected?*
- In what ways does staff involve the resident and *if applicable, the* resident representative in care planning? *If staff determine that the resident and/or resident representative involvement in care planning is not practicable, is the reason and the steps the facility took to include the resident and/or resident representative documented in the medical record?*
- *Is there evidence that the care plan is evaluated for effectiveness and revised following each required assessment, except discharge assessments, and as needed?*

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to:

- *The resident's care plan was not revised following a significant change assessment which identified an occurrence of resident-to resident sexual abuse, placing the abused resident and other residents at risk for serious injury, impairment or death.*

An example of Level 3, actual harm that is not immediate jeopardy includes, but is not limited to:

- *The facility failed to develop the comprehensive care plan within seven days of completion of the comprehensive assessment. This resulted in the resident sustaining a laceration requiring stitches due to a fall because appropriate fall prevention interventions were not implemented timely.*

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Examples of Level 2, no actual harm with potential for than more than minimal harm that is not immediate jeopardy, include, but are not limited to:

- *Residents and their representatives, if applicable, are not routinely invited to participate in care planning. While the resident did not experience an actual decline in physical, mental, or psychosocial functioning and continued to meet goals established on the care plan, the care plan goals did not show evidence of resident and if applicable, the resident representative input, having the potential for more than minimal harm.*
- *Direct-care staff were not made aware of revisions to the resident's care plan by the IDT for three days to assist the resident in brushing his teeth. This resulted in staff not assisting the resident with brushing his teeth for three days, and the resident did not suffer actual harm.*

Examples of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, include, but are not limited to:

- *Care plan was not reviewed by the IDT after the resident's quarterly assessment indicated a minor change in the resident's status..*
- *A required member of the IDT did not participate in development of the resident's care plan, which had no more than a minor negative impact to the resident.*

Effective November 28, 2017

F660 - Discharge Planning Process

Old Tag Number: F284

§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—

- ***(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.***
  - ***(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.***
- ***(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.***

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(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.

INTENT §483.21(c)(1)

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.

DEFINITIONS §483.21(c)(1)

"Discharge Planning": *A process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.*

"Home Health Agency (HHA)": *a public agency or private organization (or a subdivision of either) which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home and meets the requirements of sections 1861(o) and 1891 of the Social Security Act.*

"Inpatient Rehabilitation Facility (IRF)": *are freestanding rehabilitation hospitals or rehabilitation units in acute care hospitals that serve an inpatient population requiring intensive services for treatment.*

"Local Contact Agency": *refers to each State's designated community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, such as an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.*

"Long Term Care Hospital (LTCH)": *are certified as acute-care hospitals, but focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.*

"Patient Assessment Data": *standardized, publicly available information derived from a post-acute care provider's patient/resident assessment instrument, e.g., Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS).*

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GUIDANCE §483.21(c)(1)

Discharge Planning

Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team (as defined in §483.21(b)(2)(ii) working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge. It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions. A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition. An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.

The discharge care plan is part of the comprehensive care plan and must:

- *Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;*
- *Address the resident's goals for care and treatment preferences;*
- *Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;*
- *Be re-evaluated regularly and updated when the resident's needs or goals change;*
- *Document the resident's interest in, and any referrals made to the local contact agency;*
- *Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance*

Resident Discharge to the Community

Section Q of the Minimum Data Set (MDS) requires that individuals be periodically assessed for their interest in being transitioned to community living, unless the resident indicates otherwise. See: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html.
For residents who want to be discharged to the community, the nursing home must determine if appropriate and adequate supports are in place, including capacity and capability of the resident's caregivers at home. Family members, significant others or the resident's representative should be involved in this determination, with the resident's permission, unless the resident is unable to participate in the discharge planning process.
Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be transitioned to a community setting of their choice. The nursing home staff is responsible for making referrals to the LCA, if appropriate, under the process that the State has established. Nursing home staff should also make the resident and if applicable, the resident representative aware that the local ombudsman is available to provide information and assist with any transitions from the nursing home.

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For residents who have been in the facility for a longer time, it is still important to inquire, as appropriate, whether the resident would like to talk with LCA experts about returning to the community. New or improved community resources and supports may have become available since the resident was first admitted which may now enable the resident to return to a community setting.

If the resident is unable to communicate his or her preference or is unable to participate in discharge planning, the information should be obtained from the resident's representative.

Discharge planning must include procedures for:

- *Documentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose;*
- *Documentation of the response to referrals; and*
- *For residents for whom discharge to the community has been determined to not be feasible, the medical record must contain information about who made that decision and the rationale for that decision.*

Discharge planning must identify the discharge destination, and ensure it meets the resident's health and safety needs, as well as preferences. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:

- *Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;*
- *Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;*
- *Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;*
- *Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.*

As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).

Residents who will be discharged to another SNF/NF, HHA, IRF, or LTCH

If a resident will be discharged to another SNF, an IRF, LTCH, or HHA, the facility must assist the resident in choosing an appropriate post-acute care provider that will meet the resident's needs, goals, and preferences. Assisting the resident means the facility must compile available data on other appropriate post-acute care options to present to the resident. Information the facility must gather about potential receiving providers includes, but is not limited to:

- *Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and*
- *Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.*

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The listing of potential providers and data compiled must be relevant to the resident's needs, and be aligned with the resident's goals of care and treatment preferences.
Facilities must also comply with Section 1128B of the Social Security Act (the Federal Anti-Kickback statute) when making referrals to other provider types. Section 1128B "prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a Federal health care program," https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-laws-resourceguide.pdf.
In order to emphasize resident involvement, facilities are expected to present provider information to the resident and resident representative, if applicable, in an accessible and understandable format. For example, the facility should provide the aforementioned quality data on other post-acute care providers that meet the resident's needs, goals, and preferences, and are within the resident's desired geographic area. Facilities must then assist residents and/or resident representative as they seek to understand the data and use it to help them choose a post-acute care provider, or other setting for discharge, that is best suited to their goals, preferences, needs and circumstances. For residents who are discharged to another SNF/NF, a HHA, IRF, or LTCH the facility must provide evidence that the resident and if applicable, the resident representative was given provider information that includes standardized patient assessment data, and information on quality measures and resource use (where that data is available).

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

F624: *For concerns related to the immediate orientation and preparation necessary for a transfer which does not require discharge planning, such as transfers to a hospital emergency room or therapeutic leave.*

Summary of Investigative Procedures

Use the Community Discharge Critical Element (CE) Pathway, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility's requirement to develop and implement an effective discharge planning process.

Briefly review the most recent comprehensive assessments, comprehensive care plan (specifically the discharge care plan), progress notes, and orders to identify whether the facility has identified and addressed the resident's goals and discharge needs. This information will guide observations and interviews to be made in order to corroborate concerns identified. If there are concerns related to systematic discharge planning, this may trigger a review of the nursing home's policies and procedures for discharge assessment and care planning.

NOTE*: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

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DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety, includes, but is not limited to:

- *The facility failed to ensure that the post-discharge destination and continuing care provider could meet the resident's needs prior to the discharge of a resident with a feeding tube to a residential group facility. The surveyor discovered that within 24 hours of discharge, the resident was transferred to the hospital for aspiration, was intubated for respiratory distress and diagnosed with brain death. Review of medical records showed no documentation of the resident's tube feeding needs in the discharge plan, or whether the nursing home informed the receiving facility of the presence of the feeding tube and the need for aspiration precautions. It was also unclear whether the nursing home had determined that the receiving facility had the ability to care for a resident with a feeding tube prior to placement of the individual.*

Examples of level 3, actual harm that is not immediate jeopardy include, but are not limited to:

- *The facility failed to develop and/or implement a discharge care plan for a resident who had expressed a desire to return home as soon as possible once she completed rehabilitation for a fractured hip. The medical record revealed the therapist had discontinued the active treatment one week ago. The resident stated and the medical record verified that the facility had not developed plans for her care after her discharge and had not contacted any community providers to assist in her discharge. She indicated that she has not slept well due to worrying about returning to her home and paying the rent while in the facility. The resident's home was over an hour away. She stated she was depressed over having to remain in the nursing home, and spent most of the day in her room as it was too far for her friends to visit.*
- *A facility failed to develop discharge plans to meet the needs and goals of each resident, resulting in significant psychosocial harm, when the facility determined it would be closing, necessitating the discharge of all residents. The facility notified residents and resident representatives it would assist with relocation. Interviews with residents and observations showed residents were agitated, fearful, and in tears over the impending move. Residents indicated they were not asked their preferences and many would be relocated far away from family. Residents also indicated they were not given opportunities to provide input into the discharge planning process, specifically regarding discharge location. Record review showed no evidence of interaction with residents or resident representatives related to discharge planning. This was cross-referenced and cited at F845, Facility Closure.*

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An example of Level 2, no actual harm with potential for than more than minimal harm that is not immediate jeopardy, includes, but is not limited to:

- *Facility failed to develop a discharge care plan that addressed all of the needs for a resident being discharged home. Specifically, the care plan did not address the resident's need for an oxygen concentrator at home. After the resident was discharged to his home, a family member had to contact the physician to obtain the order and make arrangements for delivery of the equipment. Although there was a delay in obtaining the oxygen concentrator, the resident did not experience harm, however this four-hour delay had a potential for compromising the residents' ability to maintain his well-being.*

Severity Level 1 does not apply for this regulatory requirement. *The failure of the facility to provide appropriate discharge assessment and planning in order to meet the resident's needs and goals at the time of discharge from the nursing home and to ensure communication of necessary information for a safe transition of care places the resident at risk for more than minimal harm.*

Effective November 28, 2017

F712 - Physician Visits-Frequency/Timeliness/Alternate NPPs

Old Tag Numbers: F387, F388

§483.*30*(c) Frequency of physician visits

§483.*30*(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

§483.*30*(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

§483.*30*(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.*30*(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.

DEFINITIONS §483.*30*(c)

Must be seen, *for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement.* There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

"Non-physician practitioner (NPP)" means a nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA).

GUIDANCE **§483.*30*(c)**

The timing of physician visits is based on the admission date of the resident.

In a SNF, the first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days *after admission*, and then at 30 day intervals up until 90 days after the admission date. After the first 90 days, visits must be conducted at least once every 60 days thereafter.

Permitting up to 10 days' slippage of a due date will not affect the next due date. However, do not specifically look at the timetables for physician visits unless there is indication of inadequate medical care. The regulation states that the physician (or his/her delegate) must visit the resident **at least** every 30 or 60 days. There is no provision for physicians to use discretion in visiting at intervals longer than those specified at §483.*30*(c), *F712*. Although the physician may not delegate the responsibility for conducting the initial visit in a SNF, NPPs may perform other medically necessary visits prior to and after the physician's initial visit, as allowed by State law.

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After the initial physician visit in SNFs, where States allow their use, *a NPP may* make every other required visit. (See §483.*30*(*e*), *F714* Physician delegation of tasks in SNFs.) These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP. (Physician co-signature is not required, unless required by State law).

In a NF, the physician visit requirement may be satisfied in accordance with State law by *a NPP* who is not an employee of the facility but who is working in collaboration with a physician and who is licensed by the State and performing within the state's scope of practice. (See §483.*30*(*f*)).

In a NF, medically necessary visits performed by NPPs employed by the facility, may not take the place of physician required visits, nor may the visit count towards meeting the physician visit schedule prescribed at §483.20(c)(1).

In SNFs and NFs, facility policy *that* allows *NPPs* to *conduct required visits*, and*/or* allows a 10-day slippage in the time of the *required* visit, does not relieve the physician of the obligation to visit a resident *personally* when the resident's medical condition makes that visit necessary.

Table 1: Authority for *Non-physician Practitioners* to Perform Visits, Sign Orders *and Sign Medicare Part A Certifications/Re-certifications* when Permitted by the State

	Initial Comprehensive Visit /Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	*Certification/ Recertification* ±
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	*May not sign*
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	*May sign subject to State Requirements*
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	*Not applicable*
PA, NP, & CNS not a facility employee	May perform/ May sign*	May perform	May perform and sign	*Not applicable*

**A NPP may provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission. For additional requirements on physician recommendation for admission and admission orders, see §483.30(a), F710.*

^Other required visits are the physician visits required by 483.30(c)(1) other than the initial comprehensive visit.

+Medically necessary visits are independent of required visits and may be performed prior to the initial comprehensive visit.

±Though not part of a compliance determination for this section, this requirement is provided for clarification and relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

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In a facility where beds are dually-certified under Medicare and Medicaid, the facility must determine how the particular resident stay is being paid in order to identify whether physician delegation of tasks is *permissible* and if a NPP may perform the tasks. For example:

- For residents in a Part A Medicare stay, the NPP must follow the requirements for physician services in a SNF. This includes, at the option of a physician, required physician visits alternated between personal visits by the physician and visits by a NPP after the physician makes the initial *comprehensive* visit; and
- For residents in a Medicaid stay, the NPP must follow the requirements for physician services in a NF. *A NPP who is not employed by the facility and is working in collaboration with a physician* may perform any required physician task for a resident in a Medicaid-stay, at the option of the State. *(NPPs employed by the facility may not perform required physician visits but may perform other medically necessary visits)*

It is expected that visits will occur at the facility rather than the doctor's office unless office equipment is needed or a resident specifically requests an office visit. If the facility has established policy that residents leave the grounds for medical care, the resident does not object, and this policy does not infringe on his/her rights including the right to privacy, there is no prohibition to this practice. The facility should inform the resident of this practice, in accordance with §483.*10(g)(16), F581, Notice of rights and services.*

Certifications/Re-certifications in SNFs: Under 42 C.F.R. §424.20, certifications and re-certifications are required to verify that a resident requires daily skilled nursing care or rehabilitation services. NPs, CNSs, and PAs who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under the scope of practice for the State. 42 C.F.R. §424.20(e)(2).

PROBES §483.*30*(c)

- *D*oes the scheduling and frequency of physician visits relate to any identified quality of care problems?
- *If the resident is admitted under a SNF stay, did the physician conduct the initial comprehensive visit, in-person, within the first 30 days?*
- *If the resident is admitted under a NF stay, did the physician or a NPP who is not employed by the facility but who is working in collaboration with a physician conduct the initial comprehensive visit, in-person, within the first 30 days?*
- *Are physician visits conducted at the required intervals, with no more than 10 days slippage from the due date?*
- *In a SNF, if the physician delegates required visits to a NPP, does the physician personally conduct alternate visits with the NPP as required?*
- *Does the resident or resident representative report meeting with the physician? If so, how often?*

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POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

If the failure of the physician to visit the resident at the required intervals resulted in a negative outcome to the resident, also investigate compliance with §483.30(a), F710, Resident's care supervised by a physician.

DEFICIENCY CATEGORIZATION

Example of Level 4, immediate jeopardy to resident health and safety, includes, but is not limited to:

- *The facility failed to ensure the attending physician conducted required visits for several consecutive months in the facility. The physician responded to phone calls and provided verbal orders during this time-frame, however did not visit and make face-to-face contact with the resident, who experienced a significant negative change in status. No other physicians or NPPs visited the resident. This placed the resident at risk for serious harm or death.*

Example of level 3, actual harm that is not immediate jeopardy, includes, but is not limited to:

- *A resident newly admitted to the facility and determined to be at high risk of developing a pressure ulcer/injury, developed an unstageable pressure ulcer during the first 30 days. While the physician was consulted by telephone, the facility failed to ensure the physician conducted an initial comprehensive visit for over 40 days, contributing to the decline in the resident's skin status.*

Example of Level 2, no actual harm, with potential for than more than minimal harm, that is not immediate jeopardy, includes, but is not limited to:

- *The facility failed to ensure the physician conducted an initial comprehensive visit within the first 30 days after admission, for a resident under a Medicare Part A stay.*

Example of Level 1, no actual harm with potential for no more than a minor negative impact on the resident, includes, but is not limited to:

- *The facility failed to ensure that the attending physician alternated required monthly visits with the Nurse Practitioner as required for a resident under a SNF stay. A review of the Progress Notes revealed that notes were written, signed and dated by the NP for several consecutive visits, and all of the resident's needs were met. No documentation was found to indicate that the attending physician had visited and examined the resident at least once every 30 days for the first 90 days after admission or at least once every 60 days thereafter during this time.*

Effective November 28, 2017

F714 - Physician Delegation of Tasks to NPP

Old Tag Number: F390

§483.*30*(e) Physician delegation of tasks in SNFs.

§483.*30*(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;

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

(iii) Is under the supervision of the physician.

****

§483.*30*(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

§483.*30*(f) Performance of physician tasks in NFs.
At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

INTENT §483.30(e)(1)&(4)

To allow the physician, under certain conditions, to delegate tasks to a nurse practitioner, clinical nurse specialist or physician assistant, working under the physician's supervision.

DEFINITIONS *§483.30(e)(1)&(4)*

"Clinical nurse specialist" is a registered professional nurse currently *licensed to* practice in the State and who meets the State's requirements governing the qualifications of clinical nurse specialists.

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"Nurse practitioner" is a registered professional nurse *who is currently* licensed to practice in the State, who meets the State's requirements governing the qualification of nurse practitioners *and who meets one of the following conditions:*

(1) is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

(2) has satisfactorily completed a formal 1 academic year educational program that (i) prepares registered nurses to perform an expanded role in the delivery of primary care; (ii) includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and (iii) awards a degree, diploma or certificate to persons who successfully complete the program; or

(3) has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements above and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding September 22, 2006.

"Physician assistant" is a person who meets the applicable State requirements governing the qualifications for assistants to *primary* care *physicians, and who meets at least one of the following conditions:*

(1) is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

(2) has satisfactorily completed a program for preparing physician's assistants that (i) was at least 1 academic year in length; (ii) consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and (iii) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements above and has been assisting physicians for a total of 12 months during the 18-month period that ended on December 31, 1986.

***"Non-physician practitioner (NPP)"** is a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) as defined above.*

GUIDANCE* §483.*30(e)(1)&(4)

The extent to which physician services *may be* delegated to *NPPs* in SNFs *is governed* by the provisions of §483.*3*0(e), while the extent to which these services may be performed by *NPPs* in NFs *is governed by the provisions of* §483.3*0*(f). (Refer to table in *F712).*

In SNFs, when **personal** performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. The tasks of examining the resident, reviewing the resident's total program of care, writing progress notes, and signing orders may be delegated *unless prohibited by* State law *or facility policies*.

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PROBES §483.*30*(*e*)*(1)&(4)*

- Do the attending physicians delegate *tasks* to NPPs?
- *If the physician delegates tasks to NPs or PAs, does the NP or PA meet the requirements in §491.2?*
- *If the physician delegates tasks to CNSs, is the CNS licensed as such by the State?*
- Do *NPPs* follow the scope of practice allowed by State law *in conducting examinations, evaluations, writing progress notes and orders*?
- *Does the physician supervise the NPP in the SNF? Examples of supervision may include face-to-face encounters, clinical record reviews, telephone consults, e-mail, telehealth, and electronic health records.*

DEFINITIONS §483.30(f)

"Collaboration" *is a process often governed by the laws of a given State in which a non-physician practitioner (NPP) works with one or more physicians to deliver health care services within the scope of the NPP's expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms.*

In the absence of State law governing collaboration, such collaboration is to be evidenced by NPPs documenting the NPP's scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

The collaborating physician does not need to be present with the NPP when the services are furnished or to make an independent evaluation of each resident who is seen by the NPP.

***GUIDANCE* §483.*30*(*f*)**

At the option of the State, NPPs in a NF, *who are not employees of the facility, may perform physician tasks* includ*ing* performing *examinations, evaluations,* required visits *and writing orders*.

If the physician delegates the task of performing visits to the NPP, the NPP must meet all of the requirements for

- *§483.30(a), F710, physician supervision*
- *§483.30(b), F711, physician visits*
- *§483.30(c), F712, physician frequency and timeliness of visits*

NOTE: If concerns are identified regarding the NPP meeting the requirements for physician supervision, physician visits or frequency and timeliness of visits, investigate under the corresponding regulation.

Orders written by a NPP who is employed by the NF and are written during visits that are not required visits, and are therefore "other medically necessary visits," do not require physician co-signature except as mandated by State law.

Effective November 28, 2017

PROBES: §483.*30*(*f*)

- *If the physician delegates the performance of required physician tasks to the NPP in the NF, is the delegation allowed by the State?*
- *When performing physician tasks in the NF, is the NPP functioning within their scope of practice as permitted in their State?*
- If a *NPP* is performing required physician *visits in the NF, is the NPP* an employee of the facility? (Facility employees are prohibited from serving in this capacity.)
- *How does the facility ensure the NPP is* working in collaboration with the physician?

Effective November 28, 2017

F728 - Facility Hiring and Use of a Nurse Aide

Old Tag Numbers: F494, F495

§483.35(d) Requirement for facility hiring and use of nurse aides-

§483.*3*5(*d*)(*1)* General rule.

A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless—

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or

(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).

§483.*35(d)(2)* Non-permanent employees.

A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.

§483.*3*5(*d*)(*3*) *Minimum* Competency

A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).

***DEFINITIONS* §483.3*5(d)*(1-3)**

A "**permanent employee**" is defined as any employee the facility expects to continue working on an ongoing basis.

***GUIDANCE* §483.3*5(d)*(1-3)**

*A*ny individual who successfully completed *either a nurse aide training or* competency evaluation program *(NATCEP)* or a competency evaluation program *(CEP) or* has been deemed or determined competent as provided in §483.150(a) and (b) *may be employed as a nurse aide.*

*I*f an individual has not *successfully* completed a *NATCEP* program at the time of employment, that individual *may only function* as a nurse aide if the individual is *currently* in a *NATCEP* (**not**

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a competency evaluation program *(CEP)* alone) *and* is a permanent employee in his or her first four months of employment in the facility.

***Procedures and Probes* §483.35*(d)*(1-3)**

- *If there are concerns with a nurse aide's competency or qualification determine whether he/she successfully* completed *an approved NATCEP* or a *CEP*. If not, are *these individuals'* permanent employees who have worked in the facility for 4 months or less enrolled in a *NATCEP*?
- *Interview those* aides *to determine* where they received their *NATCEP* training, how long the training was and how long they have worked in the facility as a nurse aide.

If you identify deficient care practices by nurse aides who do not have evidence of having successfully completed a *NATCEP/CEP*, determine:

- If the aide is currently receiving training *in* a State-approved *NATCEP*; *and*
- If the aide has been trained, has demonstrated proficiency and determined to be proficient for the tasks to which he or she is assigned. See §483.152 for specific training that the aide is to receive.

For specific procedures for NATCEP/CEP refer to the State Operations Manual (SOM), Chapters 4 and 7.

Effective November 28, 2017

F729 - Nurse Aide Registry Verification/Retraining

Old Tag Number: F496

§483.*3*5(*d*)(*4*) Registry verification.

Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

§483.*3*5(*d*)(*5*) Multi-State registry verification.

Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act *that* the facility believes will include information on the individual.

§483.*3*5(*d*)(*6*) Required retraining.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

GUIDANCE* §483.3*5(d)(6)

If the *nurse aide provides documentation to verify that* he or she performed nursing or nursing-related services for monetary compensation *(including providing assistance with activities of daily living (ADL) care)* for at least one documented day (e.g., 8 consecutive hours) during the previous 24 months, *he/she is not required to take a new nurse aide training and competency evaluation program or a new competency evaluation program (NATCEP/CEP). It is not required that these services be provided in a nursing home setting so long as the nurse aide was performing nursing or nursing-related services including assisting with ADLs*. The State is required to remove the individual's name from the registry if the services are not provided for monetary compensation during the 24-month period.

Effective November 28, 2017

F730 - Nurse Aide Performance Review/12 Hours Year In-Service

Old Tag Number: F497

§483.35(d)(7) Regular in-service education.

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. ***In-service training must comply with the requirements of §483.95(g).***

INTENT **§483.35(d)(7)**

To focus on the performance review requirement and specific in-service education based on the outcome of those reviews for each individual nurse aide.

GUIDANCE **§483.35(d)(7)**

NOTE: *Cite this Tag only when a performance review of a nurse aide is not conducted at least every 12 months or if the in-service education provided to an aide is not based on his/her performance review.*

Each nurse aide must have no less than twelve hours of in-service education per year based on *their individual* performance review. Calculate the date by which a nurse aide must receive annual in-service education by the*ir* employment date rather than the calendar year.

For specific requirements regarding the content and requirements of training for nurse aides DO NOT cite here but refer to F947, §483.95(g).

PROBES **§483.35(d)(7)**

Surveyors should determine through information obtained by observations, interviews and verified by record reviews, whether a performance review of every nurse aide was conducted at least once every 12 months and if the regular in-service education was based on the outcome of these individual reviews.

- *What is the process for* review*ing* the performance *review* of nurse aides?
- *How are these reviews documented and does the documentation reflect at least twelve hours of in-service training per year based on an aide's individual performance review?*
- What evidence can the facility *produce* that demonstrates the in-service education *provided addresses* areas of weakness identified in performance reviews, special resident needs, and needs of residents with cognitive impairments?

Effective November 28, 2017

F851 - Payroll Based Journal

Old Tag Number: F527

§483.70(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.

§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).

§483.*70(q)(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).***

§483.70(q)(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.

§483.*70(q)(4) Data format.*

The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.

The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

Effective November 28, 2017

INTENT* §483.*70(q)

To ensure that long-term care facilities are electronically submitting direct care staffing information (including agency and contract staff) per day, based on payroll and other verifiable and auditable data. The staffing hours, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure.

GUIDANCE* §483.*70(q)

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.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F851, the investigation the surveyor's investigation will generally show that the facility failed to do any one of the following:

- *Complete data for the entire reporting period, such as hours paid for all required staff, each day;* ***or***
- *Provide accurate data;* ***or***
- *Provide data by the required deadline.*

Effective November 28, 2017

F865 - QAPI Program/Plan/Disclosure/Good Faith Attempt

Old Tag Number: F520

§483.75(a) Quality assurance and performance improvement (QAPI) program.

[§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:

§483.75(a)(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;

§483.75(a)(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)]

§483.75(a)(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

§483.75(a)(4) 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.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(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.

§483.75(b (4) Reflect the complexities, unique care, and services that the facility provides.

Effective November 28, 2017

§483.75(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:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;

§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(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.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.

A **State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.** ***[§483.75(h) will be implemented November 28, 2016 (Phase 1)]***

§483.75(i) Sanctions.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. ***[§483.75(i) implemented November 28, 2016 (Phase 1)]***

INTENT

These requirements are intended to ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

Effective November 28, 2017

GUIDANCE §483.75(a)(2)-(3), and (h)-(i)

QAPI Plan

A QAPI plan is the written plan containing the process that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. The plan describes how the facility will conduct its required QAPI and QAA committee functions. The facility is required to develop a QAPI plan and present its plan to federal and state surveyors at each annual recertification survey and upon request during any other survey, and to CMS upon request.

The QAPI plan must describe in detail the scope of the QAA committee's responsibilities and activities, and the process addressing how the committee will conduct the activities necessary to identify and correct quality deficiencies. Each nursing home, including facilities which are a part of a multi-chain organization, should tailor its QAPI plan to reflect the specific units, programs, departments, and unique population it serves, as identified in its facility assessment.

The QAPI plan must describe how the facility will ensure care and services delivered meet accepted standards of quality, identify problems and opportunities for improvement, and ensure progress toward correction or improvement is achieved and sustained.

The QAPI plan must describe the process for identifying and correcting quality deficiencies. Key components of the process include:

- *Tracking and measure performance;*
- *Establishing goals and thresholds for performance measurement;*
- *Identifying and prioritizing quality deficiencies;*
- *Systematically analyzing underlying causes of systemic quality deficiencies;*
- *Developing and implementing corrective action or performance improvement activities; and*
- *Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.*

Disclosure of Information and Good Faith Attempts

The survey process is intended to be an objective assessment of facility compliance with the requirements of participation. This assessment is guided by facility performance and outcomes as reported by Quality Measures (QMs) and Minimum Data Set (MDS) data, as well as complaints and surveyor observations, interviews, and record reviews. The surveyor task to review the QAPI Plan/QAA is intended to occur at the end of the survey, after completion of investigation into all other requirements to ensure that concerns are identified by the survey team independent of the QAPI Plan/QAA review. Surveyors must use critical thinking and investigatory skills to identify noncompliance, rather than using information provided during the QAA review as a source to identify deficiencies. The intent of §483.75(h), (i) is to:

- *Ensure information obtained from QAA committee documents that is related to the committee's good faith attempt to identify and correct quality deficiencies are not used by surveyors to identify additional concerns not previously identified during the survey; and*
- *Foster a culture where nursing homes can openly conduct their internal QAA investigations and performance improvement efforts.*

Effective November 28, 2017

Surveyors may only require facilities to disclose QAA committee records if they are used to determine the extent to which facilities are compliant with the provisions for QAA.

*Protection from disclosure is generally afforded documents generated by the QAA committee, such as minutes, internal papers, or conclusions. However, if those documents contain the evidence necessary to determine compliance with QAPI/QAA regulations, the facility must allow the surveyor to review and copy them. The **key point** is that the facility must provide satisfactory evidence that it has, through its QAA committee, identified its own high risk, high volume, and problem-prone quality deficiencies, and are making a "good faith attempt" to correct them.*

Information gleaned from disclosure of QAA committee documents will not be used to cite new issues (not already identified by the survey team) or to expand the scope or severity of concerns identified on the current survey.

***NOTE:** Prior to conducting the QAA review, the survey team must conduct a thorough investigation of all issues identified, including expanding the sample as necessary to determine the scope of the issue.*

Reports and Logs

Incident and accident reports, wound logs, or other reports or records used to track adverse events are not protected from disclosure. Surveyors may request these documents as part of their normal investigation of other areas of concern throughout the survey to support their findings.

Surveyor Access to QAA Material and Confidentiality of Patient Safety Work Products

CMS supports and encourages nursing homes to work on a confidential basis with an Agency for Healthcare Research and Quality (AHRQ) approved Patient Safety Organization (PSO) to obtain technical assistance in identifying, analyzing and preventing quality deficiencies and adverse events. The Federal Patient Safety and Quality Improvement Act of 2005 (PSQIA), Public Law 109-41, established a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues. PSQIA has afforded privileged and confidential status to "patient safety work product" (PSWP). PSWP includes data, reports, records, memoranda, analysis, or written and oral statements assembled and developed for reporting to a PSO and have been submitted to a PSO approved and listed by the Department of Health and Human Services (HHS) AHRQ.

Effective November 28, 2017

PSQIA and the Patient Safety Rule only limit the disclosure of PSWP. Neither PSQIA nor the Patient Safety Rule limit the disclosure of non-PSWP, including its disclosure to a Federal, state or local government for public health surveillance, investigation or health oversight. The preamble to the final Patient Safety Rule states:

> *"Information is not patient safety work product if it is collected to comply with external reporting, such as…certification or licensing records for compliance with health oversight agency requirements;…complying with required disclosures by particular providers or suppliers pursuant to Medicare's Conditions of participation or conditions of coverage…" (73 FR 70742-70743, November 21, 2008).*

Ultimately, it is the nursing home's final decision as to whether to enter into a relationship with a PSO and to create a patient safety evaluation system (PSES) which is the collection, management, or analysis of information for reporting to or by a PSO. Additionally, the nursing home must determine what information to place within the PSES, considering a number of factors, including how they will demonstrate compliance with the Long-term Care Requirements for Participation, in particular, the QAA requirements. A nursing home must be prepared to meet its obligation to provide surveyors access to QAA program information to demonstrate compliance without disclosing PSWP as that term is defined in 42 CFR Part 3, the regulation implementing the Federal PSQIA. There is no barrier under the PSQIA for nursing homes to maintain duplicate systems, one consisting of patient safety work product within a protected patient safety evaluation system, and another to demonstrate compliance with local, State or Federal requirements.

Surveyors should consider the following key points:

- *Surveyors assessing QAA compliance must ask nursing homes to provide evidence of QAA compliance.*
- *Surveyors must **never** ask or demand that a nursing home show them "patient safety work product." If a nursing home states that all relevant QAA material has been placed in its PSES, or is protected PSWP, surveyors must ask to see the agreement the nursing home has with an AHRQ-approved PSO, to confirm that it has an approved protected PSES.*
- *If a nursing home has placed all evidence related to QAA compliance in its PSES as patient safety work product and does not also maintain a separate non-confidential system to provide evidence of compliance, or is unable to remove evidence of such compliance from its PSES, it may not be able to demonstrate its compliance to the surveyor.*

Good Faith Attempts

If the facility, through its QAA committee, has identified and made a good faith attempt to correct the same issue identified by the survey team during the current survey, the facility will not be cited for QAA (it may however, still be cited with deficiencies related to actual or potential issues at other relevant tags).

Effective November 28, 2017

A good faith attempt to correct an identified quality deficiency involves determining where a facility is within the process of identifying and correcting a problem (or problems). Surveyors will have to determine if the facility became aware of the issue as soon as it should have – was the issue a high-risk, high-volume, or problem-prone issue they should have been tracking? Was there a negative outcome to a resident which should have alerted them to the issue? What steps did the facility take when they became aware of the issue? Has there been enough time to implement changes and to evaluate the effectiveness of those changes? Do their efforts demonstrate diligence and an honest attempt to correct the issue?

Identifying and correcting problems requires facilities to:

- *Collect data from various sources related to high risk, high volume, and problem-prone issues such as medical errors and adverse events;*
- *Analyze the data collected to identify performance indicators signaling deviation from expected performance;*
- *Study the issue to determine underlying causes and contributing factors;*
- *Develop and implement corrective actions; and*
- *Monitor data related to the issue to determine if they are sustaining corrections, or if revisions are necessary.*

If the survey team has identified a current issue which will be cited at S/S level of E or above, or has identified substandard quality of care, the surveyor conducting the QAPI/QAA Review should consider if the facility's monitoring systems should also have identified the same issue. The surveyor must take into consideration whether the QAA committee has had sufficient time through its monitoring systems to identify the issue, if it was a high risk, problem-prone issue they should have been monitoring, and whether there has been a reasonable amount of time to respond to the issue. Issues which are likely to cause serious harm, impairment, or death must be responded to immediately. If the facility has identified the issue through its QAA committee, the surveyor must then evaluate the extent to which their actions or plans to correct the issue demonstrate a "good faith attempt."

Surveyors must not use documentation provided by the facility during the QAA review to identify additional concerns not previously identified by the survey team during the current survey, nor can they expand the scope or the severity of the problem based on information gleaned from this disclosure.

Facility Refusal to Provide Evidence of Compliance

Refusal by a facility to produce evidence of compliance with QAA will lead to citation of noncompliance with F865, requiring a plan of correction, and possible imposition of enforcement remedies up to and including termination of the facility's provider agreement. In the event of a facility refusal to produce evidence of compliance, the team coordinator should contact their State Agency supervisor.

Effective November 28, 2017

The Code of Federal Regulations (CFR) 42 CFR, 489.53(a)(1), (3) and (4) stipulates the following:

*"**(a) Basis for termination of agreement with any provider.** CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider:*

(1) It is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provision of the agreement…

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs or NFs) set forth elsewhere in this chapter…

(4) It fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due."

Thus, since access to QAA committee records may be necessary to determine whether a facility meets the Medicare requirements at 483.75, denial of such access risks termination of the provider agreement.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F865, the surveyor's investigation must generally show that the facility failed to develop a QAPI plan and/or make the plan available to federal and/or state surveyors.

INVESTIGATIVE SUMMARY

Use the Facility Task Pathway for Quality Assurance and Performance Improvement (QAPI) Plan and Quality Assessment and Assurance (QAA) Review, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the QAPI plan.

Summary of Investigative Procedure

Prior to conducting the QAPI Plan/QAA review, the survey team should identify and validate systemic problems in the facility. This includes concerns identified from offsite preparation that represent repeat deficient practice, and concerns or issues identified throughout the survey that will potentially be cited at a S/S of E or above.

Phase 3 Implementation

F866 - QAPI/QAA Data Collection and Monitoring

Old Tag Number: F520

§483.75(c) Program feedback, data systems and monitoring.

(§483.75(c) will be implemented during Phase 3)

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

Effective November 28, 2017

F867 - QAPI/QAA Improvement Activities

Old Tag Number: F520

§483.75(d) Program systematic analysis and systemic action.

(§483.75(d) will be implemented during Phase 3)

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

(§483.75(e) will be implemented during Phase 3)

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section

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§483.75(g) **Quality assessment and assurance.**

§483.75(g)**(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.

[§483.75(g)(2)(ii) implemented November 28, 2016 (Phase 1) except as related to implementation of the QAPI program, which will be implemented November 28, 2019 (Phase 3)]

DEFINITIONS §483.75(g)(2)(ii)-(iii)

"Adverse Events": *An adverse event is defined as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses.*

"Corrective Action"*: A written and implemented plan of action for correcting or improving performance in response to an identified quality deficiency. Use of the term corrective action in this guidance is not synonymous with a Plan of Correction (formal response to cited deficiencies). This is also separate from the written QAPI plan.*

"High Risk, High Volume, Problem-Prone":
"High risk": *Refers to care or service areas associated with significant risk to the health or safety of residents, e.g., tracheostomy care; pressure injury prevention; administration of high risk medications such as warfarin, insulin, and opioids.*

"High Volume": *Refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem, e.g., transcription of orders; medication administration; laboratory testing.*

"Problem-prone"*: Refers to care or service areas that have historically had repeated problems, e.g., call bell response times; staff turnover; lost laundry.*

"Near Miss": *A potential harm event that did not reach a resident.*

"Plan Do Study Act (PDSA) Cycle": *An iterative four-step improvement method used to quickly test change in a process, resulting in continuous improvement. Also known as a Deming cycle, rapid-cycle improvement, or Plan Do Check Act (PDCA) cycle.*

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"Quality Assurance and Performance Improvement (QAPI)": *Nursing home QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving.*

- ***Quality Assurance (QA):*** *QA is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going and both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.*
- ***Performance Improvement (PI):*** *PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying opportunities for improvement, and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve facility processes involved in care delivery and enhanced resident quality of life. PI can make good quality even better.*

"Quality Deficiency (or Opportunity for Improvement)": *A deviation in performance resulting in an actual or potential undesirable outcome, or an opportunity for improvement. A quality deficiency is anything the facility considers to be in need of further investigation and correction or improvement. Examples include problems such as medical errors and accidents, as well as improvement opportunities such as responses to questionnaires showing decreased satisfaction. This term is not necessarily synonymous with a deficiency cited by surveyors, but may include issues related to deficiencies cited on annual or complaint surveys.*

GUIDANCE §483.75(g)(2)(ii)

Identifying Quality Deficiencies

The QAA committee's responsibility to identify quality deficiencies requires facilities to have a system for monitoring departmental performance data routinely in order to identify deviations in performance and adverse events. Issues identified must be prioritized to determine which concerns pose a high risk to resident safety, health, and well-being, those which are problem-prone, and those which are high volume (occur with frequency). Adverse events, such as the elopement without injury of a cognitively-impaired resident, should be considered a high risk problem for which corrective action is required.

Adverse Events

An adverse event is defined as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses. Facilities must have mechanisms or systems in place to ensure the QAA Committee takes necessary steps to identify the cause and correct the issue.

In 2014, the Department of Health and Human Services, Office of Inspector General (OIG) released its report "Adverse Events in Skilled Nursing Facilities (SNFs): National Incidence Among Medicare Beneficiaries," which found that one in three Medicare beneficiaries were

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harmed by an adverse event or temporary harm event within their first 35 days while residing in a SNF. The OIG determined that nearly sixty percent of the events were potentially preventable. The OIG classified the events into three categories: medication, care, and infection related adverse events.

CMS collaborated with the Agency for Healthcare Research and Quality (AHRQ) to develop a listing of common potentially preventable events that occur in nursing homes – this list is not all-inclusive of potentially preventable events. This list is subject to change as technology and research redefine what is preventable.

Potentially Preventable Events Related to:		
Medication	***Care***	***Infection***
Change in mental status/delirium related to use of opiates and psychotropic medication	*Falls, abrasions/skin tears, or other trauma related to care*	*Respiratory infections:* • *Pneumonia* • *Influenza*
Hypoglycemia related to use of antidiabetic medication	*Electrolyte imbalance (including dehydration and acute kidney injury/insufficiency) associated with inadequate fluid maintenance*	*Skin and wound infections:* • *Surgical Site Infections (SSIs)* • *Soft tissue and non-surgical wound infections*
Ketoacidosis related to use of antidiabetic medication	*Thromboembolic events related to inadequate resident monitoring and provision of care*	*Urinary tract infections (UTIs)* • *Catheter Associated UTIs (CAUTIs)* • *UTIs (non-catheter associated)*
Bleeding related to use of antithrombotic medication	*Respiratory distress related to inadequate monitoring and provision of tracheostomy/ventilator care*	*Infectious diarrhea* • *Clostridium difficile* • *Norovirus*
Thromboembolism related to use of antithrombotic medication	*Exacerbations of preexisting conditions related to inadequate or omitted care*	
Prolonged constipation/ileus/ impaction related to use of opiates	*Feeding tube complications (aspiration, leakage, displacement) related to inadequate monitoring and provision of care*	
Electrolyte imbalance (including dehydration and acute kidney injury) related to use of diuretic medication	*In-house acquired/worsened stage pressure injuries, and unstageable/suspected deep tissue injuries*	
Drug toxicities including: acetaminophen, digoxin;	*Elopement*	

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Potentially Preventable Events Related to:		
levothyroxine; ACE inhibitors; phenytoin; lithium; valproic acid; antibiotics		
Altered cardiac output related to use of cardiac/blood pressure medication		

According to the OIG report, preventable adverse events were generally caused by:

- *Appropriate treatment provided in a substandard way (56%)*
- *Resident's progress not adequately monitored (37%)*
- *Necessary treatment not provided (25%)*
- *Inadequate resident assessment and care planning (22%)*

Corrective Action

Once a quality deficiency is identified, the QAA committee has a responsibility to oversee development of "appropriate" corrective action. An appropriate corrective action is one that appears to address the underlying cause of the issue comprehensively, at the systems level.

There are many different methodologies available to facilities for developing corrective action. CMS has not prescribed a particular method that must be used. Corrective action generally involves a written plan that includes:

- *A definition of the problem – which, depending on the severity and extent of the problem, may require further study by the committee to determine contributing causes of the problem (Root Cause Analysis);*
- *Measurable goals or targets;*
- *Step-by-step interventions to correct the problem and achieve established goals; and*
- *A description of how the QAA committee will monitor to ensure changes yield the expected results.*

Corrective actions may take the form of one or more tests of change, or PDSA cycles until the desired performance goals have been met, or facilities may convene a Performance Improvement Project (PIP).

While facilities are not yet required to perform them, PIPs are a type of corrective action that generally involves a team making a concentrated effort over time to improve a systemic problem. It often requires a systematic investigation, such as a Root Cause Analysis (RCA) to identify underlying causes or factors which have contributed to, or caused the problem. Interventions are designed to address the underlying causes. Once each intervention is implemented, the team closely monitors results to determine if changes are yielding the expected improvement or if the interventions should be revised.

***NOTE:** The requirement for facilities to conduct PIPs will be implemented in Phase 3, beginning on November 28, 2019.*

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KEY ELEMENTS OF NON-COMPLIANCE

To cite deficient practice at F867, the surveyor's investigation must generally show that the facility failed to:

- *Identify quality deficiencies; and*
- *Develop and implement action plans to correct identified quality deficiencies.*

INVESTIGATIVE SUMMARY

Use the Facility Task Pathway for Quality Assurance and Performance Improvement (QAPI) Plan and Quality Assessment and Assurance (QAA) Review, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to QAA Committee identification and correction of quality deficiencies.

Summary of Investigative Procedure

Prior to conducting the QAPI Plan/QAA review, the survey team should identify and validate systemic problems in the facility. This includes concerns identified from offsite preparation that represent repeat deficient practice, and concerns or issues identified throughout the survey that will potentially be cited at a S/S of E or above.

DEFICIENCY CATEGORIZATION

Examples of Severity Level 4 Non-compliance Immediate Jeopardy to Resident Health or Safety include but are not limited to:

- *Evidence showing one or more residents received third degree burns from hot water temperatures in the month prior to the survey. QAA review showed there was no system in place for routine monitoring of hot water temperatures throughout the facility, yet no action had been taken to correct the systemic, high risk issue. (Cross-referenced at F689, Accidents)*
- *Evidence showing the facility failed to monitor their system for communicating each residents' code status. This resulted in staff having inaccurate and inconsistent information to use in emergency situations. QAA review showed the QAA committee was not aware of this systemic issue, and the QAA committee was not monitoring facility practices related to accurate and consistent communication of residents' advance directives and code status.*

Examples of Severity Level 3 Non-compliance Actual Harm that is Not Immediate Jeopardy include, but are not limited to:

- *Evidence showing the facility had no system for conducting infection surveillance, with accompanying evidence that several residents on one unit had Clostridium difficile, one of whom had a resultant decline in their ability to perform ADLs. QAA review showed the QAA committee had identified the issue, put a corrective action in place, but failed to monitor to ensure the corrective action was achieving the intended results. (Cross-reference and also cited at Infection Control).*

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- *Evidence showing the facility had repeat deficiencies for the past two surveys related to their failure to ensure residents' post discharge needs were care planned and met upon discharge. During the current survey it was determined that a resident was discharged with no education about how to manage his new onset diabetes, resulting in his rehospitalization. The QAA review showed the QAA committee was not aware of the issue, and was not monitoring its practices around discharge. (Cross-referenced and also cited at Discharge Planning.*

***Example of Severity Level 2 Considerations**: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy includes, but is not limited to:*

- *Facility failed to identify an unresolved quality deficiency involving inaccurate weights, which was previously cited on the last annual survey. This issue has the potential to cause more than minimal harm.*

Example of a Severity Level 1: No actual harm with potential for minimal harm includes but is not limited to:

- *Facility failed to ensure that monitoring occurred as planned for an identified quality deficiency. On interview it was determined that the facility's corrective action involved monitoring monthly for three months to ensure the issue was corrected, however, documentation showed that for the second month, there was no evidence that monitoring had occurred. The QAA coordinator explained that she was out of the facility during that period.*

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§483.90 Physical Environment.

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

§483.90(a) Life safety from fire.

§483.90(a)(1) Except as otherwise provided in this section –

§483.90(a)(1)(i) The LTC facility must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

§483.90(a)(1)(ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

§483.90(a)(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a long-term care facility, but only if the waiver will not adversely affect the health and safety of the patients.

§483.90(a)(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

§483.90(a)(4) A long-term care facility may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

§483.90(a)(5) A long term care facility must:

§483.90(a)(5)(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.

§483.90(a)(5)(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.

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§483.90(a)(5)(iii) Exception:

§483.90(a)(5)(iii)(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or

§483.90(a)(5)(iii)(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

§483.90(a)(6) A long term care facility must:

§483.90(a)(6)(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

§483.90(a)(6)(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

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§483.90(a)(6)(iii) Subject to approval by CMS, a long term care facility may be granted an extension of the sprinkler installation deadline for a time period not to exceed 2 years from August 13, 2013, if the facility meets all of the following conditions:

§483.90(a)(6)(iii)(A) It is in the process of replacing its current building, or undergoing major modifications to improve the living conditions for residents in all unsprinklered living areas that requires the movement of corridor, room, partition, or structural walls or supports, in addition to the installation of a sprinkler system; or, has had its planned sprinkler installation so impaired by a disaster or emergency, as indicated by a declaration under section 319 of the Public Health Service Act, that CMS finds it would be impractical to meet the sprinkler installation due date.

§483.90(a)(6)(iii)(B) It demonstrates that it has made the necessary financial commitments to complete the building replacement or modification; or pursuant to a declared disaster or emergency, CMS finds it impractical to make reasonable and necessary financial commitments.

§483.90(a)(6)(iii)(C) Before applying for the deadline extension, it has submitted plans to State and local authorities that are necessary for approval of the replacement building or major modification that includes the required sprinkler installation, and has received approval of the plans from State and local authorities.

§483.90(a)(6)(iii)(D) It agrees to complete interim steps to improve fire safety, as determined by CMS.

§483.90(a)(6)(iv) An extension granted under paragraph (a)(8)(iii) of this section may be renewed once, for an additional period not to exceed 1 year, if the following conditions are met:

§483.90(a)(6)(iv)(A) CMS finds that extenuating circumstances beyond the control of the facility will prevent full compliance with the provisions in paragraph (a)(8)(i) of this section by the end of the first waiver period.

§483.90(a)(6)(iv)(B) All other conditions of paragraph (a)(8)(iii) of this section are met.

§483.90(a)(8) When a sprinkler system is shut down for more than 10 hours, the LTC facility must:

§483.90(a)(8)(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

§483.90(a)(8)(ii) Establish a fire watch until the system is back in service.

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GUIDANCE: §483.90(a)

For additional guidance on life safety from fire and the survey procedures for these regulatory requirements, reference Appendix I in the SOM. Concerns regarding the above regulatory provisions would be addressed through the Life Safety Code survey (K-Tags).

§483.90(b) Standard: Building safety.

Except as otherwise provided in this section, the LTC facility must meet the applicable provisions and must proceed in accordance with 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).

§483.90(b)(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a LTC facility.

§483.90(b)(2) If application of the Health Care Facilities Code required under paragraph (b) of this section would result in unreasonable hardship for the LTC facility, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of residents.

GUIDANCE: §483.90(b)

For additional guidance and procedures on building safety reference Appendix I in the SOM.

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F906 - Emergency Electrical Power System

Old Tag Number: F455

§483.90(c)(1) Emergency Electrical Power System

(c) Emergency Power. (1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

Guidance: §483.90(c)(1) and (c)(2)

*"**Emergency electrical power system**" includes, at a minimum, a generator or battery-operated power system for the lighting for all entrances and exits, fire detection and alarm systems, and extinguishing systems. Life support systems are required to be powered by an emergency generator that is located on the premises, see 483.90(c)(2).*

*An "**exit**" is defined as a means of egress which is lighted and has three components: an exit access (corridor leading to the exit), an exit (a door), and an exit discharge (door to the street or public way). We define an entrance as any door through which people enter the facility. Furthermore, when an entrance also serves as an exit, its components (exit access, exit, and exit discharge) must be lighted. A waiver of lighting required for both exits and entrances is not permitted.*

*"**Life support systems**" is defined as one or more items of electrically powered equipment whose operation is necessary to maintain a patient or resident's life. For example, ventilators, suction machines if necessary to maintain an open airway, etc.. The determination of whether a piece of equipment is life support is a **medical determination** dependent upon the condition of the individual residents of the facility e.g. suction machine maybe required "life support equipment" in a facility, depending on the needs of its residents.*

***"Essential Electrical System"** is defined as a system of alternate sources of power and all commercial distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a health care facility during disruption of normal power sources, and also to minimize disruption within the internal wiring system.*

Procedures: §483.90(c)(1) and (c)(2)

Review results of inspections by the designated State fire safety authority that the emergency power system has been tested periodically and is functioning in accordance with the Life Safety Code, NFPA 99 and NFPA 110.

Check placement of lighting system to ensure proper coverage of the listed areas. Review records of monthly and annual tests to ensure that emergency lighting system for, at least, lighting all entrances and exits is operational.

If life support systems are used determine if there is a working emergency generator at the facility. A generator is not required if a facility does not use life support systems. Check that the emergency generator starts and transfers power under load conditions within 10 seconds after interruption of normal power. Where residents are on life support equipment, ***do not test*** *transfer switches by shutting off the power unless there is an uninterruptible power supply available.*

A type I Essential Electrical System is required to be installed if the facility uses life support systems and residents are on life support equipment such as a ventilator to assist in breathing.
Probes: §483.90(c)(1) and (c)(2)
Is emergency electrical service adequate?

Additional guidance is available in the National Fire Protection Association's Life Safety Code NFPA 101 and NFPA 99, Health Care Facilities Code, sections 18.5.1.2, 18.5.1.3 and 18.2.9.2 and 18.2.20.5 which are surveyed in Tags K292 and K915 of the Life Safety code survey.

Is there a working generator if the facility is using life support systems and is it maintained in accordance with the manufacturer's recommendations and NFPA 99 and NFPA 110?

Does the facility have a type I electrical system installed throughout the facility or at least to building areas where required in accordance with NFPA 72 and NFPA 99?

If applicable, is the generator and emergency electrical system tested and maintained in accordance with NFPA 99 and NFPA 110 and are records of such maintained?

Effective November 28, 2017

F908 - Essential Equipment/Safe Operating Condition

Old Tag Number: F456

§483.*90*(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.

PROCEDURES/PROBES: §483.*90*(d)(2)

How does the facility assure all mechanical, electrical and patient care equipment is maintained in safe operating condition?

Is essential equipment (e.g., boiler room equipment, nursing unit/medication room refrigerators, kitchen refrigerator/freezer and laundry equipment) in safe operating condition?

Inspect the bed control panel covering for signs of damage where liquids could leak in.

Inspect the bed's power cord, cord plug and wall plug in for damage if electrically powered bed.

Is equipment maintained according to manufacturer's recommendations?

Effective November 28, 2017

F915 - Resident Room Window

Old Tag Numbers: F454; F461

§483.*90*(a)(7) *Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.*

§483.*90*(e)(1)(vi) - Resident Rooms
Bedrooms must --

§483.*90*(e)(1)(vi) - Have at least one window to the outside; and

GUIDANCE: §483.*90*(a)(7) and §483.*90*(e)(1)(vi)

Every resident/patient sleeping room shall have an outside window. A facility with resident room windows, as defined by K381, or that open to an outside atrium such as a courtyard in accordance with Life Safety Code, can meet this requirement for a window to the outside. Windows facing an interior atrium, skylights, etc., do not meet this requirement.

In addition to conforming to the Life Safety Code, this requirement was included to assist the resident's orientation to day and night, weather, and general awareness of space outside the facility. The facility is required to provide for a "safe, clean, comfortable and homelike environment" by deemphasizing the institutional character of the setting, to the extent possible. Windows are an important aspect in assuring the homelike environment of a facility.

In buildings constructed after July 5, 2016 or for facilities certified after July 5, 2016, the maximum allowable sill height is 36 inches above the floor. The window may be operable.

PROBES: §483.*90*(a)(7) and §483.*90*(e)(1)(vi)

Is there at least one window to the outside?

If the building was constructed or certified as a provider after July 5, 2016, confirm the outside window sill is 36 inches or less above the floor.

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F947 - Required In-Service Training for Nurse Aides

Old Tag Number: F498

§483.95(g) Required in-service training for nurse aides.

***I*n-service training must—**

***§483.95(g)(1)* Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.**

***§483.95(g)(2)* Include dementia management training and resident abuse prevention training.**

***§483.95(g)(3)* Address areas of weakness as determined in nurse aides' performance reviews *and facility assessment at § 483.70(e*) and may address the special needs of residents as determined by the facility staff.**

[§483.95(g)(3) was implemented on November 28, 2016 (Phase 1) with the exception of facility assessment which was implemented on November 28, 2017 (Phase 2).]

***§483.95(g)(4)* For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.**

DEFINITION §483.95(g)

A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.

Private duty nurse aides who are not employed or utilized by the facility on a contract, per diem, leased, or other basis, do not come under the nurse aide training provision.

GUIDANCE *§483.95(g)*

All facilities must develop, implement and permanently maintain an in-service training program for nurse aides that is appropriate and effective, as determined by nurse aide evaluation or the facility assessment as specified at §483.70(e). Changes to the facility's resident population, the facility's physical environment, staff turnover, and modifications to the facility assessment may necessitate ongoing revisions to the facility's training program.

There are a variety of methods that could be used to provide training. For example, nurse aide training may be facilitated through any combination of in-person instruction, webinars and/or supervised practical training hours.

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Supervised practical training means training in a setting in which instruction and oversight are provided by a person who has relevant education and/or experience specific to the subject of the training being provided.

All training should support current scope and standards of practice through curricula which detail learning objectives, performance standards and evaluation criteria, and addresses potential risks to residents, staff and volunteers if procedures are not followed. There should be a process in place to track nurse aide participation in the required trainings.

The adequacy of the in-service education program may be measured not only by documentation of hours of completed in-service education, but also by demonstrated competencies of nurse aide staff through written exam and/or in consistently applying the interventions necessary to meet residents' needs as identified in the facility assessment. Observations of nurse aides that indicate deficiencies in their nurse aide skills may be the result of an inadequate training program and/or inadequate performance review.

A minimum of 12 hours of nurse aide training per year is required under §483.95(g)(1). The training must be sufficient to ensure the continuing competence of the nurse aides, which may require more than 12 hours of training per year to meet identified staff or resident needs.

The survey team does not need to find a negative outcome to cite a deficiency at F947.

PROCEDURES AND PROBES §483.95(g)

If there have been deficient care practices identified during the survey, review as appropriate training received by nurse aides in that corresponding subject area. For example, if a deficiency is being cited related to infection control, review the infection control portion of the facility's in-service nurse aide training program.

- *Were nurse aides observed working with residents in a manner that indicates a training need?*
- *Did interviews with residents and/or resident representatives indicate any areas where training was needed?*
- *What type of training do the nurse aides report receiving about the concern identified by the surveyor?*
- *Verify the mandatory nurse aide in-service program* is no less than 12 hours per year. Calculate the date by which a nurse aide must receive annual in-service education by the employment date rather than the calendar year.
- *Review facility training records which supports mandatory nurse aide attendance.*
- How has in-service education addressed any areas of weakness identified in performance reviews, and any special resident needs, or needs of residents with cognitive impairments?
- *How does the facility evaluate nurse aide performance to determine what topics must be included in in-service training to address areas of weakness?*
- *How does the facility determine when training content must be updated (e.g., in order to remain consistent with current professional standards and guidelines)?*

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- *What process does the facility have to encourage nurse aides to express concerns and request training in challenging situations? How does the facility respond to nurse aide's concerns and requests?*
- *Does the facility's training address nurse aide training needs to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being as determined by resident assessments and individual plans of care?*
- *How does the facility assess nurse aides to determine if the training has been effective?*

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

For concerns related to nurse aides not demonstrating competent care of a resident that is independent of or related to the training program, see 42 CFR §483.35(c) Proficiency of Nurse Aides tag F726 for guidance.

K211

Means of Egress - General

Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.

18.2.1, 19.2.1, 7.1.10.1

K353

Sprinkler System - Maintenance and Testing

Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

a) Date sprinkler system last checked. _____

b) Who provided system test. _____

c) Water system supply source. _____

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.

9.7.5, 9.7.7, 9.7.8, and NFPA 25

K355

Portable Fire Extinguishers

Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.*

18.3.5.12, 19.3.5.12, NFPA 10

K531

Elevators

2012 EXISTING

Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record.

Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)

19.5.3, 9.4.2, 9.4.3

2012 NEW

Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)

18.5.3, 9.4.2, 9.4.3

K381

Sleeping Room Outside Windows and Doors

Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor.

- 42 CFR 403, 418, 460, 482, 483, and 485

K918

Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

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F811 - Feeding Assistant Training/Supervision/Resident

Old Tag Number: F373

§483.*60*(h) Paid feeding assistants-

§483.*60*(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if—

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and

(ii) The use of feeding assistants is consistent with State law.

§483.*60*(h)(2) Supervision.

(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

(ii) In an emergency, a feeding assistant must call a supervisory nurse for help.

§483.*60*(h)(3) Resident selection criteria.

(i) A facility must ensure that a feeding assistant *provides dining assistance* only *for* residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the *interdisciplinary team's* assessment and the resident's latest assessment and plan of care. *Appropriateness for this program should be reflected in the comprehensive care plan.*

NOTE: Paid feeding assistants must complete a training program with the following minimum content as specified at §483.160.

a. Minimum training course contents. A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
   (1) Feeding techniques;
   (2) Assistance with feeding and hydration;
   (3) Communication and interpersonal skills;
   (4) Appropriate responses to resident behavior;
   (5) Safety and emergency procedures, including the Heimlich maneuver;
   (6) Infection control;
   (7) Resident rights; and
   (8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

b. Maintenance of records. A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

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INTENT §483.*60*(h)(1)-(3)

To ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. The use of paid feeding assistants is intended to supplement certified nurse aides, not substitute for nurse aides or licensed nursing staff.

DEFINITIONS §483.*60*(h)(1)-(3)

"Paid feeding assistant" is defined in the regulation at 42 CFR §488.301 as "an individual who meets the requirements specified at 42 CFR §483.*60*(h)(1)(i) and who is paid *by the facility* to feed residents, or who is used under an arrangement with another agency or organization."

NOTE: The regulation uses the term "paid feeding assistant." While we are not using any other term, facilities and States may use whatever term they prefer, such as dining assistant, meal assistant, resident assistant, nutritional aide, etc. in order to convey more respect for the resident. Facilities may identify this position with other titles; however, the facility must be able to identify those employees who meet the requirements under the paid feeding assistant regulation. *While the facility is still responsible for ensuring the safety and care of all residents, this regulation does not apply to family members or to volunteers.*

GUIDANCE **§483.*60*(h)(1)-(3)**

NOTE: The regulation *requires* that paid feeding assistant*s* must work under the supervision of an RN or LPN, and they must call the supervisory nurse in case of an emergency. Therefore, a facility that has received a waiver and does not have either an RN or LPN available in the building cannot use paid feeding assistants during those times.

Interdisciplinary Team Assessment of Resident Eligibility for Feeding Assistance

When determining whether a resident may be assisted by a paid feeding assistant facility *staff* must base resident selection on the interdisciplinary team's current assessment of the resident's condition and the resident's latest comprehensive assessment and plan of care. *Appropriateness should be reflected in the resident's comprehensive care plan.*

Paid feeding assistants are *only* permitted to assist residents who have no complicated eating or drinking problems as determined by their comprehensive assessment. *Examples of residents that a paid feeding assistant may assist* include residents who are *in*dependent in eating and/or those who have some degree of *minimal* dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems.

Paid feeding assistants are not permitted to assist residents who have complicated eating problems, such as (but not limited to) difficulty swallowing, recurrent lung aspirations, or who receive nutrition through parenteral or enteral means. Nurses or nurse aides must continue to assist residents who require the assistance of staff with more specialized training *to eat or drink*.

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*P*aid feeding assistants may assist eligible residents to eat and drink at meal times, snack times, or during activities or social events as needed, whenever the facility can provide the necessary supervision.

Supervision of Paid Feeding Assistants - Paid feeding assistant*s* must work under the supervision of an RN or LPN. While we are not prescribing the exact means by which facility RNs and LPNs assert their supervisory responsibilities, we expect that facilities will do so in a way that avoids negative outcomes for their residents. If a facility chooses to use paid feeding assistants, it is the facility's responsibility to ensure that adequate supervisory nursing staff are available to supervise these assistants.

Adequate supervision by a supervising nurse does not necessarily mean constant visual contact or being physically present during the meal/snack time, especially if a feeding assistant is assisting a resident to eat in his or her room. However, in the event that an emergency should occur, the feeding assistant must be aware of and know how to access the supervisory nurse immediately *and the nurse must be located close enough to the resident that he or she can promptly respond.* Should an emergency arise, a paid feeding assistant must immediately call a supervisory nurse for help.

*S*upervisory nurse*s* should monitor the provision of the assistance provided by paid feeding assistants to evaluate on an ongoing basis:

- Their use of appropriate feeding techniques;
- Whether they are assisting assigned residents according to their *care planned* eating and drinking needs;
- Whether they are providing assistance in recognition of the rights and dignity of the resident; and
- Whether they are adhering to safety and infection control practices.

Use of Existing Staff as Paid Feeding Assistants - Facilities may use existing staff*, i.e., licensed nurses, certified nursing assistants,* to assist residents *in feeding*. *However, other employees for example, administrative, clerical, housekeeping, dietary staff, or activity specialists, etc.* must have successfully completed a State-approved training course for paid feeding assistants, as required in §483.160.

Maintenance of Training Records - The facility must maintain a record of all employees used as paid feeding assistants. The record should include verification that they have successfully completed a State-approved training course as required in §483.160.

INVESTIGATIVE PROTOCOL - Use of Paid Feeding Assistants

Objectives - To determine *if*:

- Individuals used as paid feeding assistants successfully completed a State-approved training course;
- Sampled residents who were selected to receive assistance from paid feeding assistants were assessed and determined to be eligible to receive these services based on the latest assessment and plan of care;

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- Paid feeding assistants are supervised by an RN or LPN; *and,*
- *Paid feeding assistants know how to obtain assistance in emergencies.*

Use - When through observation, *record review, or* interview*(s)* with residents, family, or staff, a surveyor identifies concerns *that the facility may not be following the requirements regarding paid feeding assistants, including proper training and supervision, and proper assessment and selection of residents for feeding assistance.*

Procedures - *R*eview the *resident's* comprehensive assessment and interdisciplinary care plan to guide observations *and interviews*.

Observations - If *a* concern was discovered through resident or family interview*(s)*, observe the resident while he *or she is* being assisted to eat and drink by a paid feeding assistant. Determine if the assistant is using proper feeding technique and is providing the type of assistance specified in the resident's care plan. Note the resident's condition and observe for the presence of complicated feeding problems *that may require the assistance of a nurse aide or licensed nursing staff*. *The use of paid feeding assistants is intended to supplement, not substitute for, nursing staff. Also during observation note whether:*

- A paid feeding assistant was observed assisting a resident in a location without a call system available or other means of emergency notification;
- A resident who was assessed as ineligible for services due to complicated eating/drinking problems, or a resident who has not been assessed for eligibility, is being assisted by a paid feeding assistant; *and,*
- RN or LPN staff members assigned to supervise paid feeding assistants were observed to be unavailable (*for example,* not *available in case of emergency*).

If the concern was discovered through observations that were already made, only conduct additional observations if necessary to complete the investigation.

Resident and Family Interviews - If a resident is selected for this protocol through surveyor observation that he *or she is* having difficulties in eating or drinking and he *or she is* being assisted by a paid feeding assistant, interview the resident if the resident is interviewable. Ask questions to gain information about why the resident is receiving these services and the resident's experience with receiving assistance to eat and drink. If concerns are identified, inquire if the *resident has* reported these problems to a nurse. If the resident is not interviewable, ask these questions of a family member or the resident's representative.

If the concern was discovered through resident, resident representative or family interviews already conducted, focus any additional interview on questions specific to *complete* the investigation.

Paid Feeding Assistant Interviews - Interview paid feeding assistant*s* assisting the selected resident. Determine whether there are concerns with *their* training, supervision, or the selection of the resident such as:

- What training did you successfully complete in providing feeding assistance?
- What information did you receive about this resident's needs for assistance (type of assistance needed, any precautions)?

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- In what manner and by whom are you supervised while assisting residents?
- What issues/problems do you report (such as coughing, choking, changes in the resident's usual responses, or level of alertness) and to whom do you report?
- What would you do if an emergency occurred while you were assisting a resident to eat or drink? Who would you contact and how would you contact them?

Interdisciplinary Team **Interview -** Interview the nurse or other *member(s) of the interdisciplinary team* responsible for assessing *if the* resident *i*s eligible *and appropriate* to receive assistance by a paid feeding assistant. Ask:

- How they determined that this resident has no complicated feeding problems and is eligible to be assisted by a paid feeding assistant*?*
- *If a resident is appropriate to receive assistance from a paid feeding assistant, how is this resident's needs reflected in his or her comprehensive care plan?*
- How they determine that each eligible resident remains free of emergent complicated feeding problems*?*
- Who supervises paid feeding assistants and how is the supervision accomplished*?*
- Describe the processes in place to handle emergencies when a supervisor is not present in the area where paid feeding assistants are assisting residents.

Review of *Resident* Assessment of Eligibility to Receive Assistance from a Paid Feeding Assistant - Determine whether the resident's assessment regarding his or her ongoing eligibility to be assisted by a paid feeding assistant is based on identification of the current condition of the resident and any additional or new risk factors or condition changes that may impact on the resident's ability to eat or drink. This information may be contained in the RAI or in other supporting documents such as progress notes, etc. The assessment of eligibility to receive assistance from a paid feeding assistant is ongoing and should *be reflected in a resident's comprehensive care plan.*

Requirements for Training of Paid Feeding Assistants - Determine how the facility identifies that paid feeding assistants have successfully completed a State-approved training course that meets the requirements at 42 CFR §483.160 before they are allowed to assist eligible residents with eating and drinking. If the facility uses temporary (agency) staff as paid feeding assistants, request documentation that these staff have met the minimum training requirements at *42 CFR §483.160*. *Review facility's* records *for* all employees use*d* as paid feeding assistants *to verify their* completion of *a State approved* training course *(it is recommended the survey team coordinator assign one surveyor to obtain and verify these records).*

NOTE: *If the facility has not ensured any paid feeding assistant has completed a State-approved training course,* ***do not*** *cite here. Cite 42 CFR §483.95(h), F948, Required training of feeding assistants.*

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POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION §483.*60*(h)(1)-(3)

During the investigation of F811, the surveyor may have identified concerns with additional requirements related to outcome, process, and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present at these other tags. Examples of some of the related requirements that may be considered when non-compliance has been identified include, but are not limited to, the following:

- §483.*10*, F*550*, *Resident Rights*
  - Determine if staff are attentive and responsive to the resident's requests, and if they provide assistance to eat in a manner that respects the resident's dignity, meets needs in a timely manner, and minimizes potential feelings of embarrassment, humiliation, and/or isolation related to inability to assist themselves with food or fluid intake.
- *§483.10(c), F552 and F578, Planning and Implementing Care*
  - *Determine if the facility addressed the resident's right to choose or refuse treatment, including receiving assistance to eat or drink by a paid feeding assistant.*
- §483.20(b), F*636*, Comprehensive Assessments
  - Review whether facility staff initially and periodically conducted a comprehensive, accurate assessment of the resident's ability to eat and drink with or without assistance and/or identified a condition that makes the resident ineligible for this service.
- §483.*21(b)(1)*, F*656*, Comprehensive Care Plans
  - Review whether facility staff developed *or implemented* a comprehensive care plan that was based on the assessment of the resident's conditions, needs, and behaviors, and was consistent with the resident's goals in order to provide assistance with nutrition and hydration as necessary.
- §483.*21(b)*(2)(iii), F*657,* Comprehensive Care Plan Revision
  - Determine if the care plan was reviewed and revised periodically, as necessary, related to eligibility to eat and drink with assistance of a paid feeding assistant.
- §§483.25*(g)(1)-(3),* F*692*, *Nutrition/Hydration Status*
  - Review if facility staff had identified, evaluated, and responded to a change in nutritional parameters, anorexia, or unplanned weight loss, dysphagia, and/or swallowing disorders in relation to the resident's ability to eat.
  - Review if facility staff had identified, evaluated, and responded to a change in the resident's ability to swallow liquids.
- §483.25 (b)*(4)*, F*676*, ADL Assistance for Dependent Residents
  - Determine if staff identified and implemented appropriate measures to provide food and fluids for the resident who cannot perform relevant activities of daily living.
- §483.*35*(a), F*725*, Sufficient Staff
  - Determine if the facility has qualified staff in sufficient numbers to provide assistance to eat or drink to those residents who require such assistance. For residents who are not eligible to receive assistance from paid feeding assistants, determine if there are sufficient *staff* to provide this assistance to these residents in a timely fashion.
- §483.*70(h),* F*841*, Medical Director
  - Determine whether the medical director collaborates with the facility to help develop, implement, and evaluate resident care policies and procedures based on current

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standards of practice, e.g., the use of paid feeding assistants, their supervision, and the criteria for determining which residents are eligible to receive assistance to eat or drink from paid feeding assistants.

- *§483.95(h), F948, Required training of feeding assistants.*
  - *Determine if the facility has ensured the paid feeding assistant(s) has completed a State-approved training course prior to employment.*

KEY ELEMENTS OF NONCOMPLIANCE:

To cite F811, the surveyor's investigation will generally show the facility failed to do any one or more of the following:

- *Prohibit* an employee who did not complete a State-approved training to assist a resident to eat or drink; ***or***
- *Ensure all paid feeding assistants (permanent or temporary) are used consistent with State law;* ***or***
- Maintain documentation of a paid feeding assistant's successful completion of a State-approved paid feeding training course; ***or***
- *Ensure paid feeding assistants were* supervised *by a licensed nurse*; ***or***
- *Ensure a paid feeding assistant called a supervisory nurse in an emergency*; ***or***
- *Ensure paid feeding assistants are a*ssisting only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant; ***or***
- *Ensure the interdisciplinary team assessed the resident's appropriateness for paid feeding assistance and this need is reflected in the comprehensive care plan.*

DEFICIENCY CATEGORIZATION

- ***An example of Level 4, immediate jeopardy to resident health and safety, includes, but is not limited to:***
  - A resident is being assisted to eat by a paid feeding assistant *and begins to* experiencing choking. *The assistant was not trained to provide abdominal thrusts or the Heimlich maneuver and* the supervising nurse *or other qualified staff* were not available to assist.

- ***An example of Level 3, Actual harm (physical or psychological) that is not immediate jeopardy, includes, but is not limited to:***
  - A resident who *did not have a complicated feeding problem and who* was assessed to have the potential to improving *his or her* eating ability was assisted to eat by a paid feeding assistant. The assistant provided too much food too quickly and the resident was pocketing the food in *their* cheeks. The *assistant did not notice this was happening and as a result the* resident experienced coughing and subsequently vomited.

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- ***Examples of Level.2 - No actual harm with a potential for more than minimal harm (physical or psychological) that is not immediate jeopardy, includes but are not limited to:***
  - Residents are being assisted to eat by individuals who have not successfully completed a State-approved paid feeding assistant training course and who otherwise by State law would not be allowed to feed residents (note that RNs, LPNs or CNAs **are** permitted to feed residents), and there were no resident negative outcomes.
  - Paid feeding assistants are assisting eligible residents; however supervising nurses are not nearby *or immediately available to promptly respond to an emergency*, but there have been no negative resident outcomes.

Level 1 - Severity 1 does not apply for this regulatory requirement.

§ 483.160 Requirements for training of paid feeding assistants.

(a) Minimum training course contents. A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:

(1) Feeding techniques.

(2) Assistance with feeding and hydration.

(3) Communication and interpersonal skills.

(4) Appropriate responses to resident behavior.

(5) Safety and emergency procedures, including the Heimlich maneuver.

(6) Infection control.

(7) Resident rights.

(8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

(b) Maintenance of records. A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

[68 FR 55539, Sept. 26, 2003]