# F725

*(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)*

**§483.35 Nursing Services**

**The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).**

**§483.35(a) Sufficient Staff.**

**§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:**

**(i) Except when waived under paragraph (e) of this section, licensed nurses; and**

**(ii) Other nursing personnel, including but not limited to nurse aides.**

**§483.35(a)(2) Except when waived under paragraph [(e)] of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.**

**INTENT §483.35(a)(1)-(2)**

To assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.

**DEFINITIONS §483.35(a)(1)-(2)**

**"Nurse Aide,"** as defined in §483.5, 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.

**GUIDANCE §483.35(a)(1)-(2)**

**NOTE:** Cite this Tag only if there are deficiencies related to the **sufficiency** of nursing staff.

If the survey investigation reveals that there are not sufficient staff in areas other than Nursing Services, refer to:

- F741, §483.40(a) for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder;
- F801, §483.60(a) for Food and Nutrition staff;
- F826, §483.65(b) *for* Specialized rehabilitative services; *and*
- F839, §483.70(f) *for* Administration for any other staff not referenced above.

**NOTE:** The actual or potential physical, mental, or psychosocial resident outcomes related to noncompliance cited at F725 should be investigated at the relevant tags, such as Abuse *at §483.12*, Quality of Life *at §483.24*, and/or Quality of Care *at §483.25.*

Many factors must be considered when determining whether or not a facility has sufficient nursing staff to care for residents' needs, as identified through the facility assessment, resident assessments, and as described in their plan of care. A staffing deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the **potential** for physical or psychosocial harm.

As required under Administration at F838, §483.70(e) an assessment of the resident population is the foundation of the facility assessment and determination of the level of sufficient staff needed. It must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population's, acuity (the level of severity of residents' illnesses, physical, mental and cognitive limitations and conditions) and any other pertinent information about the residents that may affect the services the facility must provide. The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served.

**PROCEDURE: §483.35(a)(1)-(2)**
Although federal regulations do not define minimum nursing staff ratios, many States do. If a facility does not meet State regulations for staffing, do NOT cite that as a deficiency here, *but* refer to Administration, F836, §483.70(b). In addition, *even* if a facility meets the State's staffing regulations that is not, by itself, sufficient to demonstrate that the facility has sufficient staff to care for its residents. *Compliance with State staffing standards is not necessarily determinative of compliance with Federal staffing standards that require a sufficient number of staff to meet all of the residents' basic and individualized care needs. A facility may meet a state's minimum staffing ratio requirement, and still need more staff to meet the needs of its residents. Additionally, the facility is required to provide licensed nursing staff 24 hours a day, 7 days a week.*

Surveyors must determine through information obtained by observations, interviews and verified by record reviews, whether the facility employed sufficient staff to provide care and services in assisting residents to attain or maintain their highest practicable level of physical, mental, and psycho-social well-being. *The facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system (Refer to F851, §483.70(q)). This data can be obtained through the Certification and Survey Provider Enhanced Reports (CASPER) reporting system. This PBJ Staffing Data Report contains information about overall direct care staffing levels, including nurse staffing. Surveyors will utilize the P B J Staffing Data Report available through CASPER reporting system to identify concerns with staffing. The Long Term Care Survey Process (LTCSP) software application will alert the surveyors of specific dates that require further investigation related to staffing. Surveyors are expected to verify infraction dates indicated on the PBJ staffing data report. If concerns were identified on this report, as well as from other*

*sources, refer to the critical element pathway of Sufficient and Competent Staffing, and the probes noted below.*

***PROBES*:**

- When interviewing staff, residents and others, are concerns raised with the amount of time staff are available to provide care and services, such that there is not sufficient time allowed to provide the necessary care and services to a resident? If so, verify these concerns through observations and record review if necessary.

- Does the facility assessment describe the type and level of staff required to meet each resident's needs as *assessed* under §483.70(e). Does the type and level of the staff onsite reflect the expectations described in the facility assessment?

- Does the workload or assignments of the nursing staff allow them time to participate in team meetings, care planning meetings, attend training, spend time caring for residents and take time for breaks including meal breaks?

- *Are the numbers of licensed staff sufficient such that those staff members have enough time to provide direct services to residents as well as to assist and monitor all of the aides they are responsible for supervising?*

- Do residents and families report that nursing staff are responsive to residents' request for assistance, such as call bells typically answered promptly? Do they feel that they can have a conversation with a direct caregiver and not feel rushed?

- Are there any indications of delays in responsiveness for staff such as pungent odors, residents calling out, or residents wandering with inadequate supervision?

- Are there any indications of *inappropriate* use of devices or practices to manage residents' behaviors or activities *that may suggest facility staff are using these devices or practices to compensate for lack of sufficient staff? Examples include high numbers and/or inappropriate* use of position-change alarms, positioning residents in chairs that limit their movement, or residents who are subdued or sedated?

- Are residents who are unable to use call bells or otherwise communicate their needs checked frequently (e.g., each half hour) for safety, comfort, bathroom needs positioning, and offered fluids and other provisions of care? Have care problems associated with a specific unit, day or tour of duty been identified by the facility? For example, does documentation show that skin integrity issues are identified more on days following a long weekend? *Does the facility have adequate staff to monitor residents at risk for wandering?*

- Has the use of overtime hours increased? (If overtime hours have increased substantially, it can indicate that there is not sufficient staff or a back-up plan when staff call-out).
- When there are staff call-outs, did the facility fill those positions in a timely manner? *Does the facility have licensed nursing staff 24 hours a day?*

- *If the surveyor is made aware of the absences of licensed nursing staff in a 24 hour period:*

  - *Interview direct care staff;*
    - *Are you ever made aware of the absence of licensed nursing staff during your shift?*
    - *When was the last time that licensed staff was not available during your shift?*
    - *How often does this occur?*
    - *How does this impact residents in the facility?*
    - *Are you aware of any residents that missed medications or treatments due to no available licensed nurse?*
    - *Who do you notify in the event of an emergency and there is no licensed nurses available?*
  - *Interview the Director of Nursing or Administrator;*
    - *When was the last time that licensed nursing staff were not available on a shift?*
    - *How often does the facility not have licensed nursing staff at all times?*
    - *What is the facility's policy when there is not a licensed nurse available in a 24 hour period?*
    - *How does the facility provide care to residents that require a licensed nurse if one is not available to work?*
    - *How does this impact residents in the facility?*

Concerns such as falls, weight loss, dehydration, pressure ulcers, as well as the incidence of elopement and resident altercations can also offer insight into the sufficiency of the numbers of staff. Surveyors must investigate if these adverse outcomes are related to sufficient staffing.

**KEY ELEMENTS OF NONCOMPLIANCE**

To cite deficient practice at F725, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's *basic* needs *and individual needs as required by the resident's diagnoses, medical condition, or plan of care;* **or**
- Ensure licensed nurse coverage 24 hours a day, except when waived; **or**

- Ensure a licensed nurse is designated to serve as a charge nurse on each tour of duty, except when waived.

## DEFICIENCY CATEGORIZATION

Once the survey team has completed its investigation, analyzed the data, reviewed the regulatory requirements, and determined that noncompliance exists, the team must determine the severity of each deficiency, based on the harm or potential for harm to the resident.

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

- A resident with a Stage 4 pressure injury, did not receive skin assessments and treatments for two weeks due to the absence of the only trained wound nurse on the resident's scheduled skin assessment days. No accommodations were made for coverage in the absence of this wound nurse and no other nursing staff were trained to provide this care. The pressure injury became infected during this timeframe and resulted in the resident being hospitalized requiring IV antibiotics for sepsis. Failure to provide sufficient staff with the necessary skill set to provide skin assessments and treatments *created the likelihood for* serious injury*, harm, impairment or death for* the resident.

- *A resident had complained of chest pain and shortness of breath after eating their evening meal. The nursing assistant stated they would inform the licensed nurse. The nursing assistant was informed there would be no licensed nurse available onsite. At 10:00 p.m. the resident was found unresponsive with minimal respirations. Because there was no licensed nurse on duty at that time, the nursing assistant called 911 and the resident was sent to the emergency room.*

- *The survey team was made aware the facility had 4 days in the previous quarter of PBJ submission when there were no licensed nurses in the facility for all 24 hours of each day. After a thorough investigation, the team determined the absences of a licensed nurse in the facility created the likelihood for serious injury, harm, impairment or death for all residents.*

**Examples of Level 3, actual harm (physical or psychosocial) that is not immediate jeopardy includes, but are not limited to:**

- A resident's room has a strong smell of urine. Upon further investigation, the surveyor discovers the resident is incontinent and has soiled undergarments. Upon interview, the resident stated he called for help about an hour ago and was told by staff that they were short-staffed today and would get to him as soon as they could. He also mentioned that this happens almost every day and he is embarrassed to ask staff for help to clean himself up, so he remains withdrawn in

his room until a staff member can assist him. Refer to the Psychosocial Outcome Guide for additional direction.

- *A resident was admitted to the facility with a recently repaired hip fracture and required assistance with ambulation. The resident used the calling device to request assistance to the bathroom. After several minutes no help arrived so the resident attempted to ambulate with a walker to the bathroom without assistance. The resident subsequently fell and was found by nursing assistants. The resident was assisted back to bed by the nursing assistants and complained of pain in the area of the recently repaired hip fracture. There was no licensed nurse on duty to assess the resident for any injuries or provide medication for pain. The next morning the resident complained of increased pain in the area of the repaired hip fracture. After assessment by the day shift licensed nurse the resident was sent to the hospital. The resident was admitted and required surgery to repair the re-fractured hip.*

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

A resident's family complained that their loved one's personal hygiene was never completed in a timely manner due to lack of staff. When interviewed, staff stated that they typically assist this resident once the care is completed for all other residents in their assignment since it takes longer to provide care for him. This resulted in the resident occasionally missing occupational therapy. There has been no *recent documented* decline in ADL function but there is a potential for decline.

- Residents complain that they are not allowed choices such as receiving showers consistently on the days or at times they prefer due to inadequate staffing. *Review of staffing data submitted via the PBJ system revealed the facility had a one-star staffing quality rating. Follow up interviews with the staffing coordinator revealed that only one CNA was available to provide showers, and therefore residents' preferences for timing of showering could not be met cause anxiety.* Refer to the Psychosocial Outcome Guide for additional direction.

***Severity Level 1: No Actual Harm with Potential for Minimal Harm***
*The failure of the facility to provide sufficient staffing including licensed nurses creates a risk that is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement*

## F726
**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§483.35 Nursing Services**
**The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-**

**being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).**

**§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.**

**§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.**

**§483.35(c) Proficiency of nurse aides.**
**The facility must 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.**

**INTENT §483.35(a)(3)-(4),(c)**
To assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.

**DEFINITIONS §483.35**
**"Competency"** is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

**GUIDANCE §483.35(a)(3)-(4),(c)**
Cite this Tag only if there are deficiencies related to the **competency** of nursing staff.

If the survey investigation reveals that there are concerns with the competency of staff in areas other than Nursing Services refer to;

- F741, §483.40(a) for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder;
- F801, §483.60(a) for Food and Nutrition staff;
- F826, §483.65(b), Specialized rehabilitative services;
- F839, §483.70(f), Administration for any other staff not referenced above.

**NOTE:** The actual or potential physical, mental, or psychosocial resident outcomes related to noncompliance cited at F726, should be investigated at the relevant tags, such as Abuse, Quality of Life, and/or Quality of Care.

All nursing staff must also meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations.

Many factors must be considered when determining whether or not facility staff have the specific competencies and skill sets necessary to care for residents' needs, as identified

through the facility assessment, resident-specific assessments, and described in their plan of care. A staff competency deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the **potential** for physical and psychosocial harm.

As required under F838, §483.70(e), the facility's assessment must address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. Additionally, staff are expected to demonstrate competency with the activities listed in the training requirements per §483.95, such as preventing and reporting abuse, neglect, and exploitation, dementia management, and infection control. Also, nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program, per §483.152.

Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as;

- Resident Rights;
- Person centered care;
- Communication;
- Basic nursing skills;
- Basic restorative services;
- Skin and wound care;
- Medication management;
- Pain management;
- Infection control;
- Identification of changes in condition;
- Cultural competency.

**Staff Competencies in Identifying Changes in Condition**

A key component of competency is a nurse's (CNA, LPN, RN) ability to identify and address a resident's change in condition. Facility staff should be aware of each resident's current health status and regular activity, and be able to promptly identify changes that may indicate a change in health status. Once identified, staff should demonstrate effective actions to address a change in condition, which may vary depending on the staff who is involved. For example, a CNA who identifies a change in condition may document the change on a short form and report it to the RN manager. Whereas an RN who is informed of a change in condition may conduct an in-depth assessment, and then call the attending practitioner.

These competencies are critical in order to identify potential issues early, so interventions can be applied to prevent a condition from worsening or becoming acute. Without these competencies, residents may experience a decline in health status, function, or need to be transferred to a hospital. Not all conditions, declines of health status, or hospitalizations are preventable. However, through the facility assessment (§483.70(e)), facilities are required to address the staff competencies that are necessary to provide the level and

types of care needed for the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. Furthermore, per §483.95, facilities must determine the amount and types of training based on the facility assessment. We also note that the curriculum of a nurse aide training program must include training on recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor (§483.152(b)(2)(iv)).Therefore, facility staff are expected to know how to identify residents' changes in conditions, and what to do once one is identified.

Facilities may adopt certain tools to aid staff with these competencies, as these tools have proven to be effective. For example, the Agency for Healthcare Research and Quality (AHRQ) has training modules for detecting and communicating resident changes in condition https://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule1.html. Also, Interventions to Reduce Acute Care Transfers (INTERACT) is a program with several resources aimed at improving staff competencies in this area https://interact2.net/tools_v4.html. Staff may inform surveyors of the tools they use to help show evidence of the required competencies. However, merely stating or referencing the tools is not enough on its own to verify compliance. Staff must also demonstrate that they possess the competency to use the tools in a manner that accomplishes their purpose, of aiding to effectively identify and address resident changes in condition.

**Cultural Competencies**

Cultural competencies help staff communicate effectively with residents and their families and help provide care that is appropriate to the culture and the individual. The term cultural competence (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. With regard to health care, cultural competence is a set of behaviors and attitudes held by clinicians that allows them to communicate effectively with individuals of various cultural backgrounds and to plan for and provide care that is appropriate to the culture and to the individual.

The following resources are intended for informational purposes only:

- The National Center for Cultural Competency https://nccc.georgetown.edu/index.html
- The National Standards for Culturally and Linguistically appropriate Services in Health and Health Care (developed by the Office of Minority Health in HHS) https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf

**NOTE:** References to non-CMS sources do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services and were current as of the date of this publication.

**Demonstration of Competency**

Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Examples for evaluating competencies may include but are not limited to:

- Lecture with return demonstration for physical activities;
- A pre- and post-test for documentation issues;
- Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;
- Reviewing adverse events that occurred as an indication of gaps in competency; or
- Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

Nursing leadership with input from the Medical Director should delineate the competencies required for all nursing staff to deliver, individualize, and provide safe care for the facility's residents. There should also be a process to evaluate staff skill levels, and to develop individualized competency-based training, that ensure resident safety and quality of care and service being delivered. A competency-based program might include the following elements:

a. Evaluates current staff training programming to ensure nursing competencies (e.g. skills fairs, training topics, return demonstration).
b. Identifies gaps in education that is contributing to poor outcomes (e.g. potentially preventable re-hospitalization) and recommends educational programing to address these gaps.
c. Outlines what education is needed based on the resident population (e.g. geriatric assessment, mental health needs) with delineation of licensed nursing staff verses non-licensed nursing and other staff member of the facility.
d. Delineates what specific training is needed based on the facility assessment (e.g. ventilator, IV's, trachs).
e. Details the tracking system or mechanism in place to ensure that the competency-based staffing model is assessing, planning, implementing, and evaluating effectiveness of training.
f. Ensures that competency-based training is not limited to online computer based but should also test for critical thinking skills as well as the ability to manage care in complex environments with multiple interruptions.

**PROCEDURES AND PROBES §483.35(a)(3)-(4),(c)**

For specific survey procedures see the Sufficient and Competent Staffing Critical Element Pathway.

Surveyors must determine through information obtained by observations, interviews and verified by record reviews, whether the facility employs competent nursing staff to provide care and services in assisting residents to attain or maintain their highest practicable level of physical, mental, functional and psychosocial well-being.

- How are staff competencies and skill sets evaluated upon their initial hire and routinely thereafter and when new technologies/equipment are put into use?
- Does the facility assessment describe the type of competencies required to meet each resident's needs as required under §483.70(e). Do the competencies of the staff reflect the expectations described in the facility assessment?
- Is there evidence that staff are able to identify and address resident changes in condition? What are the practices or tools used that demonstrate this ability? Is there evidence of a lack of competency, such as:
  - Adverse events that could have been prevented;
  - Conditions that occurred that could have been identified and addressed earlier to prevent them from worsening; or
  - Hospital transfers that could have been potentially avoided if the reason for the transfer had been identified and addressed earlier.
- How are staff evaluated to determine that they demonstrate knowledge of individual residents and how to support resident preferences?
- When observing the provision of care, does the nursing staff demonstrate:
  - Necessary competencies and skill sets in accordance with current standards of practice? For example, if the resident requires a manual lift for transferring, do staff demonstrate knowledge and skill in the proper use of the lift and perform the activity in a safe manner?
  - The use of techniques and skills that maintain or improve the resident's physical, mental or psychosocial functioning as identified through required assessments and the care plan such as, but not limited to, the following:
    1. Providing mobility assistance, such as assistance with walking and transferring.
    2. Assisting with Activities of Daily Living: eating, bathroom needs, bed mobility, bathing, oral care, incontinence care, dressing, etc.
    3. Providing care to residents with communication needs and ensuring that devices are utilized per the care plan.
    4. Demonstrating knowledge about residents' condition and behavior and when to report changes to the licensed or registered nurse.
- Determine how agency/contract staff have been evaluated to ensure their competencies and skills to care for the facility's resident population.

**POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION §483.35(a)(3)-(4),(c)**

If there are concerns with staff skills and competencies it may be necessary to review the facility's assessment as required at F838, §483.70(e) to determine how competencies are evaluated. Also, review the facility's process for assessing these competencies and skills and addressing staff performance for the effective application of knowledge and skill in the practice setting. It may also be necessary to review the Training requirements at §483.95.

**KEY ELEMENTS OF NONCOMPLIANCE**

To cite deficient practice at F726, the surveyor's investigation will generally show that the facility failed to do the following:

- Ensure the licensed nurses and other nursing personnel have the knowledge, competencies and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan.

**DEFICIENCY CATEGORIZATION**

Once the survey team has completed its investigation, analyzed the data, reviewed the regulatory requirements, and determined that noncompliance exists, the team must determine the severity of each deficiency, based on the harm or potential for harm to the resident.

**Examples of Level 4, immediate jeopardy to resident health and safety includes, but are not limited to:**

- A resident sustained a serious injury that required hospitalization and surgery resulting from a fall from a mechanical lift due to an unsafe transfer by one staff member. When interviewed, this staff member stated that she was not familiar with how to use the mechanical lift. The facility failed to ensure the staff was competent to operate the equipment.
- Staff did not demonstrate competency in maintaining the airway of a resident with a tracheostomy when it became obstructed by a mucous plug. Staff were unable to act immediately to the situation resulting in the resident experiencing a respiratory arrest. Staff did not have the necessary skills to adequately meet the needs of the resident resulting in a life-threatening situation for the resident.
- A new resident was recently admitted to the nursing home with a diagnosis of diabetes. Upon interview several staff stated that they were not familiar with using this new blood sugar monitor. As a result the resident's blood sugar levels were inaccurate and not reliable. The levels continued to fluctuate from very high to very low and in each case the amount of insulin administered to the resident was adjusted based on these results. As a result after 3 days the resident went into diabetic shock and was hospitalized.
- The facility failed to ensure that licensed nurses had the skills and knowledge to detect changes in a resident's condition. After the nurse's aide notified the nurse on duty that the resident has swelling in her feet, the nurse determined that the resident has 2+ pitting edema and documented the finding in the medical record. No further action was taken. The nurse did not review the medical record which identified the resident's history of congestive heart failure (CHF). The next day the resident's edema increased, the nurse notified the attending physician but did not inform the physician of the resident's history of CHF. The nurse did not conduct any further assessment of the resident, secure orders from the physician, or document a request for intervention from the physician. On day three the resident experienced respiratory distress and was admitted to the hospital with CHF exacerbation. The inability of the nursing staff to conduct a thorough assessment and to recognize the signs and symptoms of CHF resulted in heart failure and placed the resident at risk for serious harm or death.

**Examples of Level 3 actual harm that is not immediate jeopardy includes but are not limited to:**

- An increase in facility acquired Stage 2 pressure injuries was noted over the past two months for residents with darker pigmentation. When interviewed, several nursing staff, including the Director of Nursing, stated that in residents with darker pigmentation, staff cannot identify pressure injuries until the skin is no longer intact. The facility failed to provide staff with the necessary skill set to identify and prevent pressure injuries and meet the residents' needs.
- A resident who usually gets up at 6am and eats breakfast in the dining room every day has been getting up at 8am for the past few days. When interviewed he says he doesn't want to eat breakfast and just wants to sleep. Staff have been letting him continue to sleep throughout the day. When interviewed they said they think he is just tired and this went on for several days. The resident then began to decline to eat dinner and seems confused about his whereabouts. The nurse stated she thinks he is just tired and continues to let him sleep. In the morning, the resident is falling in and out of sleep, is incoherent and has a fever. The facility orders a hospital transfer where the resident is admitted with a high fever and a positive lab result for a Urinary Tract Infection.
- A 78 year old with a diagnosis of hypertension, Peripheral Vascular Disease, Diabetes and CVA (cerebrovascular accident) receives anticoagulant therapy. The resident developed a nose bleed. Since the resident is on anticoagulant therapy the MD was notified and an order for PT/INR was ordered and obtained. The INR was noted to be elevated requiring the resident to receive an injection of Vitamin K. When staff were interviewed CNA #1 stated that two days prior she had noted the resident's gums were bleeding during oral care and thought that maybe he just needed his teeth cleaned but she did mention it to the nurse. CNA #2 reports that the resident had a medium black tarry stool the night before but she became busy and forgot to report it to the Charge Nurse. The facility failed to provide staff with the necessary skill set to identify residents at risk for bleeding related to anticoagulant therapy so therefore the facility staff did not meet the needs of the resident.

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

- Resident did not have pacemaker check performed via telephone due to lack of knowledge by staff on procedure.

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

## F727

***(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)***

**§483.35(b) Registered nurse**

**§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.**

**§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.**

**§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.**

**DEFINITIONS §483.35(b)**
**"Full-time"** is defined as working *40* or more hours a week.

*"Charge Nurse" is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care.*

***PROCEDURE AND*** **GUIDANCE §483.35(b)**

*Nurse staffing in nursing homes has a substantial impact on the quality of care and outcomes that residents experience. A registered nurse (RN) is typically responsible for overseeing the care provided to nursing home residents by other staff such as Licensed Practical Nurses (LPN) or Certified Nurse Aides (CNA). The RN is generally responsible for more advanced care activities such as resident assessments, consulting with physicians, and administering intravenous fluids or medications.*

*Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week. However, per Facility Assessment requirements at F838, §483.70(e), facilities are expected to identify when they may require the services of an RN for more than 8 hours a day based on the acuity level of the resident population. If it is determined the services of an RN are required for more than 8 hours a day, refer to the guidance at F725 related to sufficient nurse staffing for further investigation.*

*Facilities may choose to have differing tours of duty (e.g. 8 hour- or 12-hour shifts) for their licensed nursing staff. Regardless of the approach, the facility is responsible for ensuring the 8 hours worked by the RN are consecutive within each 24-hour period.*

The facility must designate a registered nurse (RN) to serve as the DON on a full-time basis. The facility can only be waived from this requirement if it has *obtained* a waiver under subsections §483.35(e) or (f). *The facility may permit the DON to serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.*

*The facility is responsible for submitting staffing data through the PBJ (Refer to F851, §483.70(q)). This data is available through PBJ reports that can be obtained through the Certification and Survey Provider Enhanced Reports (CASPER) reporting system. These reports, titled PBJ Staffing Data Report will be utilized by surveyors and contains information about overall direct care staffing levels as well as licensed nurse staffing,*

*and if an RN was onsite for 8 hours a day, 7 days a week. If concerns were identified on this report, as well as from other sources, refer to the Critical Element pathway Sufficient and Competent Staffing, and the probes noted below.*

*Probes:*

- *Review the facility's posted daily staffing data.*
- *Does the facility have an RN on duty at least 8 consecutive hours a day, 7 days a week?*
- *Does the facility have an RN to serve as the DON on a full time basis?*
- *Does the facility ensure that the DON serves as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents?*
- *If there is no RN coverage for at least 8 consecutive hours each day, (e.g., as indicated by the PBJ Staffing Report), interview:*
  - *front line staff (i.e., nurse aides, LPNs/LVNs)*
    - *Is there an RN providing services to the residents for at least 8 consecutive hours in the day?*
    - *Are you ever made aware when there is no RN available in the facility?*
    - *Are you ever aware of a resident who needed care or services only performed by an RN (i.e., intravenous medications, assessment) and did not receive it?*
  - *Director of Nursing or Administrator;*
    - *How often are there days with no RN onsite?*
    - *What does the facility do when there is not an RN available to work the required 8 consecutive hours each day?*
    - *How does the facility provide care to residents that require an RN if one is not available to work?*

*Deficiency Categorization:*
***Example of Severity Level 4 Noncompliance: Immediate Jeopardy to Resident Health or Safety includes but is not limited to:***

- *The annual recertification survey of a facility indicates that it provides care for residents with high acuity needs including residents that receive medications and fluids via central intravenous lines (IV) and ventilator dependent residents. The investigation revealed an RN was not onsite for at least 8 consecutive hours during the day. During the period when there was no RN, the LPN had to perform assessments and maintain central line (IV) infusions, which is out of the scope of practice for an LPN in the absence of supervision of the RN. The facility's failure to have an RN on duty for at least 8 consecutive hours a day as required by the regulation, created the likelihood for serious injury, harm, impairment or death. Specifically, the RN was not present to meet the critical needs of these high acuity residents.*

***Example of Severity Level 3 Noncompliance: Actual Harm that is not Immediate Jeopardy includes, but is not limited to:***

- *Investigation of falls occurring in the facility with a census greater than 60 residents revealed the monthly fall evaluation for one resident was not completed with the interdisciplinary team after the resident experienced 2 falls. Interview with the Director of Nursing (DON) revealed this was the DON's responsibility; however, because she had been serving as the charge nurse, there was no time to complete the evaluation for this resident who experienced another fall resulting in a sprained wrist. Record review revealed that the resident experienced a fall after the DON failed to complete the fall evaluation in response to the two initial falls. Staff ultimately determined the resident was falling due to a change in the resident's condition (deteriorating eyesight) that was not timely identified because of the DON's failure to complete a monthly fall evaluation.*

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

- *Review of the PBJ Staffing Data Report revealed concerns related to the facility's requirement to have a Registered Nurse on duty for at least 8 consecutive hours a day. The surveyor verified an RN was routinely on duty for only 7 consecutive hours a day last quarter. No actual harm to residents was identified. However, there was a potential for more than minimal harm due to the facility's failure to have an RN on duty for at least 8 consecutive hours a day, 7 days a week in order to ensure that all the residents' clinical needs were met either directly by the RN or indirectly by the LPNs or CNAs for whom the RN was responsible for overseeing resident care.*

- *Review of the PBJ Staffing Data Report, other staffing documentation, and staff interviews revealed that the Director of Nursing routinely served as a charge nurse when the facility had an average daily occupancy of between 65-70 residents. No actual harm to residents was identified. However, there was a potential for more than minimal harm resulting from the Registered Nurse's dual role in simultaneously serving as both the Director of Nursing and the Charge Nurse for greater than 60 residents.*

***Severity Level 1: No Actual Harm with Potential for Minimal Harm***

- *The failure of the facility to provide an RN creates a risk that is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.*

## F728

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

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

**§483.35(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 §483.35(d)(1-3)**

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

**GUIDANCE §483.35(d)(1-3)**

Any 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.

If 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 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.

## F729

***(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)***

**§483.35(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.**

**§483.35(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.**

**§483.35(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 §§483.35(d)*(4)-(*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*, for monetary compensation.* 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.

***PROCEDURE***

*If concerns are identified with Nurse Aide Services at F725 and F726, review a minimum of five nurse aide personnel files including any specific staff members with whom concerns were identified.*

- *Review the nurse aide personnel folder to determine if the facility received registry verification that the individual has met competency evaluation requirements before the employee's start date unless an exception applies as noted in §483.35(d)(4).*
- *Review the nurse aide personnel folder to determine if the facility verified information from every State registry that the facility believes will include information concerning that individual before the employee's start date.*
- *If records reveal a nurse aide has not provided nursing related services for monetary compensation over a 24-month period, did the individual complete a new training and competency evaluation program?*

## F730

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§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 their 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 reviewing 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?

## F731

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§483.35(e) Nursing facilities**
**Waiver of requirement to provide licensed nurses on a 24-hour basis.**
**To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—**

**§483.35(e)(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;**

**§483.35(e)(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;**

**§483.35(e)(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;**

**§483.35(e)(4) A waiver granted under the conditions listed in paragraph (e) of this section is subject to annual State review;**

**§483.35(e)(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;**

**§483.35(e)(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the**

**protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and**

**§483.35(e)(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.**

**§483.35(f) SNFs**
**Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.**

**§483.35(f)(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—**

- **(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;**
- **(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and**
- **(iii) The facility either—**
  - **(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or;**
  - **(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;**
- **(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and**
- **(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.**

**§483.35(f)(2) A waiver of the registered nurse requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary.**

**INTENT §483.35(e)-(f)**
To give the facility flexibility, in limited circumstances, when the facility cannot meet nurse staffing requirements.

**GUIDANCE §483.35(e)-(f)**
If the facility is Medicaid-certified only, the State has the authority to grant a waiver of the RN requirement, and/or the 24-hour licensed nurse requirement. CMS is delegated the waiver authority for SNFs, including dually-participating facilities (SNF/NFs). The Medicare waiver authority is far more limited than is the States' authority under

Medicaid since a State may waive any element of the nurse staffing requirement, whereas the Secretary (CMS) may only waive the RN requirement. The requirements that a registered nurse provide services for 8 hours a day, 7 days a week (more than 40 hours a week), and that there be an RN designated as director of nursing on a full-time basis, may be waived by the Secretary (CMS) in the following circumstances:

- The facility is located in a rural area with an inadequate supply of SNF services to meet area needs. Rural is defined as "all areas not delineated as `urban`" by the Bureau of Census, based on the most recent census;
- The facility has one full-time registered nurse regularly working 40 hours a week. This may be the same individual, or part-time individuals. This nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires; **and either**;
    - The facility has only residents whose physicians have noted, in writing, do not need RN or physician care for a 48-hour period. This does not relieve the facility from responsibility for providing for emergency availability of a physician, when necessary, nor does it relieve the facility from being responsible for meeting all needs of the residents during those 48 hours; **OR**
    - A physician or RN will spend the necessary time at the facility to provide care residents need during the days that an RN is not on duty. This requirement refers to clinical care of the residents that need skilled nursing services.
- If a waiver of this requirement has been granted, conduct a survey of nursing services during each certification survey. Dually-participating facilities must meet the waiver provisions of the SNF.

A survey of Nursing Services must be conducted if a waiver has been granted or requested.

**PROBES §483.35(e)-(f)**

Before granting a continuation of this waiver, or during the annual review, coordinate with the State Survey Agency, and at a minimum, determine:

- The facility's recruitment efforts and its results.
- How the facility ensures residents' needs are being met in the absence of a licensed nurse.
- How all nursing policies and procedures are followed on each shift during times when licensed services are waived?
- If there is a qualified licensed nurse to assess, evaluate, plan and implement resident care.
- If care is being carried out according to professional practice standards on each shift.
- Whether the survey team can assure the State that the absence of licensed nurses will not endanger the health or safety of residents.
- Whether there are trends in the facility, which might be indicators of decreased quality of care as a result of insufficient staffing to meet resident needs (e.g., increases in incident reports, the infection rate, hospitalizations, loss of function, etc.).

- Whether there is evidence that preventive measures (e.g., turning, ambulating) are taken to avoid poor quality of care outcomes and avoidable sudden changes in health status.
- Whether there is evidence that sudden changes in resident health status and emergency needs are being properly identified and managed by appropriate facility staff and in a timely manner.
- Whether the residents or resident representatives been notified that the facility has a waiver to provide licensed nurses on a 24-hour basis.
- Whether there is an increase in hospitalizations because licensed personnel are not available to provide appropriate services.
- Whether the facility meets all applicable requirements to continue to receive a waiver.
- Whether the staff indicates that an RN or physician is available to respond immediately to telephone calls when licensed nurses are not available.

If the SNF has a waiver of the more than 40 hours a week RN requirement:

- Is there an RN on duty 40 hours a week?
- If more than one RN provides the 40 hour per week coverage, how is information exchanged that maintains continuity of resident care?
- Does each resident's clinical record have documentation by the physician that the resident does not need services of a physician or an RN for a 48-hour period each week?
- Are there any emergency or routine services that should be, but are not, provided to residents during the days that a registered nurse is not on duty?
- If specific skilled care is necessary for a resident during the time that an RN is not on duty, does an RN or physician provide that service on an "as needed" basis?
- Did the facility notify the residents of the facility and their resident representatives of the waiver?

If the SNF requests continuation of the waiver to provide the services of a registered nurse for more than 40 hours a week, the survey team is to provide the CMS Regional Office with information needed to grant this continuation.

- Does the SNF meet all requirements necessary for continuation of the waiver?

**PROCEDURES §483.35(e)-(f)**

The following procedure should be used to document that a facility has a waiver of nurse staffing requirements.

When a facility does not meet the nurse staffing requirements, cite the appropriate tag. If the facility does have a waiver, reference the tag number based on the type of facility. The type of facility (SNF, NF, or SNF/NF) determines what type of waiver is granted:

- For SNFs and SNF/NFs which may be waived from the requirement to provide more than 40 hours of registered nurse services a week, and for NFs which have been granted a waiver from the 56-hour registered nurse requirement, cite F727;
    - For NFs that have a waiver of the 24-hour licensed nursing requirement, cite F725, or

- Both facility types could be waived for the requirement to designate a registered nurse as the director of nursing on a full-time basis. Cite F731.

If the facility has an approved nurse staffing waiver, it is **not** considered a deficiency. The facility does not need to submit a Plan of Correction.

## F732

***(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)***

**§483.35(g) Nurse Staffing Information.**
**§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:**

**(i) Facility name.**
**(ii) The current date.**
**(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:**
**(A) Registered nurses.**
**(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).**
**(C) Certified nurse aides.**
**(iv) Resident census.**

**§483.35(g)(2) Posting requirements.**
**(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.**
**(ii) Data must be posted as follows:**
**(A) Clear and readable format.**
**(B) In a prominent place readily accessible to residents and visitors.**

**§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.**

**§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.**

**INTENT §483.35(g)**
To make *nurse* staffing information readily available in a readable format to residents and visitors at any given time.

**GUIDANCE §483.35(g)**
The facility's *staffing data* "document" may be a form or spreadsheet, as long as all the required information is displayed clearly and in a visible place. The information should be displayed in a

prominent place *that is readily* accessible to residents and visitors and presented in a clear and readable format. This information posted must be up-to-date and current.
The facility is required to list the total number of staff and the actual hours worked by the staff to meet this regulatory requirement. The information should reflect staff absences on that shift due to call-outs and illness.

Staffing must include all nursing staff who are paid by the facility (including contract staff). The nursing home is not *required to* include in the posting *the data for* staff *who are* paid for through other sources; examples include hospice staff covered by the hospice benefit, or individuals hired by families to provide companionship or assistance to a specific resident.

***Probes:***
***PROCEDURES AND PROBES §483.35(g)***
*Surveyors must determine through information obtained by observations and verified by record reviews the following:*

- *The facility posts the following information on a daily basis*
  1. *Facility name*
  2. *The current date*
  3. *The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides.*
  4. *Resident census*
- *The facility must post the nurse staffing data mentioned above on a daily basis at the beginning of each shift.*
- *The data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors.*
- *The facility must upon oral or written request make nurse staffing data available to the public for review at a cost not to exceed the community standard.*
- *The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.*

**KEY ELEMENTS OF NONCOMPLIANCE**

To cite deficient practice at F732, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Ensure staffing information was posted in a prominent place readily accessible to residents and visitors; **or**
- Ensure staffing information was accurate and current; **or**
- Ensure staffing information was complete and was not missing information (e.g. specific units were not reflected on the posting); **or**
- *Make daily staffing available to the public for review upon request:* ***or***

Maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

# F838

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

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

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

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

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

**INTENT §483.70(e)**
The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.

**DEFINITIONS §483.70(e)**
**"Competency"** is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully.

**GUIDANCE §483.70(e)**
A facility assessment may be similar to common business practices for strategic and capital budget planning. Strategic planning is an organization's process of defining its strategy, or direction, and making decisions on allocating its resources to pursue this strategy. However, while a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.

The facility assessment will enable each nursing home to thoroughly assess the needs of its resident population and the required resources to provide the care and services the residents need. It should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources, and may include the operating budget necessary to carry out facility functions.

To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager, and other department heads (for example, the dietary manager, director of rehabilitation services, or other individuals including direct care staff should be involved as needed.

Although not required, facility staff are strongly encouraged to seek input from the resident/family council, residents, their representative(s), or families and incorporate that information as appropriate when formulating their assessment.

An assessment of the resident population is the foundation of the facility assessment. It must include an evaluation of diseases, conditions, physical, functional or cognitive status, acuity of the resident population, and any other pertinent information about the residents that may affect and plan for the services the facility must provide (e.g., MDS data, Facility Characteristics report form CMS 672). The assessment of the resident population will also contribute to identifying the physical space, equipment, assisted technology, individual communication devices, or other material resources that are needed to provide the required care and services to residents.

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

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

The assessment must include or address the facility's resources which include supplies, equipment or other services necessary to provide for the needs of residents.

The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. If there are any concerns regarding training refer to §483.95 Training.

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

The facility assessment must consider health information technology resources, such as managing resident records and electronically sharing information with other organizations. For example, the assessment should address how the facility will securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility.

The facility assessment must include an evaluation of the physical environment necessary to meet the needs of the residents. This must include an evaluation of how the facility needs to be equipped and maintained to protect and promote the health and safety of residents. This should also include an evaluation of building maintenance capital improvements, or structures, vehicles, or medical and non-medical equipment and supplies.

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

Risk Assessment is general terminology that is within the emergency preparedness regulations and preamble to the Final Rule (81 Fed. Reg. 63860, Sept. 16, 2016) which describes a process facilities are to use to assess and document potential hazards within their areas and the vulnerabilities and challenges which may impact the facility.

Additional terms currently used by the industry are all-hazards risk assessments, also referred to as Hazard Vulnerability Assessments (HVAs, or all-hazards self-assessments. For the purposes of these guidelines, we are using the term "risk assessment," which may include a variety of current industry practices used to assess and document potential hazards and their impacts.

Hazard Vulnerability Assessments (HVAs) are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. The HVA describes the process by which a provider or supplier will assess and identify potential gaps in its emergency plan(s).

Potential loss scenarios should be identified first during the risk assessment. Once a risk assessment has been conducted and a facility has identified the potential hazards/risks they may face, the organization can use those hazards/risks to conduct a Business Impact Analysis.

This guidance is not specifying which type of generally accepted emergency preparedness risk assessment facilities should have, as the language used in defining risk assessment activities is meant to be easily understood by all providers and suppliers that are affected by this final rule and is aligned with the national preparedness system and terminology (81 Fed. Reg. 63860, at 63875). However, facilities are expected to conduct a full assessment of hazards based on geographical location and the individual facility dynamics, such as patient population.

**PROCEDURES §483.70(e)**

If systemic care concerns are identified that are related to the facility's planning, review the facility assessment to determine if these concerns were considered as part of the facility's assessment process. For example, if a facility recently started accepting bariatric residents, and concerns are identified related to providing bariatric services, did facility staff update its assessment before accepting residents with these needs to identify the necessary equipment, staffing, etc., needed to provide care that is effective and safe for the residents and staff? Questions surveyors should consider include, but are not limited to, the following:

- How did the facility assess the resident population? Does this reflect the population observed?
- How did the facility determine the acuity of the resident population?
- How did the facility determine the staffing level?
- How did the facility determine what skills and competencies would be required by those providing care?
- Who was involved in conducting the facility assessment?
- How did the facility determine what equipment, supplies, and physical environment would be required to meet all resident needs?
- How did the facility develop its emergency plan?
- If a deficient practice is systemic and is observed at another tag, was this related to an incomplete facility assessment? How?

**KEY ELEMENTS OF NONCOMPLIANCE**

To cite deficient practice at F838, the surveyor's investigation will generally show that the facility failed to do any one of the following:

- Annually and as necessary, conduct, document, review and update a facility-wide assessment; **or**
- Address or include in the facility assessment the minimum requirements as described in sections (1)(i-v), (2)(i-vi), and (3) above.

**DEFICIENCY CATEGORIZATION**

- **An example of Level 4, immediate jeopardy to resident health and safety, includes, but is not limited to:**
  - When conducting dining observations, each surveyor noted concerns regarding lack of staff availability to assist residents during meals. Interviews with residents and families indicated that often they had to wait for staff to assist the resident and the food was often cold by the time someone came to help. In addition, a record review of several of these residents noted that they each had a significant unplanned weight loss in the past two months and one of these residents had been recently hospitalized with a diagnosis of malnutrition and dehydration. A review of the facility's most current Facility Assessment did not include an evaluation of the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population (e.g., assistance with eating).

- **An example of Level 3, Actual harm (physical or psychological) that is not immediate jeopardy, includes, but is not limited to:**
- One of the sampled residents had experienced a fall while staff were transferring them bed to a chair. The resident's care plan indicates requiring a two-person assist using a mechanical lift. After the fall, the resident was evaluated and although he did not suffer any physical harm, upon interview he did express psychological harm and stated he was afraid of using these lifts and would prefer to remain in bed. Interviews with nursing staff indicated that many of the lifts are old, in frequent need of repair and often malfunction when used. They also stated that they have brought this matter to the attention of management many times. A review of the most recent Facility Assessment did not include or address equipment necessary to provide for the needs of residents.

- **An example of Level 2 - No actual harm with a potential for more than minimal harm (physical or psychological) that is not immediate jeopardy, includes but is not limited to:**
  - The facility recently admitted several individuals, some that follow a vegan diet and others that follow the Judaism faith, both of which include dietary restrictions. Although these residents still consumed the food offered by the facility, they expressed concerns that they are not always able to choose foods

that are consistent with their cultural beliefs. Upon review of the facility assessment, the facility had not addressed the cultural dietary needs of these residents, and how they would be met.

- **Examples of Level 1 - No actual harm with a potential for minimal harm include but are not limited to:**
  - When reviewing the Facility Assessment, the survey team identified that while the assessment included all the required components, it had not been reviewed for any potential updates in the last 15 months. Facilities are required to review and update the assessment at least annually. The facility's failure to review the assessment within 12 months may result in the facility failing to identify a factor that would require a change to the assessment, thereby potentially placing the residents at risk for at least minimal harm.

**POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION**

If the survey investigation reveals that there are not sufficient or competent staff refer to:

- F639, §483.21(b)(3), Comprehensive Person-Centered Care Planning;
- F725 or 726, §483.35(a),(c) for any nursing services not related to behavioral health care or dementia care;
- F741, §483.40 for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder;
- F801, §483.60(a) for Food and Nutrition staff;
- F826, §483.65(b), Specialized rehabilitative services;
- F839, §483.70(f), Staff qualifications;
- F837, §483.70(d), Governing Body
- F865, §483.75, QAPI/QA&A

# F839

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§483.70(f) Staff qualifications.**
**§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.**

**§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.**

**DEFINITIONS §483.70(f)**
**"Licensed health professional"** as defined at §483.5 is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.

**PROCEDURES §483.70(f)**

If there is reason to doubt the qualifications or competencies of **any personnel**, including temporary, agency and contracted individuals, verify qualifications with the appropriate State registry or practitioner professional licensing body.

If the survey investigation reveals that there are concerns with the qualifications or competencies of:

- Activities professionals refer to F679, §483.24(c)(2);
- Nursing Staff refer to F726, §483.35;
- Any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder refer to F741, §483.40;
- Food and Nutrition staff refer to F801, §483.60(a);
- Individuals providing Specialized rehabilitative services refer to F826, §483.65(b),;
- Social Workers refer to F850, §483.70(p);

**NOTE:** Only cite F839 for any staff not referenced above or if any professional staff is not licensed, certified, or registered in accordance with applicable State laws. This includes any physician or practitioner including the Medical director that does not hold a valid license to practice in the State where the Nursing Home is located.

If a facility has not designated a physician to serve as a Medical Director refer that citation under F841.

# F851

*(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)*

**§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.**

**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.

*The surveyors can obtain PBJ data from the Certification And Survey Provider Enhanced Reports (CASPER) report to determine if the facility submitted the required staffing information based on payroll data in a uniform format.* ***The facility's failure to submit PBJ data as required will be reflected on their CASPER report and result in a deficiency citation.***

*If concerns were identified based on the CASPER report, or from any other source, refer to the critical element pathway "Sufficient and Competent Staffing."*
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 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; or,
- *Submit the required staffing information based on payroll data in a uniform format.*

*Noncompliance at F851 focuses on the submission of staffing data. If the surveyor identifies concerns related to sufficient staffing, surveyors would investigate these concerns using the Sufficient and Competent Staff Critical Element Pathway, and guidance at §483.35 Nursing Services (F725 & F727).*

# F947

***(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)***

***§483.95 Training Requirements.***
***Training topics must include but are not limited to—***

**§483.95(g) Required in-service training for nurse aides.**
**In-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)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.**

***DEFINITIONS***
A "nurse aide" is *defined in §483.5 as* 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.

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 *and therefore are not required to take the training*.

*Performance Reviews: The process used to evaluate the performance of staff on a periodic basis, which may be annually.*

*NOTE: See Tag F730-§483.35(d)(7) related to the conduct of performance reviews for every nurse aide at least once every 12 months.*

**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 *performance* reviews *[see §483.35(d)(7)] and* 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 *(though, should not be webinars alone)* and/or supervised practical training hours *and should be reflective of nurse aides' performance reviews in order to address identified weaknesses. When able, each nurse aide should be evaluated based on individual performance, and the facility should develop training that can be utilized and beneficial to all nurse aide staff when applicable.*

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. *If there is a concern about required in-service training for nurse aides, interview staff and review training records to determine the following:*

- 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.
- 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)?
- 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.

## F948

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§483.95(h) Required training of feeding assistants.**
**A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.**

**DEFINITION §483.95(h)**
Paid feeding assistant is defined in the regulation at 42 CFR 488.301 as "an individual who meets the requirements specified in §483.60(h)(1) of this chapter and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization."

**GUIDANCE §483.95(h)**

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

- Feeding techniques.
- Assistance with feeding and hydration.
- Communication and interpersonal skills.
- Appropriate responses to resident behavior.
- Safety and emergency procedures, including the Heimlich maneuver.
- Infection control.
- Resident rights.
- Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

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.

**PROBES §483.95(h)**

- Were paid feeding assistants 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 paid feeding assistants report receiving about the concern or deficient practice identified by the surveyor?
- If the facility is using paid feeding assistants and the residents requiring assistance with eating are determined to have avoidable negative nutritional outcomes, request proof that the paid feeding assistants successfully completed a State-approved training program.

Tag 948 is only to be cited if it is determined the paid feeding assistant(s) has not completed a State-approved training program as specified in §483.160. It is not required to have an outcome deficiency cited for this tag to be cited related to staff training.

**POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION**

If concerns related to the performance of the paid feeding assistant are identified, see 42 CFR §483.60(h) Paid Feeding Assistants, tag F811, for guidance.