Phase 1 Implementation of New LTC Regulation Training

Phase I and F-tag Slides

1. Phase 1 Implementation of New Long-Term Care Regulations
Hello my name is Bonnie Reed, a registered nurse consultant with the Centers for Medicare and Medicaid. Synora Jones, also a nurse consultant with the Centers for Medicare and Medicaid, and I have worked with others in the division of nursing homes at CMS to provide you with an overview of the Phase 1 implementation of the new Long-Term Care regulations.

2. Phase 1 Overview
Phase 1 of the revised nursing home regulations is scheduled to be effective November 28th 2016. There are five areas of implementation we’ll highlight briefly. Full implementation of Basis and Scope at 483.1 and Definitions at 483.5. Regulatory Groupings become Regulatory Sections. This expanded from 15 to 21. There will be full implementation of five regulatory sections. Minor modifications to 15 other regulatory sections, and 20 of the 21 Regulatory Sections have all or some regulations implemented in Phase I.

3. Regulatory Sections Overview
Here is an overview of the Regulatory Sections. You’ll notice the key fully implemented in Phase I are highlighted in blue.

4. New Regulatory Sections
However, all regulatory sections with the exception of Compliance and Ethics have a Phase I component.

5. Regulatory Grouping Removed
One regulatory grouping, Resident Behavior and Facility Practices, has been merged with other regulatory sections.

6. 5 of 21 Regulatory Sections are Fully Implemented in Phase I
The five Regulatory Sections that are fully implemented in Phase I are Resident Assessment, Quality of Life, Physician Services, Laboratory, radiology and other diagnostic services, and Specialized Rehabilitation.

7. 15 of 21 Regulatory Sections are Partially Implemented in Phase I
Phase I provides a foundation for full implementation of nursing home reform. 15 of the 21 Regulatory Sections are partially implemented in Phase I.
8. Citing Deficiencies in Phase 1
Because Phase I of the implementation of the new nursing home regulations are effective starting November 28th 2016, you’ll find there is no new interpretive guidance. A surveyor might ask: “If I identify a potential deficiency associated with a new regulation, how do I cite it in ASPEN?” The response from CMS is, you’ll use the current F-tags. I think that’s worth repeating. For the Phase I implementation, of the new Long-Term Care regulation, the current F-tag numbering system will remain. The new regulatory language was incorporated into the existing numbering system. CMS has created some tools. You can reference those tools during Phase I.

9. Phase 1 Tools in S&C-17-07-NH
CMS released S&C memo 17-07-NH. This memo included 3 attachments; an F-tag Job Aide, Draft Appendix PP, Regulation Text by Current Tag Order.

10. Phase 1 Tool Overview
Here is a table that might help differentiate between the tools:
- An F-tag Job Aide that identifies the current F-tag associated with a new regulation,
- A Draft Appendix PP that examines updated regulatory language in context,
- Regulation Text by Current Tag Order that will assist you in quickly locating regulatory details about a specific tag.

11. F-tag Job Aide
Here is a screen shot of the F tag job aide.

12. Draft Appendix PP
Here is an example of how the draft Appendix PP will appear.

13. Regulation Text by Current Tag Order
And lastly, here is the tool that will list the regulation text by current tag order. You’ll notice the new regulatory language in red italics.

14. Phase 1 Regulatory Changes Overview
Let’s get started on the overview of the regulatory changes in Phase 1. You’ll find the areas discussed in this training are grouped by regulatory sections in numerical order. We’ll list the key points and F-tag references for modifications. If the F-tag has no changes in regulatory language, we will not be discussing them here today. Don’t forget you can examine the Phase 1 tools provided for specific information after and during this overview.
15. § 483.5 Definitions
Next, we'll discuss 483.5 Definitions. There are now added definitions of the following:
Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or
punishment with resulting physical harm, pain or mental anguish.
Adverse event: were defined to ensure clarity in our requirements related to proposed
requirements for QAPI.
Exploitation: the unfair treatment or use of a resident or the taking of a selfish or unfair
advantage of a resident for personal gain, through manipulation, intimidation, threats, or
coercion.
Misappropriation of resident property: defined as the deliberate misplacement,
exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money
without the resident's consent.
Mistreatment: means “to inappropriately treat or exploit a resident.”
Neglect: the facility and its employees are neglectful when a reasonable person would
conclude that a deprivation of the omitted goods and services would cause, among other
things, emotional distress (rather than mental disorder)
Person-centered care: focusing on the resident as the locus of control and supporting the
resident in making their own choices and having control over their daily lives.
Resident representative: include both an individual of the resident’s choice who has access
to information and participates in healthcare discussions, as well as personal representative
with legal standing, such as a power of attorney for healthcare, legal guardian, or health
care surrogate, or proxy appointed in accordance with state law to act in whole or in part on
the resident’s behalf.
Sexual abuse: defined as non-consensual sexual contact of any type with a resident, and
Willful: the individual must have acted deliberately, not that the individual must have
intended to inflict injury or harm.

16. Resident Rights Overview
Now we’ll move on to the Resident Rights Overview.

17. § 483.10 Resident Rights
Resident Rights section. There are 14 slides in this training dedicated to Resident rights. All
existing resident rights have been retained. The language and organization of the resident
rights provisions have been updated to improve logical order and readability, such as
replacing the term “legal representative” with “resident representative”. Regulations have
been clarified where necessary, such as adding information regarding physician credentials.
Provisions have been updated to include advances such as electronic communications.
18. § 483.10 Resident Rights—continued
Key points to look for at F151 are the facility’s efforts to support the resident in the exercise of his or her rights. For F152, key points to look for is, the resident who was not adjudged incompetent had the right to designate a resident representative. Equal treatment of a same-sex spouse who is a designated resident representative. To ensure the resident representative only exercises their decision-making responsibilities as delegated by the resident or court and in accordance with the applicable law, and in accordance with the resident’s wishes and preferences. The resident retains the right to make those decisions outside the representative’s authority. Report concerns about a resident representative as required by State law. Lastly, care planning concerns should be cited under F280 and we will address this later in the training.

19. § 483.10 Resident Rights—continued
Key points to look for at F153: Personal and medical records are provided as requested by the individual. Records are provided in a manner the resident can understand. A reasonable, cost-based fee was assessed as described in the regulation.

20. § 483.10 Resident Rights—continued
Key points to look for at F154: Resident was informed of the type of care giver or professional furnishing care, and the resident was informed of the risk and benefits of the proposed care and to choose the alternative or option he or she prefers.

21. § 483.10 Resident Rights—continued
Key points to look for at F155: New regulatory language was added. Regulation will move to Quality of Life and new guidance will appear at Phase II implementation. The resident also has the right to request and/or discontinue treatment, or to participate in experimental research. If the facility did not provide the information about Advance Directives, the facility needs to ensure an outside contractor did and met the requirements of this section. If the adult individual was incapacitated at the time of admission, the information was provided to the resident representative and then to the resident, if the resident condition changed, was no longer incapacitated, and was able to understand the information.

22. § 483.10 Resident Rights—continued
Key points to look for at F156: The resident was made aware of who or how to contact other primary care professionals involved in their care. The resident received both an oral and written notification containing the specific information, such as the expanded resources, home and community based service programs, etc. The resident was able to request information about returning to the community, and the facility had identified that information to provide upon request. The resident was made aware of changes to charges for services not covered under Medicare or Medicaid, or by facility’s per diem rate, meeting the stated requirements. And refunds were made to the resident, resident representative, or estate, as applicable, meeting the stated requirements. An admission contract did not conflict with the requirements of this regulation.
23. § 483.10 Resident Rights —continued
Key points to look for at F158: the resident is informed of charges in advance that are imposed and also refer to F162.
At F159 there are now differing dollar amounts for Medicaid residents and other residents.
At F160, key points to look for are conveyance of funds for discharged or evicted residents.

24. § 483.10 Resident Rights —continued
Key points to look for at F162 under Resident Rights, that residents receiving services under Medicaid or Medicare are not charged for food and nutrition or hospice services. Items and services that maybe charged to residents if not required to achieve resident’s goals have been expanded to include: cellphones, computers and other electronic devices. Facility has taken into consideration resident food and cultural preferences when preparing meals. And lastly, the resident was informed orally and in writing for any item or service where there is a charge.

25. § 483.10 Resident Rights —continued
Key points to look for at F163: verify physician is licensed to practice, determine if resident was informed that their attending physician is unable or unwilling to meet the requirements, and that the facility is seeking an alternate physician, ensure the resident’s choice of physician is honored as long as they meet the requirements, and at F164, ensure medical records are kept confidential except in cases cited in this regulation.

26. § 483.10 Resident Rights —continued
Key points to look for at F166: determine the residents have information on how to file grievances or complaints. Ensure that there is grievance policy that includes at a minimum requirement listed that ensures prompt resolution of all grievances and identifies a Grievance Official. F167: ensure that the most recent survey results during the 3 preceding years, as well as certification and complaint investigations are posted and readily accessible to residents, and resident representatives. Ensure that identifying information about complaints or residents are not available.

27. § 483.10 Resident Rights —continued
Continuing on with Resident Rights – key points to look for at F168: to ensure that the facility did not prohibit or discourage a resident from communicating with external entities. At F169, we will ensure the facility cannot require a resident to perform services for that facility.

28. § 483.10 Resident Rights —continued
At F170, privacy of electronic communications is to be provided, and the resident is able to receive mail and packages from other than the postal service. At F171, we’ll need to ensure the facility supported resident’s right to communication, including the ability to send mail.
29. § 483.10 Resident Rights—continued
F172: the surveyor should determine if residents have the right to receive visitors of their choosing and at the time of their choosing, and that they do not impose on the rights of other residents. The surveyor will need to determine that the facility has a policy that includes visitation rights and clinically necessary or reasonable restrictions. The facility will need to ensure that a resident or their visitors are informed of the visitation policies, and that facility staff do not restrict, limit or deny visitation privileges and that privileges are consistent with the resident’s preferences. At F174, key points to look for are: expanded access to cell phone use, TTY and TTD services.

30. § 483.10 Resident Rights—continued
F175 key points to look for are the right to choose a roommate. F176: how the facility determined self-administration was clinically appropriate. F177 the facility may not perform a transfer solely for the convenience of the staff.

31. § 483.10 Resident Rights—continued
Key points to look for at F240: we would determine that every resident is treated with respect and dignity, and the facility has policies for practices such as transfer, discharge, and equal access to services regardless of payment source.

32. § 483.10 Resident Rights—continued
Key points to look for at F242: resident’s right to choose was afforded to the expanded/clarified requirements. At 243, reasonable steps were taken to notify residents and family of upcoming meetings in a timely manner.

33. § 483.10 Resident Rights—continued
At F244 under Resident Rights, the facility will need to ensure the resident was provided a response and a rationale for their response. At 247, as notice was provided in writing and included the reason for the change.

34. § 483.10 Resident Rights—continued
At F252, the key points to look for are: ensuring the environment maximizes resident independence, and responsibility for the protection of the resident’s property. Lastly at F280, the key points to look for is that the resident has participation in his or her person-centered care plan.

35. Freedom from Abuse Neglect and Exploitation Overview
So now we’ll move on to the Freedom from Abuse, Neglect, and Exploitation overview.

36. §483.12 Freedom from Abuse, Neglect, and Exploitation
The new regulatory language strengthens existing protections, in addition to review of policies and procedures. Language was added related to resident “right to be free from neglect” and “exploitation.” The regulation requires facilities to investigate and report all allegations of abusive conduct. Individuals who had a disciplinary action due to abuse,
neglect, mistreatment of residents, or misappropriation of their property taken against their professional license by a state licensure body cannot be hired by facilities.

37. §483.12 Freedom from Abuse, Neglect, and Exploitation—continued
At F223, key points to look for that we’ll continue to review citations related to abuse, corporal punishment, and involuntary seclusion and, as noted earlier in this training, the new definitions for abuse and sexual abuse are included in F223.

38. §483.12 Freedom from Abuse, Neglect, and Exploitation—continued
Key points at F224: The regulation more specifically requires implementing policies and procedures for: Prohibiting and preventing neglect, exploitation, and misappropriation. Investigating all alleged violations. Training for the prevention of neglect, exploitation, and misappropriation. Activities that constitute neglect, exploitation, and misappropriation. Procedures for reporting, and dementia management and resident abuse prevention.

39. §483.12 Freedom from Abuse, Neglect, and Exploitation—continued
Key points to look for at F225: The facility requirement is not only limited to only facility employees but also individuals the facility engages. The facility must not employ/engage any individuals with: A finding of exploitation or misappropriation of resident property. Have a disciplinary action in effect against his or her professional license that is related to a finding of abuse, neglect, exploitation, mistreatment, or misappropriation. Alleged violations must be reported immediately. Maximum timeframes are outlined in the regulation, but it is expected that reports would occur more quickly to protect residents. No later than 2 hours if the allegation involves abuse or results in serious bodily injury, and no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury.

40. §483.12 Freedom from Abuse, Neglect, and Exploitation—continued
Key points to look for at F226: The regulation more specifically requires developing and implementing policies and procedures for: Prohibiting and preventing abuse, neglect, exploitation, and misappropriation. Investigating all alleged violations. Training for prevention of abuse, neglect, exploitation, and misappropriation, which includes those activities that constitute abuse, neglect, exploitation, and misappropriation. Procedures for reporting, Dementia management and resident abuse prevention. It should be determined if training was provided about: what activities constitute abuse, neglect, exploitation, and misappropriation of resident property. Training should be provided about procedures for reporting, and training should be provided about dementia management and resident abuse prevention.

41. §483.12 Freedom from Abuse, Neglect, and Exploitation—continued
F221 key points to look for: deficiencies related to physical restraints will be cited at F221. F222 involves deficiencies related to chemical restraints. The facility must use the least restrictive alternative for the least amount of time, and documenting ongoing re-evaluation of the need for restraints.
42. Admission, Transfer and Discharge Rights Overview
   Now, we’ll look at the regulatory section of Admission Transfer and Discharge Rights.

43. §483.15 Admission, Transfer, and Discharge Rights
   Transfer or discharge to be documented in medical record, including specific information
   which should be exchanged with receiving provider or facility when a resident is
   transferred.

44. §483.15 Admission, Transfer, and Discharge Rights—continued
   Key points to look for at F201 under Admission, Transfer, and Discharge Rights, requires
   additional documentation: If the facility has transferred or discharged residents while an
   appeal is pending because keeping the residents in the facility endangers the health or
   safety of the residents, or others in the facility the medical record should show
   documentation of what danger is posed if the facility does not transfer or discharge the
   resident.

45. §483.15 Admission, Transfer, and Discharge Rights—continued
   Key points to look for at F203: Requires the facility to send a copy of transfer or discharge
   notice to the ombudsman. Requires the facility to provide resident and/or the resident
   representative with additional information in the notice regarding the process for appealing
   transfer or discharge. And requires the facility to update recipients of transfer/discharge
   notice of any changes to the notice as soon as possible (if those changes occur prior to the
   transfer or discharge).

46. §483.15 Admission, Transfer, and Discharge Rights—continued –
   F204: New regulatory language at F204 adds that the orientation facilities provided to
   residents regarding transfer or discharge must be in a manner that they understand, such as
   at an appropriate educational level, in the resident’s language and/or taking into
   consideration other communication barriers, and physical and mental impairments.

47. §483.15 Admission, Transfer, and Discharge Rights—continued
   Key points to look for at F205: There are changes of “readmission” language to “return”.
   New language requires facilities to provide written information to resident or resident
   representative about payment needed to hold a bed if the individual state requires
   payment to hold the bed. And we’ve listed corrections to references in the Final Rule.
§483.15 Admission, Transfer, and Discharge Rights—continued
Key points to look for at F206: If the facility decides a resident cannot return to the facility, the facility would then discharge a resident. A facility can only discharge a resident for the reasons listed under 483.15 paragraph c. The medical record should show documentation of the reason for the discharge. The documentation regarding the basis for transfer or discharge should also be in the notice to the resident or resident representative. If a resident is transferred, and then the facility cannot/does not take them back, then the individual is considered a discharge, and the facility has to meet all discharge requirements that are implemented in Phase 1.
Readmission to a composite distinct part provision is not new but has been added to F206 if concerns are identified regarding this issue. Room changes in a composite distinct part is not a new provision but it has been added to F207 since it may indicate unequal treatment of residents.

§483.15 Admission, Transfer, and Discharge Rights—continued
Key points to look for at F208: Adds admission policy regarding personal property loss to ensure facility has not required the resident to waive potential facility liability in the event of loss of property.
It adds requirements for the facility to disclose any special characteristics or limitations of the facility. Surveyors may identify concerns related to this provision through interviews or complaints. For example, a facility may have a religious affiliation that guides its practices and routines which must be communicated to any potential resident or a facility may have limitations in the type of medical care it can provide which must be communicated prior to admission.

50. Resident Assessment Overview
Now, we’ll review the Resident Assessment Overview.

§483.20 Resident Assessment
Clarification to what constitutes appropriate coordination of a resident’s assessment with the Preadmission Screening and Resident Review program under Medicaid. The regulatory section also includes the addition of references to statutory requirements that were inadvertently omitted from the regulation when sections 1819 and 1919 of the Act were first implemented.

§483.20 Resident Assessment—continued
F272 key points to look for: Inclusion of the resident’s strengths, goals, life history and preferences in his or her comprehensive assessment, as well as inclusion of the resident and direct care staff (licensed and non-licensed staff) participation in the resident’s comprehensive assessment.
53. §483.20 Resident Assessment—continued
F285 key points to look for: that would include coordination. Coordination includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

54. §483.20 Resident Assessment—continued
F286: There are no new regulatory language at F286, the language was updated to read “use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.” This was not previously included in the State Operations Manual. You will refer to §483.21 comprehensive person-centered care planning to evaluate use of the resident assessment data, in the development, review, and revision of the resident’s care plan.

55. Comprehensive, Person-Centered Care Planning Overview
Now that leads us to Comprehensive, Person-Centered Care Planning Overview

56. §483.21 Comprehensive Person-Centered Care Planning
Comprehensive Person-Centered Care Planning includes the addition of nurse aide and member of the food and nutrition services staff to required members of the interdisciplinary team that develops care plans.

57. §483.21 Comprehensive Person-Centered Care Planning—Continued
It also requires facilities to develop and implement a discharge planning process focusing on resident’s discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable re-admissions. Implementing discharge planning requirements mandated by The Improving Medicare Post-Acute Care Transformation Act of 2014, also known as the IMPACT Act, by revising, or adding where appropriate, discharge planning requirements for Long-Term Care facilities.

58. §483.21 Comprehensive Person-Centered Care Planning—Continued
Key points to look for at F279: The care plan must be centered on the resident’s needs including measurable objectives and time frames. The care plan must include specialized services facility will provide as a result of the PASARR. The facility must have a documented rationale in medical record if they disagree with the PASARR findings. And the Care plan must include goals for admission and discharge preferences.
59. §483.21 Comprehensive Person-Centered Care Planning – Continued
Key points to look for at F280: The facility involved a nurse aide responsible for resident and member of the food and nutrition service, along with the attending physician and a registered nurse would be on the interdisciplinary team. Any other professionals needed in development of the care plan as based on the residents care needs would also be involved in the interdisciplinary team. And if the facility has reviewed and revised care plan after each assessment for both comprehensive and quarterly assessments.

60. §483.21 Comprehensive Person-Centered Care Planning – Continued
F281 key points to look for: The services outlined in the comprehensive care plan meet professional standards of quality. In F283, when discharge is anticipated for a resident facility must have a discharge summary.

61. §483.21 Comprehensive Person-Centered Care Planning – Continued
F284: Discharge planning this begins on admission with comprehensive assessment of resident’s discharge goals. Discharge plan part of the care plan and must be re-evaluated with each comprehensive assessment and significant change assessment. The Discharge plan must involve resident and/or the representative, and be developed by the interdisciplinary team including the physician.

62. §483.21 Comprehensive Person-Centered Care Planning – Continued
F284 continued: Discharge plan must include documentation of the local contact agency involvement in the resident wishes to be discharged to the community. If discharge to the community is not feasible, facility must document. Facilities must assist residents and resident representatives wishing to be discharged to another SNF, Home Health Agency, Inpatient Rehabilitation Facility, or Long-Term Care Hospital by providing them with standardized patient assessment data (where available), data on quality measures, and resource use, such as staffing, to assist the resident representative in selecting a provider.

63. Quality of Life Overview
And now we’ll review the changes to the regulatory section of Quality of Life.

64. §483.24 Quality of Life
There are no brand new requirements in this section. The “Highest Practicable Well-Being” language continues in this section. Each resident is to receive and the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.
65. §483.24 Quality of Life—continued
Specific intent of the regulatory language at F309 includes: The provision for assuring that all care and services that a resident receives enhances his or her quality of life. Although, the regulation language at F309 doesn’t specifically address end of life and/or hospice care and services provided by a Medicare certified hospice, the surveyor is directed to survey the concerns related to end of life or hospice services at this outcome tag. The regulation for a hospice agreement between the nursing home and a Medicare certified hospice is found at F526. New revised interpretive guidance for investigating the provision of end of life care and/or hospice care and services is in the CMS clearance process.

66. §483.24 Quality of Life—continued
Specific intent of the regulatory language at F309 includes: The provision for assuring that all care and services that a resident receives enhances his or her quality of life. Although, the regulation language at F309 doesn’t specifically address end of life and/or hospice care and services provided by a Medicare certified hospice, the surveyor is directed to survey the concerns related to end of life or hospice services at this outcome tag. The regulation for a hospice agreement between the nursing home and a Medicare certified hospice is found at F526. New revised interpretive guidance for investigating the provision of end of life care and/or hospice care and services is in the CMS clearance process.

67. §483.24 Quality of Life—continued
Key points to look for at F310: The area was moved to quality of life, it adds oral care and expanded to including dining, meals and snacks. You’ll note that F311 and F312 was also moved to Quality of Life.

68. Quality of Care Overview
Now we’ll review the Quality of Care section.

69. §483.25 Quality of Care
We added special care issues, many of which were previously cited under F309, if there were care issues. Specific areas such as restraints, pain management, bowel incontinence, and dialysis services. Based on comprehensive assessment of a resident, facilities required to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices.

70. §483.25 Quality of Care—continued
There were no significant changes at F313 and F314 .... STOP ... and we took a break. We resumed after break. There are no significant changes to F313 and F314. At F315, residents who are continent of bladder and bowel receive necessary services and assistance in order to maintain continence; Residents admitted with, or subsequently receiving a catheter are assessed for removal as soon as possible; and Residents with fecal incontinence receive appropriate treatment and services to restore as much normal bowel function as possible.
71. §483.25 Quality of Care—continued
Key points to look for at F323: The facility must attempt to use appropriate alternatives prior to installing a side or bed rail and must ensure the correct installation, use, and maintenance including, but not limited to: Assessing the resident for risk of entrapment, review risks and benefits of the bedrails with the resident or resident representative and obtain informed consent prior to installation. Ensure the bed’s dimensions are appropriate for the resident’s size and weight.

72. §483.25 Quality of Care—continued
Key points to look for at F328: Expanded regulatory language in the areas of: Foot care, colostomy, ureterostomy, or ileostomy care, parental Fluids, respiratory care, and Prostheses. It expanded regulatory language includes professional standards and care provided in accordance to the comprehensive person-centered care plan.

73. Physician Services Overview
Now we’ll review Physician Services.

74. §483.30 Physician Services
Attending physicians to delegate dietary orders to qualified dietitians or other clinically qualified nutrition professionals and therapy orders to therapists.

75. §483.30 Physician Services—continued
Key points to look for at F385: Orders to meet the immediate care and needs of the resident. At F390, if the dietitian, other clinically qualified nutrition professional, or a qualified therapist has been delegated the task of writing orders: They are to do so in accordance with State law; the written order when delegated by physician; and they are acting under the supervision of a physician.

76. Nursing Services Overview
Now we’ll take a look at the Nursing Services Section Overview.

77. §483.35 Nursing Services
Addition of competency requirement for determining the sufficiency of nursing staff, based on a facility assessment, which includes but is not limited to the number of residents, resident acuity, range of diagnoses, and the content of individual care plans.

78. §483.35 Nursing Services—continued
Key points to look for at F353: The facility to determine if there is sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to each resident. The facility provided a sufficient number of nurse aides, along with other nursing personnel, on a 24-hour basis to provide nursing care to all residents in accordance with the resident’s care plans.
79. §483.35 Nursing Services—continued
F497 key points to look for: The surveyor will need to determine if in-service training complies with the requirements at 483.95(g): Facilities are required to include dementia management and abuse training in Prevention in their regular in-service education for all Nurse Aides.

80. Behavioral Health Services Overview
And now we’ll take a look at the Overview for Behavioral Health Services.

81. §483.40 Behavioral Health Services
Comprehensive assessment and medically related social services. New requirement (incorporates highest practicable well-being, specialized rehabilitation, and medical social services). An addition of new section focusing on requirement to provide necessary behavioral health care and services to residents, in accordance with their comprehensive assessment and care plan. The addition of “gerontology” to the list of possible human services fields from which a bachelor degree could provide the minimum educational requirement for a social worker.

82. §483.40 Behavioral Health Services—continued
Key points to look for at F319: Review of residents who display and/or are diagnosed with mental disorder or psychosocial adjustment difficulty. The facility must correct resident’s assessed problem or assist resident in attaining their highest practicable mental and psychosocial well-being.

83. §483.40 Behavioral Health Services—continued
Key points to look for at F320: Review of residents who do not have diagnosis of a mental disorder or psychosocial adjustment difficulty, to ensure they do not have an avoidable decrease in social interaction since admission to the facility.

84. Pharmacy Services Overview
Now we’ll take a look at the Overview for Pharmacy Services.

85. §483.45 Pharmacy Services
The pharmacist must review a resident’s medical chart during each monthly drug regimen review; Revision of existing requirements regarding “antipsychotic” drugs to refer to “psychotropic” drugs; Define “psychotropic drug” as any drug that affects brain activities associated with mental processes and behavior; Requiring several provisions intended to reduce or eliminate the need for psychotropic drugs, if not clinically contraindicated, to safeguard the resident’s health.
86. §483.45 Pharmacy Services—continued
F428 under Pharmacy Services, requires new process for medication regimen review (MRR) and requires facilities to develop and maintain policies and procedures to address all aspects of the medication regimen review. Including, the pharmacist must now report medication regimen review irregularities to the medical director as well as the attending physician and director of nursing (DON). Irregularities are defined as medications that meet the criteria for unnecessary medications. The pharmacist provides a written report regarding irregularities to the attending physician, medical director, and DON. The attending physician must document: that he/she reviewed the identified irregularity, the action taken to address the irregularity, or the reason for not changing the medication related to the identified irregularity.

87. Laboratory, radiology and other diagnostic Services Overview
And now we'll take a look at the Laboratory, radiology and other diagnostic Services.

88. §483.50 Laboratory, radiology, and other diagnostic services
A physician assistant, nurse practitioner, or clinical nurse specialist may order laboratory, radiology, or other diagnostic services for a resident in accordance with State law, including scope-of-practice laws.

89. §483.50 Laboratory, radiology, and other diagnostic services—continued
Key points to look for at F504: Facility provides or obtains laboratory services by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope-of-practice laws.

90. §483.50 Laboratory, radiology, and other diagnostic services—continued
F505: Facility staff promptly notifies the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

91. §483.50 Laboratory, radiology, and other diagnostic services—continued
F510, key points to look for: The facility provides or obtains radiology and other diagnostic services by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

92. §483.50 Laboratory, radiology, and other diagnostic services—continued
And at F511, facility staff promptly notifies the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s order.
93. Dental Services Overview
And now we’ll review the Dental Services Overview.

94. §483.55 Dental services
For Dental Services, there were limited changes to update and clarify.

95. §483.55 Dental services—continued
Key points to look for at F411: Assistance is not only provided when deemed necessary by the facility, but also when requested by the resident. And transportation is provided to any location providing dental services, not just the dentist office. Key points to look for at F412: The facility submitted an application for reimbursement of dental services under the State plan, if the resident is eligible and wishes to participate.

96. Food and Nutrition Services Overview
And now we’ll review Food and Nutrition Services. And we will just note that Dietary Services is now Food and Nutrition Services.

97. §483.60 Food and Nutrition Services
Facilities to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

98. §483.60 Food and Nutrition Services
Facilities to employ sufficient staff, including the designation of a director of food and nutrition service, with the appropriate competencies and skills sets to carry out the functions of dietary services while taking into consideration resident assessments and individual plans of care, including diagnoses and acuity, as well as the facility’s resident census.

99. §483.60 Food and Nutrition Services—continued
Key points to look for at F360 is indications for the emphasis on resident preferences.
100. §483.60 Food and Nutrition Services—continued
Demonstration of staff competencies and skills in food service. For a qualified dietitian or other clinically qualified nutrition professional hired prior to November 28, 2016, the facility has 5 years to ensure they have the regulatory required qualifications if hired after November 28, 2016. There is no one year grace period for meeting the requirements if hired after November 28, 2016. For the position of director of food and nutrition services hired prior to November 28, 2016, the facility has five years to ensure they have the regulatory required qualifications. For the position of director of food and nutrition services hired after November 28, 2016, the facility has one year to ensure they have the regulatory required qualifications. Explicit regulatory requirement to meet State requirements for food service or dietary managers—surveyors must be aware of what the specific requirements are for the State they are surveying in to determine compliance.

101. §483.60 Food and Nutrition Services—continued
Key points to look for at F362: The change from “competent” to “safely and effectively.” Verify who from the Food and Nutrition Services staff is participating on the interdisciplinary team as required. And F363, the facility to ensure the menu reflects the religious, cultural, and ethnic needs of the resident population and input from residents and resident groups.

102. §483.60 Food and Nutrition Services—continued
Key points to look for at F364: Drinks must now also meet these requirements. Expanded to include meeting hydration needs and preferences regarding fluids.

103. §483.60 Food and Nutrition Services—continued
At F366, meeting explicit requirements for accommodating resident allergies, intolerances, and preferences. Alternatives must also now be appealing to the resident. Surveyors must be aware of their state’s laws governing the ability for the registered/licensed dietitian to write orders. They may not write orders, if not allowed under State law; and that’s a key point for F367.

104. §483.60 Food and Nutrition Services—continued
F368 key points to look for are that the meals meeting resident needs, preferences, requests, care plan are now explicitly required. Alternative meals/snacks must be provided to residents eating outside of traditional/scheduled times. Food must be suitable, nourishing, and consistent with care plan. F369, appropriate assistance is provided to the resident to use the assistive devices when consuming meals and snacks.
105. §483.60 Food and Nutrition Services—continued
Key points to look for at F371: Foods from local producers meet applicable state and local laws or regulations. Produce from facility gardens are grown and handled safely. Explicit requirement that residents are able to have foods from outside the facility. F373, Interdisciplinary team is responsible for assessing resident for having a feeding assistant, not just the charge nurse; and the rationale for resident being in feeding assistant program should be reflected in the comprehensive care plan of the resident.

106. Specialized Rehabilitation Services Overview
And now we’ll take a look at the Overview for Specialized Rehabilitation Services.

107. §483.65 Specialized rehabilitative services
We’ll find the addition of respiratory service to those services identified in this section.

108. §483.65 Specialized rehabilitative services—continued
Key points to look for at F406: Facility provides, either directly or from an outside resource, respiratory services or services of a lesser intensity as required at §483.12. If any specialized rehabilitative services are provided by an outside resource, the requirements at §483.70 should be met.

109. Administration Overview
And now the Overview for the Section of Administration

110. §483.70 Administration
Various portions of this section have been relocated into subpart B.

111. §483.70 Administration—continued
F251 Key points to look for: Social workers - bachelor's degrees can now include gerontology. F492, the regulatory language provides additional protection against discrimination and for protection for health information.

112. §483.70 Administration—continued
Key points to look for at F493 is to ensure that the administrator reports to and is accountable to the governing body. F514, the medical record should include the resident's representative. And the surveyor should ensure that records be kept confidential and only released as authorized by the regulations.

113. §483.70 Administration—continued
Key points to look for at F519: When a resident is transferred to the hospital in an emergency situation by another practitioner, it is in accordance with facility policy and consistent with state law. Also, ensure the exchange of resident care information regardless of resident care setting to determine if they can return to the community or be placed in less restricted setting.
114. §483.70 Administration—continued
Key points to look for at F523: Written notification of an impending closure must be submitted by the facility to the following: State Survey Agency; State LTC ombudsman; Residents of the facility; Legal representative of the residents (or other responsible parties); and ensure the facility does not admit any new residents on or after the date the written notification is submitted.

115. §483.70 Administration—continued
The new regulation at F526 - Hospice Services is a process tag which is meant to identify what processes and procedures must be in place in order for Medicare certified hospice to be able to provide hospice services for a resident who elects the hospice benefit. This written agreement must be in place prior to a nursing home allowing a hospice to provide hospice care to a nursing home resident. When evaluating the provision of F526, the nursing home surveyor must not enforce or cite non-compliance of any Medicare hospice regulations during the course of a nursing home survey. The Medicare-certified hospice and the Medicare and/or Medicaid certified nursing home must each meet the certification regulations that apply to their entity. Each provider retains responsibility for the quality and appropriateness of care it provides in accordance with their respective laws and regulations.

116. §483.70 Administration—continued
Key points to look for F527: Facilities must electronically submit CMS complete and accurate staffing information, including information for agency and contract staff, based on payroll and other variable and audible data in a uniform format according to specifications established by CMS. 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.

117. Quality Assurance and Performance Improvement Overview
And now we’ll look at the Overview for Quality Assurance and Performance Improvement.

118. §483.75 Quality Assurance and Performance Improvement
Facilities will develop, implement, and maintain effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care, and quality of care.

119. §483.75 Quality Assurance and Performance Improvement—continued
Key points to look for at F520: Contains clarifying language regarding committee members. The facility must report to their governing body or designated persons regarding its activities; and the QA & A Committee must meet at least quarterly.

120. Infection Control Overview
The Infection Control Overview is next.

121. §483.80 Infection Control
Facilities are to develop an Infection Prevention and Control Program (IPCP).
122. §483.80 Infection Control—continued
Key points to look for at F441: The facility has developed and implemented an infection control program such as written policies and procedures to identify surveillance requirements: When and to whom to report infections; What types of transmission-based precautions will be used and when to use them; Infection control incidents and the facility’s corrective actions. Appropriate use of standard precautions including: Hand hygiene; Respiratory and cough etiquette; Use of personal protective equipment; injection practices; Safe handling of potentially contaminated equipment or surfaces are used and implemented. The IPCP policies and procedures are reviewed and updated annually.

123. Physical Environment Overview
And now the Physical Environment Overview.

124. §483.90 Physical Environment
Facilities are constructed, re-constructed, or newly certified after the effective date of this regulation to accommodate no more than two residents in a bedroom; and facilities that are constructed, or newly certified after the effective date of this regulation to have a bathroom equipped with at least a commode and sink in each room.

125. §483.90 Physical Environment—continued
Key points to look for at F457: Bedrooms must accommodate no more than two residents. Key points to look for at F457, for facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. At F461, the facility should conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.

126. §483.90 Physical Environment—continued
F461, key points to look for: The resident room must be equipped with/or located near toilet and bathing facilities. If the facility received approval of construction, or are newly certified after November 28, 2016, each residential room must have its own bathroom equipped with at least a commode and sink.

127. Training Requirements Overview
And now, we’ll look at the Training Requirements Overview.
128. §483.95 Training Requirements
This is a new section to subpart B. The facility must develop, implement, and maintain an effective training program for all new and existing staff... STOP...additional slides on training added and revisions to deck occurred in real time. Under Training Requirements new section...STOP...do over...A new section to subpart B in the Training Requirements: Facilities must develop, implement, and maintain an effective training program for all new and existing staff. Other individuals must be trained consistent with their specific roles including contract staff and volunteers.

129. §483.95 Training Requirements
Key points to look for at F495, this addresses required in-service training for nurse aides; includes dementia management training and resident abuse prevention training. At 373, a facility must not use an individual working in the facility as a paid feeding assistant unless the individual has successfully completed a State-approved training program for feeding assistants.