Final Rule: Phase 1...moving down the road
Missouri Health Care Association Mid-Year Conference

Objectives

• Participants will be able to verbalize understanding of the changes in Resident Rights in Final Rule Phase 1
• Participants will be able to verbalize understanding of how Quality of Life Regulations and Quality of Care Regulations are integrated in Final Rule Phase 1
• Participants will be able to verbalize understanding of changes in Physician Services, Nursing Services, Pharmacy Services, Diagnostic Services and Dental Services in Final Rule Phase 1
• Participants will be able to verbalize understandings of changes to Food and Nutrition Services in Final Rule Phase 1
Remember the “Why”

The simple act of caring is HEROIC

-Edward Albert

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<th>Phase</th>
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| Phase 1 | * Resident Rights and Facility Responsibilities*  
| (*) this section is partially implemented in Phase 2 and/or 3 | * Freedom from Abuse Neglect and Exploitation*  
| | * Admission, Transfer and Discharge*  
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Resident Rights & Facility Responsibilities

Resident Rights

- **CMS Summary**: Current regulations at §483.10 address a number of resident rights and facility requirements, including those establishing a resident's right to exercise his or her rights, including rights associated with a dignified existence, self-determination, planning and implementing care, access to information, privacy and confidentiality...retained all existing residents' rights but updated language & organization of the resident rights provisions to improve logical order & readability, to clarify aspects of the regulation that warranted it, & to update provisions to include technological advances such as electronic communications.

- Clarified resident's right to be supported in his/her exercise of rights; the facility ensure that the resident could exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

- Staff must be trained with regard to resident rights & facility responsibilities regarding resident rights.
Resident Rights

- Includes parallel “facility responsibilities” into resident rights requirements. For example, as a resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality, and protect the rights of the resident, including equal access to quality care.

- Resident must receive information (oral and written) in language that he or she can understand about various topics, including their rights, medical condition, Medicare and Medicaid benefits, and information about how to contact their physician.

- The facility must furnish a written description of legal rights, including a list of and contact information for all pertinent State regulatory and informational agencies and advocacy groups.

Resident Rights

- Exercise his/her rights
- Be informed about what rights & responsibilities resident has
- If he/she wishes, have facility manage personal funds
- Choose a physician & treatment & participate in decisions & care planning
- Privacy & confidentiality
- Voice grievances & have facility respond to those grievances
- Examine survey results-3 years

- Work or not work
- Privacy in sending & receiving mail
- Visit & be visited by others from outside facility including advocates
- Use a telephone in privacy including TTY & TDD services
- Retain & use personal possessions to maximum extent that space & safety permit
- Share a room with a spouse if that is mutually agreeable
- Self-administer medications if IDT determines it is safe
- Refuse a transfer from a distinct part within institution
Resident Rights

• Resident representative:
  • Resident has the right to designate a representative in accordance with State law, and the resident representative has the right to exercise the resident’s rights to the extent those rights are delegated to them. The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.
  • The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse.
  • If the facility has reason to believe the representative is making decisions or taking actions not in the resident’s best interest, the facility shall report such concern in a manner required under State law.

• Facility must have a policy and procedure for and inform residents (or their representative, where appropriate) of the visitation rights of the resident, including any clinical or safety restriction or limitation of such rights when consistent with the regulation.

• Resident has a right to choose his or her attending physician, and that physician must be licensed to practice and meet facility requirements (credentialing).

• If resident deposits personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident’s funds (NOTE: This was moved from guidance into regulation to strengthen the expectation of facilities).
Resident Rights

• Resident has a right to receive written notice, including the reason for the change when the resident's room or roommate in the facility is change and added a new, final (e)(7)(iii) to clarify that a room change cannot be solely for the convenience of staff.

• Resident has a right to share a room with his or her roommate of choice when practicable, including sharing a room with his or her spouse when married residents live in the same facility.
  • It does not require the provision of a private room.
  • Included the phrase “when practicable”, as such arrangements may not always be possible, or may require some delay in order to accommodate

• Resident has the right to reasonable access to and privacy in their use of electronic communications.

• Facility must have a grievance policy and a Grievance Official responsible for overseeing the grievance process.

Resident Rights

• Expectation that the discussions resulting from these rights would include discussions tailored to the resident's specific situation, including, as appropriate, discussions around the types of care that would be covered by Advance Directives.

• Rule requires that a facility provide to a resident a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
  • A safe, home-like environment includes the security of the residents' personal belongings.
  • Added language stating that the facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
  • Personal possessions must comply with fire safety
    • Require that such use must not infringe upon the safety of other residents.
    • Facilities are required to comply with requirements related to Life Safety Code
Resident Rights

- One resident’s use of video communications must not infringe upon the rights of other residents
- Clarified in §483.10(c)(5) that the physician or other practitioner or professional informs the resident of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options
- Stricter standard imposed retaining the addition of availability of any plan of correction in effect with respect to facility, as proposed, and including the requirements that the notice of availability of such reports are prominent and accessible to the public and shall not make available identifying information about complainants or residents
- Facility must take reasonable steps, with the approval of the group (Resident or Family Council), to make residents and family members aware of upcoming meetings in a timely manner
  - Added “or other guests” to the list of individuals who may only attend a resident or family group meeting at the group’s invitation

Resident Rights

- Admission contract, whether the facility requires it or not, must not conflict with the requirements of these regulations
- Facility must exercise reasonable care for the protection of the resident’s property from loss or theft
  - “Not request or require residents or potential residents to waive potential facility liability for losses of personal property”
Abuse, Neglect & Exploitation

New & Revised Definitions

• “Abuse”: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.”

• “Adverse Event”: Harm resulting from medical care

• “Exploitation”: taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion
New & Revised Definitions

• “Mistreatment”: Inappropriate treatment or exploitation of a resident

• “Neglect”: The failure of the facility, its employees or service providers to provide goods & services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress

Abuse, Neglect, and Exploitation

• CMS Summary: We are requiring facilities investigate and report all allegations of abusive conduct. We also are specifying that facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property.
Freedom from Abuse, Neglect & Exploitation

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

• “Convenience” is defined as any action taken by the facility to control a resident’s behavior or manage a resident’s behavior with a lesser amount of effort by the facility and not in the resident’s best interest.

• “Discipline” is defined as any action taken by the facility for the purpose of punishing or penalizing residents.

ANE

• “Medical Symptom” is defined as an indication or characteristic of a physical or psychological condition.

• The physician’s order alone is not sufficient to warrant the use of the restraint. It is further expected, for those residents whose care plans indicate the need for restraints, that the facility engages in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). This systematic process would also apply to recently admitted residents for whom restraints were used in the previous setting.
ANE

• § 483.12(a) The facility must—

• (3) Not employ or otherwise engage individuals who—

• (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

• (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

• (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property

ANE

• Requires written policies and procedures that:

• Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

• Establish policies and procedures to investigate any such allegations,

• Include training as required in § 483.95,

• Establish coordination with the QAPI program required under § 483.75, and

• Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act.

• The policies and procedures must include 7 specific components specified in the rule.
ANE Reporting Clarification from AHCA

- CMS interprets this language to mean: all allegations of abuse, and injuries of unknown source that result in serious bodily injury, MUST be reported to the State Agency immediately upon awareness of the allegation of abuse or knowledge of serious bodily injury of unknown source and no longer than 2 hours after becoming aware of the allegation or injury of unknown source.

- The guidance, to be released no later than November 2017, will hopefully provide additional clarification. I hope this information is helpful to you and your members.

Admission, Transfer and Discharge
Admissions, transfers & discharges

- Discharge appears 76 times
- Transfer appears 55 times
- Discharge & Transfer requirements appear in:
  - 483.11 Facility responsibilities
  - 483.15 Admissions, transfers & discharge rights
  - 483.20 Resident assessment
  - 483.21 Comprehensive person-centered care planning
  - 488.426 Transfer of residents, or closure of the facility & transfer of residents

Understand the regulatory intent

- Increase ability of residents who want to go home to be discharged
- Provide information to facilitate care coordination during transitions
- Treat all discharges the same regardless of residents’ Payor status
- Decrease inappropriate transfers or discharges
- Provide information to residents & their representative about:
  - Post-discharge plans & follow-up
  - Their rights to remain or return to facility
  - Due process for discharges & transfers
F177 Transfer to Another Room In the Facility

• §483.10(e)(7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
  • to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
  • to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
  • solely for the convenience of staff.

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

Increase ability of residents who want to go home to be discharged

• 483.21-c) Discharge planning: (1) The facility must develop & implement an effective discharge planning process that focuses on:
  • Resident's discharge goals
  • Preparing residents to be active partners in post-discharge care
  • Effective transition of the resident from SNF to post-SNF care
  • Reduction of factors leading to preventable readmissions
Discharge planning starts at admission

- 483.21 Comprehensive person-centered care planning: (iv) in consultation with the resident & the resident’s representative(s)
  - The resident’s goals for admission & desired outcomes
  - The resident’s preference & potential for future discharge
    - Facilities must document whether the resident’s desire to return to the community was assessed & any referrals to local contact agencies and/or other appropriate entities, for this purpose
  - Discharge plans in the comprehensive care plan as appropriate

Discharge planning process

- 483.21 The facility’s discharge planning process must:
  - Ensure that the discharge needs of each resident are identified & result in the development of a discharge plan for each resident
  - Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes
  - Involve the interdisciplinary team, as defined by 483.21(b)(2)(ii) in the ongoing process of developing the discharge plan
Discharge planning process

- Consider caregiver/support person availability & the resident’s or caregiver’s/support person(s) capacity & capability to perform the required care as part of the identification of discharge needs
- Involve the resident & resident representative in the development of the discharge plan and inform the resident & resident’s representative of the final plan
- Address the resident’s goals of care & treatment preferences
- Document that the resident has been asked about their interest in receiving information regarding returning to the community

Involvement of resident

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

• (vii) Document that a resident has been asked about their interest in receiving information about returning to the community
  • If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose
  • Facilities must update a resident’s comprehensive care plan & discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities
  • If discharge to the community is determined to not be feasible, the facility must document who made the determination & why

Residents prepared for discharge

• 483.15 Facility Responsibilities. (7) Orientation for transfer or discharge:
  • Facility must provide and document sufficient preparation & orientation to residents to ensure safe & orderly transfer or discharge from the facility. This orientation must be provided in a form & manner that the resident can understand
Tips on how to comply

- Develop a resident discharge plan template with:
  - Resident goals
  - Resident preference for discharge
  - Referrals to local agencies made
  - Services needed after discharge
  - Capacity of resident & caregiver to provide services
  - Discharge feasible or not

- Resident education & orientation to discharge
- Resident & representative involvement in plan
- Interdisciplinary team members involvement in plan
- Date last updated
- Date comprehensive assessment completed
- Date shared with resident &/or representative

Providing quality info at discharge

- Assist residents & their resident representative in selecting a post-acute care provider (e.g. SNF, HHA, IRF, or LTCH) by using data that includes, but is not limited to:
  - Standardized assessment data
  - Data on quality measures
  - Data of resource use to the extent data is available

- Information needs to be “relevant and applicable to the resident’s goals of care & treatment preferences.”
Use Medicare compare site

- Doctors & other health professionals
- Nursing homes
- Hospitals
- Home health services
- Dialysis services
- Health & drug plans
- Suppliers of medical equipment & supplies

Transfers & discharges are appropriate

- Involuntary Discharges
- 483.15 The documentation must be made by the resident’s physician when transfer or discharge is necessary
  - Documentation in the resident’s medical record must include:
    - The basis for the transfer
    - The specific resident need(s) that:
      - Cannot be met
      - Facility attempts to meet the resident needs, and
    - The service available at the receiving facility to meet the need(s)
Treat discharges same regardless of payor

• 483.11 Facility responsibilities & 483.15 Transitions of Care

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

Criteria for discharge & transfers #1

• 483.15 (1) Facility requirements—ii) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:
  • The transfer or discharge is necessary for the resident’s welfare & the resident’s needs cannot be met in the facility
  • The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility
  • The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident
  • The health of individuals in the facility would otherwise be endangered
Criteria for discharge & transfers #2

• 483.15(1) Facility requirements-ii) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:
  • The resident has failed, after reasonable & appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment does not apply unless the resident does not submit the necessary paperwork for third party payment or until the third party, including Medicare or Medicaid, denies the claim & the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
  • The facility ceases to operate

No discharge/transfers pending appeal

• 483.15 The facility may not transfer or discharge the resident while the appeal is pending, pursuant to 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to 431.220(a)(3) of this chapter
Tips to comply

- Develop an internal checklist to follow that:
  - Lists criteria for transfer or discharge that resident meets
  - Physician note & order in chart
  - Document discharge summary complete
  - Resident & representative notified
  - Resident oriented to discharge follow up
  - Status of any appeal

- Use a template discharge/transfer order to be signed by the physician that states:
  - Why person needs to be transferred or discharged
  - Why facility can’t meet the needs of the resident
  - What services the resident needs following discharge

Documentation to Help with Care Coordination

- 483.12(b) Transfer & discharge-(2)
- Documentation
  - When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (b)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider
Discharge summary requirements

• 483.15 Resident Assessment (2) Documentation.
• (i) Documentation in the resident’s medical record must include:
  • (A) The basis for the transfer per paragraph (b)(1)(ii) [AKA criteria]
  • (B) the specific resident need(s) that
    • Cannot be met
    • Facility attempts to meet the resident needs
    • The service available at the receiving facility to meet the need(s)

Discharge summary requirements

• 483.21 Resident Assessment (2) Discharge Summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to the following:
  • A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of disorder/treatment or therapy, & pertinent lab, radiology, & consultation results
  • A final summary of the resident's status to include items in the comprehensive assessment at the time of discharge
  • Reconciliation of all pre-discharge medications with the resident’ post-discharge medications (both prescribed & over-the-counter)
  • A post-discharge plan of care that is developed with the participation of the resident, and with the resident's consent, the resident representative, which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care & any post-discharge medical & non-medical services
Discharge summary requirements

- **483.15** Discharge summary document must be made by (B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following:
  - Contact information of the practitioner responsible for the care of the resident
  - Resident representative information including contact information
  - Advance Directive information
  - All special instructions or precautions for ongoing care, as appropriate
  - Comprehensive care plan goals
  - All other necessary information, including a copy of the resident's discharge summary, consistent with 483.21©(2), as applicable, & any other documentation, as applicable, to ensure a safe & effective transition of care

**Tips to comply**

- **Create a Discharge Summary Template** that has headings for:
  - Reason for discharge or transfer
  - List resident's medical history specified in 483.15 (prior slide)
  - List specified in 483.21 (prior slide)
  - Resident orientation about transfer completed
  - Residence of the resident’s post-discharge
  - Follow-up plans for resident post-discharge
  - Resident's consent acquired to share information
  - Physician name & signature & date
Resident notice before transfer

- 483.15 Transitions of Care (3) Before a facility transfers or discharges a resident, the facility must-
  - Notify the resident and the resident's representative(s) of the transfer or discharge & the reasons for the move in writing & in a language & manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
  - Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section [ADA clinical discharge summary].
  - Include in the notice the items described in [contents of Notice] section.

Timing of notice

- 483.15 Transitions of Care; (4) Timing of the notice
  - (i) Except as specified in (ii) and (b)(8) [AKA closure of facility], the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
  - (ii) Notice must be made as soon as practicable before transfer or discharge when
    - (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section.
    - (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section.
    - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge under paragraph (b)(1)(ii)(B) of this section.
    - (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section.
    - (E) A resident has not resided in the facility for 30 days.
Content of notice #1

- 483.15(5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:
  - (i) The reason for transfer or discharge
  - (ii) The effective date of transfer or discharge
  - (iii) The location to which the resident is expected to be transferred or discharged
  - (iv) A statement including the name, address (mailing & email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form & assistance in completing the form & submitting the appeal hearing request
  - (v) The name, address (mailing & email) & telephone number of the Office of the State Long-Term Care Ombudsman

Content of notice #2

- (vi) For nursing facility residents with intellectual & developmental disabilities, the mailing and email address & telephone number of the agency responsible for the protection & advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance & Bill of Rights Act of 2000 (42 U.S.C.10802)

- (vii) For nursing facility residents with mental disorder, the mailing & email address & telephone number of the agency responsible for protection & advocacy of individuals with mental disorder established under the Protection & Advocacy for Mentally Ill Individuals Act
Changes to notice

• (6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

Notice of Bed-hold Policy & readmission

• (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
  • (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return & resume residency in the nursing facility;
  • (ii) The reserve bed payment policy in the state plan, under 447.40 of this chapter, if any
  • (iii) The nursing facility’s policies regarding bed-hold periods, which must be consistent with paragraph (c)(3) of this section, permitting a resident to return;
  • (iv) The information specified in paragraph (c)(3) of this section [AKA permitting resident to return]
Bed hold notice upon transfer

• (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section [AKA content of bed hold policy]

(3) Permitting Return of resident

• A nursing facility must establish & follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following:
  • (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns, to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—
    • (A) Requires the services provided by the facility
    • (B) Is eligible for Medicare SNF services or Medicaid nursing facility services
  • (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges
Tips to comply

• Incorporate transfer & discharge & bed hold practices into admission consent & admission orientation material for residents and their representative(s)

• Create a checklist to make sure all required notification steps are followed in specified time frames

• Develop handout on advocacy organizations including addresses & email addresses for:
  • State Ombudsman
  • Agency responsible for individuals with developmental disabilities
  • Agency responsible for individuals with mental disorder

Summary: impact & approach

• Incorporate discharge planning starting at admission & include in care plan

• Discharge Summary will need more information on all transfers & discharges

• Recommend developing template for facility to help complete

• Will need to involve (& document) resident & family members/representative(s)

• Need good medication list to reconcile with medications they will take upon discharge from facility
Resident Assessment

• Facility must coordinate assessments with the pre-admission screening & resident review (PASARR) program under Medicaid to maximum extent practicable to avoid duplicative testing & effort. Coordination includes:
  • Incorporating the recommendations from the PASARR level II determination & the PASARR evaluation report into a resident's assessment, care planning & transitions of care
  • Referring all level II residents & 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
Resident Assessment

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

• The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual—
  • Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
  • Who requires nursing facility services for the condition for which the individual received care in the hospital, and
  • Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

Resident Assessment

• §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
Comprehensive, Person-Centered Care Planning

Person-Centered Care

• “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.

• Care planning involves identification of the resident’s interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident’s involvement/engagement in activities.

• In addition to the activities component of the comprehensive care plan, information may also be found in a separate activity plan, on a CNA flow sheet, in a progress note, etc.
Person Centered Care Planning

- Facility must ensure that the care planning process facilitates the inclusion of the resident or resident representative, includes an assessment of the resident's strengths and needs, and incorporates the resident's personal and cultural preferences in developing goals of care.

- Adding a nurse aide and a member of the food and nutrition services staff to the required members of the interdisciplinary team that develops the comprehensive care plan.

- Requires that facilities develop and implement a discharge planning process that focuses on the 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.

Person-Centered Care Plan

- Resident has the right to see the care plan, along with the right to sign it after significant changes.

- The intent is to ensure that the resident, to the extent practicable and consistent with the resident's choices, demonstrates his or her participation in and review of his or her care planning and that participation is evident to care-givers, surveyors, and other interested parties.

- If resident and representative(s) do not participate in development of plan, an explanation must be included in the resident’s medical record.

- Services must be culturally-competent and trauma-informed. NOTE: trauma-informed is a Phase 3 requirement.

- Must include specialized services or specialized rehabilitation services as a result of PASARR recommendations; goals for admission and preference for further discharge; and discharge plans.
Quality of Life

• F309
• § 483.24 Quality of life

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

• The intention of the quality of life requirements is to specify the facility’s responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.

F240

• §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality.

• The facility must protect and promote the rights of the resident.

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

- F309
- § 483.24 Quality of life

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

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

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

• Dementia Care
  • A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. [§483.40(b)(3) will be implemented beginning November 28, 2017 (Phase 2)]

Dementia Care (Cont)

• It is expected that the resident’s record reflects the implementation of the following care processes:
  • Recognition and Assessment;
  • Cause Identification and Diagnosis;
  • Development of Care Plan;
  • Individualized Approaches and Treatment;
  • Monitoring, Follow-up and Oversight; and
  • Quality Assessment and Assurance (QAA).
Hospice Services F526

• §483.70(o)(1) A long-term care (LTC) facility may do either of the following:
  • (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
  • (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

• §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
  • (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
  • (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: Review for requirements of agreement...

Incontinence (F315)

• (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

• (2) For a resident with urinary incontinence, based on the resident’s comprehensive assessment, the facility must ensure that—
  • (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary;
  • (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is necessary and...
Incontinence (F315)

- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

- (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

Physician Services
Physician Services

• F385: A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident’s immediate care and needs.

• F390: Physician delegation of tasks in SNFs: resident’s attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who—
  • (i) Is acting within the scope of practice as defined by State law; and
  • (ii) Is under the supervision of the physician.

Physician Services

• §483.30(e)(3) A resident’s attending physician may delegate the task of writing therapy orders, consistent with §483.65, to a qualified therapist who—
  • (i) Is acting within the scope of practice as defined by State law; and
  • (ii) Is under the supervision of the physician.
• 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

• §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.
Nursing Services

• §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

Nursing Services

• DEFICIENCY CATEGORIZATION (See SOM Appendix P, Part IV)

• Surveyors should be mindful of the elevated risk of psychosocial harm associated with the regulation at tag F353 that may lead to noncompliance, and consider this during their investigation.

• Once the team has completed their investigation, analyzed the data, reviewed the regulatory requirements, and identified any deficient practice(s) that demonstrate that noncompliance with the regulation at F353 exists, the team must determine the scope and severity of each deficiency, based on the resultant harm or potential for harm to the resident.

• The survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to sufficient staffing. See also the Psychosocial Outcome Severity Guide and Investigative Protocol in Appendix P, Part IV, Section E for additional information on evaluating the severity of psychosocial outcomes.
Pharmacy Services

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

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug (F329).

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility’s medical director and director of nursing and lists, at a minimum, the resident’s name, the relevant drug, and the irregularity the pharmacist identified.
Pharmacy Services

• (iii) The attending physician must document in the resident’s medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident’s medical record.

• (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

Laboratory, Radiology and Other Diagnostic Services
Diagnostic Testing: Laboratory and Radiology Testing

- F504: (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

- F505: Promptly notify 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.

- F510: Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

- F511: Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of 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.

Dental Services
Dental Services

• The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities

• A facility—Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;

• §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

• §483.55(a)(4) Must if necessary or if requested, assist the resident;
  • (i) In making appointments; and
  • (ii) By arranging for transportation to and from the dental appointment

• §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
Food & Nutrition

F322 Assisted Nutrition and Hydration

- (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—

- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

- §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

- “Avoidable” means there is not a clear indication for using a feeding tube or there is insufficient evidence that it provides a benefit that outweighs associated risks.

- “Unavoidable” means there is a clear indication for using a feeding tube or there is sufficient evidence that it provides a benefit that outweighs associated risks.
F360 Food & Nutrition

- §483.60 Food and nutrition services.

- The facility must 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.

F361 Food & Nutrition Staffing

- §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-

  - Holds a bachelor’s or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

  - Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

  - Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

  - For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.
F361 Food & Nutrition Staffing (Cont)

- §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who--
  - For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
    - A certified dietary manager; or
    - A certified food service manager; or
    - Has similar national certification for food service management and safety from a national certifying body; or
    - Has an associate’s or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
  - In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
  - Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

F362 Support Staff

- §483.60(a)(3) Support staff.
  - The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.
    - “Sufficient support personnel” is defined as enough staff to prepare and serve palatable, attractive, nutritionally adequate meals at proper temperatures and appropriate times and support proper sanitary techniques being utilized.
  - §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).
F363 Menus & Nutritional Adequacy

• Menus must
  • §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines;
  • §483.60(c)(2) Be prepared in advance;
  • §483.60(c)(3) Be followed;
  • §483.60(c)(4) Reflect, based on a facility’s reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;
  • §483.60(c)(5) Be updated periodically;
  • §483.60(c)(6) Be reviewed by the facility’s dietitian or other clinically qualified nutrition professional for nutritional adequacy; and
  • §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident’s right to make personal dietary choices.

F366 Food Prepared in Form Designed to Meet Individual Needs

• §§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;

• §§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and

• §§483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.
F368 Frequency of Meals

- §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.

- §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

- §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

F371 Food Safety Requirements

- §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
  - This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
  - This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
  - This provision does not preclude residents from consuming foods not procured by the facility.

- §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

- §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
Therapeutic Diets

• §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.

• §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by State law.

Specialized Rehabilitation
Specialized Rehabilitative Services

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

• In consultation with the resident and the resident’s representative(s)—
  • The resident's goals for admission and desired outcomes.
  • The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
  • Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Specialized Rehabilitative Services

• F406
• §483.65 Specialized rehabilitative services.

• Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident’s comprehensive plan of care, the facility must—
  • Provide the required services; or
  • In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.
• §483.70(c) Relationship to Other HHS Regulations.

• In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.
Administration

• Reports to and is accountable to the governing body.

• Transfer agreement
  • Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law
  • Receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii).

Administration

• §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.
Intent & Purpose

Have a system that

a. Monitors and investigates current practices to
   • Prevent adverse events
     • Definition: “Harm resulting from medical care”
     • Increases consistent use of evidence based practices

b. Creates teams to make changes to achieve better outcomes
The First Law of Improvement

Every system is perfectly designed to achieve exactly the results it gets

-Paul Batalden, MD, Dartmouth

Phase 1 Requirements

• Form a QAA Committee for facility with at least the following 5 members:
  • DON
  • Medical Director or designee
  • At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and
  • The infection control and prevention officer.
• Inform QAA committee that documents may be requested to evaluate regulatory compliance: NOTE: Facility does not need to share all the details & information from the QAA committee but do need to show information on how they address adverse events & how they follow the QAPI processes
Phase 1 Requirements

• The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
  • Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary
  • Develop and implement appropriate plans of action to correct identified quality deficiencies;
  • Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

Phase 1 Requirements

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

• §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
Infection Control

Overview of Requirement for Infection Prevention & Control

- Expands required elements of center’s Infection Prevention & Control Program (IPCP)
- Conduct annual review of center’s IPCP and update program as necessary
- Incorporates language change from resident’s legal representative to resident’s representative.
Infection Control

- Written standards, policies, and procedures for the program, which must include, but are not limited to:
  - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  - When and to whom possible incidents of communicable disease or infections should be reported;
  - Standard and transmission-based precautions to be followed to prevent spread of infections;

- When and how isolation should be used for a resident; including but not limited to:
  - The type and duration of the isolation, depending upon the infectious agent or organism involved, and
  - A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
  - The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
  - The hand hygiene procedures to be followed by staff involved in direct resident contact.

- Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
Phase 1: November 28, 2016
Implementation Strategies

• Review Influenza and Pneumococcal immunization policies & procedures to determine if consistent with changes to requirements
  • Consider changing language in policy from resident’s legal representative to resident’s representative
  • At time of admission, must determine current immunization status & if have not received vaccine must offer if admission occurs between October 1 & March 31

Phase 1: November 28, 2016
Implementation Strategies

• Review organizational practices related to linen handling, storage, process and transport to ensure they are consistent with preventing spread of infection
Phase 1: November 28, 2016
Implementation Strategies

• Provide training to all staff in accordance with facility’s IPCP

• Incorporate identified areas for process improvement from steps above into QAPI program
  • Infection Control Domains for Gap Assessment:
    • Infection Control Program and Infrastructure
    • Healthcare Personnel and Resident Safety
    • Surveillance and Disease Reporting
    • Hand Hygiene
    • Personal Protective Equipment (PPE)
    • Respiratory/ Cough Etiquette
    • Antibiotic Stewardship
    • Injection safety and Point of Care Testing
    • Environmental Cleaning
Physical Environment

Physical environment (483.90)

• Maintain all existing and additions
• Conduct regular inspection of all bed frames, mattresses & bed rails to identify areas of possible entrapment
• Be equipped to allow residents to call for staff assistance through communication system which relays the call directly to a staff member or to a centralized staff work area from each resident’s bedside (Phase 3)
• Establish policies, in accordance with applicable Federal, State, & local laws & regulations, regarding smoking, smoking areas & smoking safety that also take into account non-smoking residents (Phase 2)
• New construction or reconstruction: each room accommodate no more than 2 residents & each room have its own bathroom
Whew! Thank You All
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