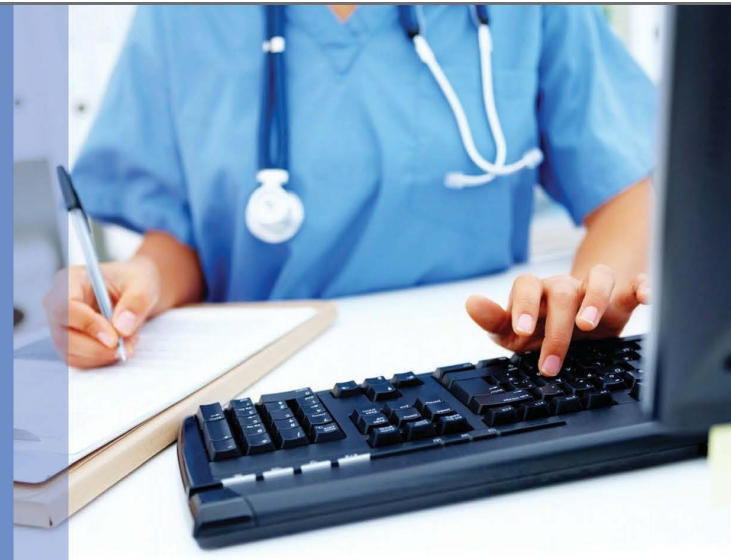


Synopsis of Federal Regulations in the Nursing Facility

Implications for Attending Physicians & Medical Directors



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SYNOPSIS OF FEDERAL REGULATIONS IN THE NURSING FACILITY

Implications for Attending Physicians / Non-Physician Practitioners and Medical Directors

Revised 2025¹

Where do these regulations come from?

Congress passes federal laws, which the Executive Branch must interpret and implement.

The Executive Branch includes the Office of the President as well as federal departments and agencies. The Centers for Medicare and Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS), is responsible for managing federal health care programs such as Medicare. CMS' functions include administering the program, paying claims, and writing regulations regarding such programs. Medicaid is a joint federal and state program, with CMS writing regulations that states then administer.

The 1987 Omnibus Budget Reconciliation Act (P.L. 100-203) authorized nursing facility (OBRA '87) reform regulations, so named because they are based on the nursing home reform amendments contained in the law, were the first major revisions of federal nursing home requirements in almost two decades. This law expanded requirements for nursing home care. Over the past 30 years, CMS has been developing and updating related tools and guidance. In 2016, the regulations were extensively updated and expanded further, followed by the development of related tools and surveyor guidance and have been subsequently updated through 2025.

Where are the details of these requirements published?

These regulations are included in the *Code of Federal Regulations* (CFR), an indexed and codified compilation of all current substantive federal rules. These rules are divided into 50 "titles" covering major functional or administrative areas of government (for example, Title 21 – Food and Drugs; Title 40 – Protection of the Environment; Title 42 – Public Health; and Title 45 – Public Welfare). The CFR helps locate specific rules.

The *Federal Register* publishes changes in regulations as well as background information, comments, and responses. The *Federal Register* and the CFR are cross-referenced to one another.²

¹ CMS will post notifications of imminent releases to State Survey Agencies on its website at <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/quality-and-safety-special-alerts>

² Each title in the CFR is divided into levels covering a progressively narrower range of programs or administrative areas. The Index of the CFR refers to these levels: Titles; Subtitles; Chapter; Subchapter (roman numerals); Part; Subpart; and Subsection. For example, 42 part 405 refers to Title 42, part 405. Material cited in legal form shows the Title first, the reference CFR and then the part, subpart, and subsection numbers. 42 CFR 405.1101 refers to Title 42, Code of Federal Regulations, Part 405, Subsection 1101.

Federal Regulations affecting long-term care services are included in the CFR. The previous 42 CFR Part 405 – Medicare regulations for SNFs, and Part 442 – Medicaid regulations for SNFs and ICFs were combined into one set: **42 CFR part 483 – Medicare and Medicaid Requirements for Long-Term Care Facilities** and published in the *Federal Register* of February 2, 1989. The requirements became effective October 1, 1990, but the final version, with some further changes, was published in the September 26, 1991, *Federal Register*. Amendments and technical corrections were published as of September 23, 1992.

How are these regulations enforced?

The *State Operations Manual* (SOM) includes the guidelines for surveyors to interpret the regulations (including detailed instruction for conducting surveys and approaches to enforcement). There are also separate guidelines for enforcement and penalties. This synopsis includes revisions through 2023. The section of the SOM that includes the guidelines for surveyors of long-term care facilities is Appendix PP. This guidance is also sometimes referred to as the Interpretive Guidelines.

To qualify for federal reimbursement under Medicare and Medicaid, nursing facilities must meet these requirements. CMS has the authority to apply a wide array of sanctions for noncompliance. Some states have adopted similar requirements for all nursing facilities, even those that are not reimbursed by Medicare or Medicaid.

These requirements apply equally to Medicare Skilled Nursing Facilities (SNFs), and to Medicaid Nursing Facilities (NFs), the term replacing the former Medicaid Intermediate and Skilled Facility designations. However, they do not apply to ICFs for those with developmental delay or related conditions. Most nursing homes care for both skilled (SNF, sometimes referred to as Medicare Part A or post-acute) residents and custodial (NF, sometimes referred to as Medicaid or long-term care) residents.

The regulations require facilities to provide services to meet “the highest practicable physical, medical and psychological well-being” of every resident. The medical regimen must be consistent with the resident’s assessment (using a uniform assessment instrument known as the Minimum Data Set) and the interdisciplinary care plan. Any decline in the resident’s physical, mental or psychological well-being must be shown to be medically unavoidable.

What are the deficiency “Tags”?

Surveyors use the Interpretive Guidelines and additional Critical Element Pathways to help determine compliance with the requirements. Critical Element Pathways are investigative protocols used by the survey team to assess if the “critical elements” are met for the facility to be in compliance with Quality of Care or Quality of Life Indicators (QCLIs). These Critical Element Pathways are publicly available to be used as part of long-term care facilities’ quality program.

Each regulation has multiple subcomponents, and each of these is given a number. If a facility is found to be out of compliance with a regulation, the citation is referred to as an “F-Tag”; i.e. F-Tag or Tag Number (“TN” in the Synopsis). Violations of certain

Tags is designated as Substandard Quality Care. Violations are rated by how serious and widespread they are, this is referred to as “Scope and Severity”. Scope has 3 levels: isolated, pattern and widespread. Severity ranges from Level 1 (minor) to Level 4 (very serious, also called Immediate Jeopardy). The combination of these two results is captured as A (least serious) to L (most serious).

What does the attached information cover?

The Table below is provided as a reference document about what attending physicians / non-physician practitioners and medical directors can and should do, and why they should do it in a particular way, in order to provide good care and help the facility meet regulatory requirements. Many of these tasks are routine, while others can be done intermittently as the need arises.

The left-hand (“Regulation/Tag #”) column notes where the regulation can be found in the Code of Federal Regulations, and which Federal Tag will be cited if deficient practice is found. In the middle column, regulatory language is identified in the Table in **bold** text, Interpretive Guideline information is depicted in underlined text, and additional information relevant to practitioner compliance and good quality long term care is included in plain text.

The right-hand column (“Recommendations for Attending Physicians/NPPs, and Medical Directors”) identify things that attending physicians / non-physician practitioners and medical directors can do to simultaneously provide good quality care and support facility compliance. Sometimes, surveyors review directly for provider compliance, but they often infer it from their review of resident outcomes and overall facility care. Recently revised surveyor guidance instructs surveyors to interview medical directors about numerous issues. In addition, if an extended survey becomes necessary because of deficiencies in key parts of the survey, the surveyors may scrutinize medical director and attending physician compliance in even greater depth.

Every nursing home must have a medical director and every nursing home resident must have an attending physician. Many (but not all) of these recommendations that apply to nursing home attending physicians are also relevant to clinical responsibilities that are fulfilled by nonphysician practitioners (NPPs, including nurse practitioners, physician assistants and clinical nurse specialists). When a regulation specifically distinguishes between the responsibilities of physicians and non-physician practitioners, it will be noted in the right-hand column. NPPs should practice based on the same regulatory expectations as the attending physicians. Attending physicians cannot simply avoid their regulatory responsibilities by deferring to a NPP.

ATTENDING PHYSICIAN/NPP AND MEDICAL DIRECTOR RESPONSIBILITIES AND GUIDELINES UNDER OBRA '87

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Accidents	CFR483.25(d)(1)(2) <u>Quality of Care</u> TN:F689 483.25 (n)(1)-(4) Bed Rails TN: F700	<p>The facility must ensure that (1) the resident environment remains as free of accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><u>The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:</u></p> <ul style="list-style-type: none"> • <u>Identifying hazard(s) and risks(s);</u> • <u>Evaluating and analyzing hazard(s) and risk(s);</u> • <u>Implementing interventions to reduce hazard(s) and risk(s); and</u> • <u>Monitoring for effectiveness and modifying interventions when necessary.</u> <p>This requirement addresses the safety of the physical environment in addition to use of assistive devices and restraints, falls, resident smoking (including electronic cigarettes), resident-to- resident altercations and staffing for supervision. It also describes a “systems approach” that outlines a process for identification, evaluation, analysis, implementation, and monitoring the systems that the facility uses to address concerns regarding safety and supervision.</p> <p><u>Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home. Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents.</u></p> <p>Bed Rails</p> <p>483.25(n) – Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: (1) Assess the resident for risk of entrapment from bed rails prior to</p>	<p><u>AP:</u> Periodically review with staff and observe and document the resident’s situation and surroundings for risk factors and safety hazards, and notify staff of concerns. Review for the indications and appropriate use of any assistive devices and restraints. Evaluate the resident for medical conditions and medications and substance use that may increase fall risk or other complications and modify orders accordingly. Review the resident’s function and behavior with staff periodically. Guide the staff in developing a care plan to limit risk of injury that is based on a resident’s medical conditions, risk factors, and quality of life considerations.</p> <p><u>MDIR:</u> Periodically assess the facility’s practices and systems to help identify ways to reduce risks and improve safety. Observe for safety issues in the physical environment and report concerns. Evaluate how the facility’s policies and practices identify and address safety concerns. Guide the facility in optimizing its approaches to identifying and addressing risk factors and hazards, analyzing trends, and monitoring for ongoing effectiveness of interventions. Periodically evaluate if practitioners and staff are addressing identified risk concerns in their care of residents. Guide the facility in considering resident-level and facility-level safety in its quality-related discussions and actions. Help the facility review for appropriate use of bed rails.</p>

		<p>installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed’s dimensions are appropriate for the resident’s size and weight. (4) Follow the manufacturers’ recommendation and specifications for installing and maintaining bed rails.</p> <p><u>Facilities must attempt to use appropriate alternatives prior to installing or using bed rails. CMS encourages facilities to refer to published information from recognized authorities such as the Food and Drug Administration, which has identified the following alternatives to bed rail use: “Alternatives include: roll guards, foam bumpers, lowering the bed and using concave mattresses that can help reduce rolling off the bed.” This and more information may be found at:</u></p> <p><u>https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362843.htm</u></p>	
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		<p>This requirement is to ensure that prior to installation of bed rails, the facility has attempted to use alternatives; if the alternative that were attempted were not adequate to meet the resident's needs, the resident is assessed for the use of bed rails, including entrapment risk; and informed consent is obtained from the resident or, if applicable, the resident representative. The facility must ensure the bed is appropriate for the resident and that bed rails are properly installed.</p> <p>When a facility uses bedrails on a resident's bed, it must ensure correct installation, use, and maintenance of bedrails, including attempting to use alternatives prior to installing a side rail or bedrail, assessing the resident for risk of entrapment from bedrails prior to installation, reviewing the risks and benefits of bedrails with the resident and obtaining informed consent prior to installation, ensuring that the bed's dimensions are appropriate for the resident's size and weight, and following the manufacturer's recommendations and specifications for installing and maintaining bedrails.</p>	
Administration	<p>CFR483.70 TN: F835</p> <p>CFR§483.70(e) Facility Assessment TN: F838</p>	<p>Administration: A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Facility Assessment 483.70(e). The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</p> <p><u>The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.</u></p> <p>Facility Assessment 483.70(e). An annual facility assessment must be done that includes: the resident population (number, capacity, types of diseases/disabilities/acuity); staff competencies needed for the identified population; physical environment, equipment, services needed for the identified population; ethnic, cultural or religious factors (including impact on activities/food & nutrition); resources (buildings, vehicles, equipment; services (therapy, pharmacy); personnel (employed, contracted, volunteers with description of education and competencies; contracts to provide services/equipment (normal operations and emergencies); and health</p>	<p><u>AP</u>: Discuss periodically with the medical director the <i>nature, characteristics, and needs</i> of the patients and help identify any <i>gaps</i> in facility staffing and services.</p> <p><u>MDIR</u>: Actively participate in the facility assessment and be prepared to explain to surveyors how you were involved. Help the facility assess its <i>services and staffing</i> and its population's <i>characteristics and needs</i> and guide the facility in identifying areas for improvement.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		<p>information technologies.</p> <p>Facilities should not admit residents whose needs they cannot meet based on the Facility Assessment requirements.</p>	
Admission	<p>CFR483.30(a)(1)(2)</p> <p><u>Physician services</u></p> <p>TN: F710</p>	<p>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.</p> <p><u>A physician’s personal approval of an admission recommendation must be in written form. The written recommendation for admission to the facility must be provided by a physician and cannot be provided by an NPP. This may be accomplished through a hospital transfer summary written by a physician, paperwork completed by the resident’s physician in the community, or other written form by a physician. If a physician does not provide a written recommendation that the individual be admitted to the facility prior to the resident’s admission, the physician’s admission orders for the resident’s immediate care as required in §483.20(a) will be accepted as “personal approval” of the admission if the orders are provided by a physician. Admission orders in lieu of a physician’s written recommendation for admission to the facility cannot be provided by an NPP.</u></p> <p>In addition to a physician’s recommendation that the individual be admitted to a facility, a physician or NP/PA/CNS must provide orders for the resident’s immediate care and needs [483.40, introduction]. A physician must approve the admission but someone else can authorize the orders.</p> <p>The nursing facility must disclose to a resident or a potential resident prior to the time of admission, any special characteristics or service limitations of the facility.</p>	<p><u>AP:</u> Confirm that a resident needs <i>nursing facility placement</i> and help the facility identify alternative placement if necessary.</p> <p>Provide (or have a NP/PA/CNS provide) <i>orders</i> for the resident’s immediate care and needs.</p> <p>Review discharge potential at, or soon after, admission and periodically thereafter.</p> <p><u>MDIR:</u> Help the facility identify the <i>types and complexity</i> of patients that it can care for. Help the facility identify what it <i>needs to provide or obtain</i> to care for its admissions.</p> <p>Advise the facility on admissions policies that support <i>appropriate screening and selection</i> of prospective admissions, based on medical, functional, and psychosocial needs.</p> <p>Periodically review <i>physician/NP/PA compliance</i> with these expectations.</p>
Admission Orders	<p>CFR483.20(a)</p> <p><u>Resident assessments</u></p>	<p>At the time each resident is admitted, the facility must have physician orders for resident’s immediate care.</p> <p><u>“Physician orders for immediate care” are those written and/or verbal orders that facility staff need to provide essential care to the resident, consistent with the resident’s mental and physical status upon admission to the facility. These orders should, at a minimum, include</u></p>	<p><u>AP:</u> On admission, authorize <i>medical orders</i> needed to provide essential care, including diet and other treatment orders. Review the orders soon <i>after admission</i> for pertinence, doses, and possible causation of current medical or psychiatric instability or complications. Identify medications and other factors that may affect <i>appetite, nutritional status, and other conditions and risks</i>.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
	TN: F635	<p><u>dietary medications (if necessary) and routine care to maintain or improve the resident’s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.</u></p> <p>At the time of admission, a facility must have physician orders needed to provide essential care, consistent with the resident’s current mental and physical status.</p> <p>A physician’s personal approval of an admission recommendation must be in written form. The written recommendation for admission to the facility must be provided by a physician and cannot be provided by a NPP. This may be accomplished through a hospital transfer summary written by a physician, paperwork completed by the resident’s physician in the community, or other written form by a physician. If a physician does not provide a written recommendation that the individual be admitted to the facility prior to the resident’s admission, the physician’s admission orders for the resident’s immediate care as required in §483.20(a) will be accepted as “personal approval” of the admission if the orders are provided by a physician. Admission orders in lieu of a physician’s written recommendation for admission to the facility cannot be provided by a NPP.</p> <p>Many residents are admitted to a SNF/NF already on a psychotropic medication. The medication may have been started in the hospital or the community, which can make it challenging for the IDT to identify the indication for use. However, the attending physician in collaboration with the consultant pharmacist must reevaluate the use of the psychotropic medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission. Additionally, the facility is responsible for: • Preadmission screening for mental illness and intellectual disabilities, see §483.20(k), F645 and F646; and • Obtaining physician’s orders for the resident’s immediate care, see §483.20(a), F635.</p> <p>The physician’s admission orders for the resident’s immediate care as required in §483.20(a) will be accepted as “personal approval” of the admission if the orders are provided by a physician</p>	<p>Identify and address medical conditions and medications that may be affecting <i>function</i>. Identify high risk medications or conditions that should be monitored and schedule appropriate clinical evaluation or labs. Evaluate the indication for psychotropic medication(s) and consider if the medication is still indicated. Validate that any psychiatric diagnoses, especially schizophrenia and related diagnoses, were made based on an evaluation with evidence that the resident meets established professional criteria for the diagnosis (ex: DSM-5). If this documentation is not available, the resident should be evaluated to determine if they currently meet criteria for the diagnosis.</p> <p>MDIR: Guide the <i>physicians</i> about their <i>role</i> in the medical assessment and management of residents. Guide the facility about how to obtain <i>needed input from physicians</i> regarding medical issues and medications that affect function, behavior, medical conditions, and quality of life. Guide the facility regarding <i>essential medical orders</i>, including (but not limited to) on admission. As part of QA activities, <i>review diagnoses and orders</i> on new admissions selectively for pertinence, accuracy, and possible causation of current medical or psychiatric instability or complications. Identify whether physicians are <i>fulfilling</i> their <i>proper role</i> on new admissions, including actions to identify and address risk factors for hospital <i>readmissions</i>. Review for whether the physicians and staff are identifying and addressing <i>medical conditions and medications</i> that may be <i>affecting function</i>. Evaluate if there is a process for review of psychotropic medication use on admission. If a provider is not adhering to professional practices, address these deviations. Be prepared to discuss the process for recognizing and addressing deviations from professional standards during the survey process.</p>

<p>Admission Preadmission screening for Mental Disorders & Intellectual Disability (PASARR)</p>	<p>CFR483.20(k)(1)-(3)</p> <p>Preadmission screening for individuals with a mental disorder and individuals with intellectual disability</p> <p>Resident</p>	<p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <ul style="list-style-type: none"> • Mental disorder, unless the state mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and if the individual requires such level of services, whether the individual requires specialized services; or • Intellectual disability, unless the State intellectual disability or developmental disability authority has determined prior to admission that because of the physical and mental condition of the individual, the individual requires level of services provided by a nursing facility; and if the individual requires such level of services, 	<p><u>AP</u>: Help the facility validate and correct all <i>diagnoses</i>, including those related to psychiatric and behavioral issues.</p> <p>Guide the facility in what is required to meet a resident's <i>mental health and psychosocial needs</i> and adequately manage any behavior issues.</p> <p>Review and validate indications for all <i>medications</i>, including those intended to treat behavior and psychiatric issues and others that may affect mood, cognition, and behavior.</p> <p><u>MDIR</u>: Guide the facility's implementation of procedures</p>
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
	Assessments TN: F645	<p>whether the individual requires specialized services for intellectual disability.</p> <ul style="list-style-type: none"> Exceptions: The pre-admission screening program under (k)(1) of this section need not provide for determination 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- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. <p><u>The intent of this Section is to ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.</u></p> <p>A nursing facility cannot admit anyone with intellectual disability or a serious mental disorder unless a state agency screens and approves the admission, to ensure that the facility can provide appropriate services to meet the individual's needs. Residents who are readmitted to a nursing facility from a hospital, or those admitted from a hospital with an anticipated stay of less than 30 days who require treatment at the nursing facility for the same problem for which they were hospitalized, are exempt from such screening.</p>	<p>regarding <i>admissions and preadmission screening</i>, including the assessment and management of individuals with behavior and psychiatric issues (including, but not limited to, those with mental illness and developmental disability).</p> <p>Review the appropriateness of the overall <i>management of behavior and psychiatric issues</i> including diagnostic accuracy, management of underlying medical causes, and use of psychopharmacological medications, and guide the facility accordingly.</p> <p>Help the facility review the <i>quality of its services and care</i> for those with mental disorders and intellectual disabilities.</p>
Advance Directives, Consent and refusal of treatment or research	<p>CFR 483.10 (c)(6) CFR 483.10(c)(8) CFR483.10(g)(12) (i)-(v)</p> <p>Resident Rights TN: F578</p>	<p>The resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive as specified in in paragraph (8) below.</p> <p>(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>(12) The facility must comply with the requirements specified in 42 CFR part 489 subpart I (Advance Directives).</p> <p>i. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p>	<p><u>AP:</u> Inform the resident, or a legally authorized representative as required or indicated, about the <i>risks and benefits</i> of accepting or declining treatments, including life-sustaining treatments, relevant to the resident's goals, wishes, medical condition, and prognosis. Explain the resident's <i>medical condition</i> and other relevant medical considerations. Document the <i>rationale for recommendations and treatment decisions</i> related to these treatment options.</p> <p>Help the interdisciplinary team determine the resident's <i>decision-making capacity</i>.</p>

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		<p>ii. This includes a written description of the facility’s policies to implement advance directives and applicable State law.</p> <p>iii. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>iv. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual’s resident representative in accordance with State Law.</p> <p>v. The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p><u>The resident has the right to request treatment; however, facility staff are not required to provide medical treatment or services if the requested treatment or services are medically unnecessary or inappropriate. While the resident also has the right to refuse any treatment or services, the resident’s refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. For example, facility staff would still be expected to provide appropriate measures for pressure injury prevention, even if a resident has refused food and fluids and is nearing death.</u></p>	<p>Communicate with the interdisciplinary team about a resident’s <i>treatment choices</i>. Incorporate <i>treatment choices</i> into the medical <i>treatment plan</i> and <i>medical orders</i>. Periodically review whether the resident wishes to change or continue the existing <i>care instructions</i>, and inform the interdisciplinary team accordingly. Identify situations, such as a significant decline in the resident’s condition, requiring <i>healthcare decision making</i> and/or a review of current <i>advance care planning choices</i>.</p> <p>Review the <i>protocol and consent</i> form for any residents involved in experimental research and periodically assess any residents involved in a research activity and identify whether they wish to continue.</p> <p><u>MDIR</u>: Review the facilities’ policies and procedures on providing information to residents about advance directives, implementing advance directives and resident refusal of treatments or services.</p>
Assessments, comprehensive, of resident	CFR483.20(b)(1)(2)(i)(iii) <u>Resident assessment</u> TN: F636	<p>A facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.</p> <p>Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: identification and demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior patterns; psychosocial well-being; physical functioning and structural problems; continence; disease diagnosis and health</p>	<p><u>AP</u>: Review information about the residents to help <i>identify risk factors</i>, <i>validate diagnoses</i>, and <i>verify</i> that <i>interventions</i> are appropriate and not causing complications or increasing risk. Help the staff <i>interpret the meaning</i> of the information they collect via the assessment. <i>Clarify any discrepancies</i> between the information from the medical assessment, the diagnoses, and the staff’s findings and interventions. Guide the staff regarding the <i>pertinence of the care plan</i>, based on identification of medical issues and medications that cause or contribute to medical and</p>

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		<p>conditions; dental and nutritional status; skin conditions; activity pursuit; medications; special treatments and procedures; discharge planning; documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set; documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p><u>Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines and the CAAs) to assess each resident. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.</u></p>	<p>psychiatric symptoms or instability. Help the staff identify the <i>need for additional assessment</i> or reassessment, as indicated.</p> <p><u>MDIR:</u> Guide the physicians about their role in the <i>medical assessment and management</i> of residents. Guide the facility about how to <i>obtain needed input</i> from physicians regarding medical issues and medications that affect function, behavior, medical symptoms, and quality of life. As part of QA activities, review <i>diagnoses and orders</i> selectively for pertinence, accuracy, and possible relationships to current medical or psychiatric instability or complications. Identify whether physicians are <i>identifying and addressing medical conditions and medications</i> that may be affecting function and quality of life. Help the facility assess the <i>accuracy and pertinence</i> of its <i>care plans</i> relative to underlying medical causes of issues.</p>
Assessments, comprehensive, of resident (continued)	<p>CFR483.20(b)(2)-(d) <u>Resident assessment</u></p> <p>TN: F637</p>	<p>F637:A facility must conduct a comprehensive assessment of a resident as follows: within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.). The assessment must be updated not less often than once every 12 months.</p> <p><u>A Significant Change in Status Assessment (SCSA) including Care Area Assessments (CAAs) must be completed within 14 days after a determination has been made that a significant change in the resident's status from baseline occurred. This may be determined by comparison of the resident's current status to the most recent comprehensive assessment and most recent Quarterly assessment, and the resident's condition is not expected to return to baseline within 2 weeks. A SCSA is appropriate if there are either two or more MDS areas of decline or two or</u></p>	<p><u>AP:</u> <i>Diagnose</i> the <i>causes</i> of a resident's medical and psychiatric symptoms, including any significant changes in condition, and <i>guide staff</i> in implementing appropriate <i>interventions</i>. Review with staff <i>information obtained</i> from recent and previous health care providers prior to the current admission or readmission, especially regarding a clinically pertinent <i>rationale for diagnosis and treatment</i>, evidence of complications related to a recent stay in another setting, and the presence of risk factors (e.g., additional medications, skin injury) that may have arisen elsewhere. <i>Examine</i> individuals with significant condition changes, as needed. Document <i>pertinent history and physical</i> findings.</p> <p><u>MDIR:</u> Identify key components of <i>physician evaluation and documentation</i> for admissions, readmissions and significant condition changes. As part of QA activities, review cases for whether medical practitioners are appropriately <i>assessing new</i></p>

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		<u>more MDS areas of improvement or if the IDT determines that the resident would benefit from the SCSA assessment and subsequent care plan revision. The facility should document in the medical record when the determination is made that the resident meets the criteria for a Significant Change in Status Assessment.</u>	<i>admissions and readmissions</i> , identifying risk factors, <i>diagnosing and managing</i> complications and acute and other significant changes of condition, reviewing and validating diagnoses, reviewing and managing medication regimens, and documenting appropriately. Address any deviations from professional practices that are identified.
Assessments, comprehensive, of resident (continued)	CFR483.20(c) Resident assessment, quarterly (every 3 months) TN: F638	<p>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.</p> <p><u>At least every 92 days, the facility shall review each resident with respect to those MDS items specified in the CMS quarterly assessment (MDS).</u></p> <p><u>A Quarterly assessment is considered timely if:</u></p> <ul style="list-style-type: none"> • <u>The Assessment Reference Date (ARD) of the Quarterly MDS is within 92 days (ARD of most recent OBRA assessment +92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment) AND</u> • <u>The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).</u> <p><u>If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the Significant Change in Status Assessment.</u></p>	<p><u>AP:</u> Review and discuss <i>pertinent information</i> from the staff's resident assessment and correlate with medical information, to identify and help staff <i>understand</i> the <i>causes</i> of symptoms and impairments, risk factors, the <i>connection between</i> various <i>causes and consequences</i>, and the rationale and continued pertinence of both medical and nonmedical interventions. Help define each individual's <i>current overall condition, prognosis, and risk factors</i>. <i>Correlate medical findings</i> with key findings in the staff's assessment.</p> <p><u>MDIR:</u> Review adequacy of <i>physician assessments</i> and <i>participation</i> in analyzing and clarifying medical issues. Use case reviews to identify whether physician and staff assessments and conclusions are <i>mutually consistent, pertinent, and accurate</i>. Identify whether <i>care plans</i> related to medical, functional, and behavioral issues effectively <i>reflect</i> each patient's underlying <i>medical causes and risk factors</i>, based on appropriate physician input and support, and whether <i>causes</i> of impairments, decline, and changes of condition are being <i>assessed and managed appropriately</i>.</p>

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Behavioral Health	<p>Behavioral health services</p> <p>CFR §483.40</p> <p>F740</p>	<p>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.</p> <p><u>Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.</u></p> <p><u>All residents should be screened for serious mental disorders and intellectual disabilities prior to admission to determine if specialized services under PASARR are required and that they are able to provide or arrange such services.</u></p> <p><u>Behavioral health care and services could include:</u></p> <ul style="list-style-type: none"> • <u>Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;</u> • <u>Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.</u> • <u>Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being. Residents living with mental health and SUDs may require different activities than other nursing home residents. Facilities must ensure that activities are provided to meet the needs of their residents.;</u> • <u>Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;</u> • <u>Using Behavioral contracts as part of individualized care plan, can only be</u> 	<p>AP: Perform a <i>pertinent medical assessment</i> of a resident who displays or is diagnosed with <i>mental or psychosocial adjustment difficulty</i> in order to help the facility ensure that a resident attains the highest practicable quality of life and psychosocial well-being. Document the clinical rationale and diagnostic criteria used to diagnose. Address <i>underlying medical and medication-related causes</i> of these issues to the extent possible.</p> <p>Prescribe <i>psychopharmacological medications</i> safely and appropriately, and actively avoid their inappropriate use. When not clinically contraindicated for the resident, help identify pharmacological or behavioral interventions to try to <i>reduce</i> the use of <i>unnecessary psychopharmacological medications</i>. Document clinically pertinent explanations, based on resident-specific evidence, for any <i>unavoidable change and/or decline</i> in a resident's physical, psychosocial or mental well-being.</p> <p>Even if a psychiatric consultant is involved in the care, remain involved and <i>communicate and coordinate</i> with the psychiatric consultant, as with any other consultant service.</p> <p>MDIR:</p> <p>Advise the facility about the <i>skills and performance of practitioners and direct care staff</i> in providing nursing, social and medically related services to assure resident safety and treatment to maintain the highest practicable physical, mental, and psychosocial well. Help review for whether the facility is providing <i>services for those with mental disorders and intellectual disabilities</i> that are required in the resident's comprehensive plan of care.</p> <p>As part of QA activities, review and promote the appropriate assessment and diagnoses of mental disorders, including schizophrenia, and the <i>safe and effective use of psychopharmacological medications</i>. Discourage the inappropriate use of psychopharmacological medications.</p> <p>Review cases to check that the attending physicians remain</p>

		<p><u>implemented if resident has capacity. The facility and staff have to be careful implementing the plan, it does not become a system of rewards or punishment</u></p> <ul style="list-style-type: none"> • <u>Residents with MD or SUD have the right to leave. The facility should explain right to have a leave of absence, leaving with facilities knowledge and leaving AMA.</u> • <u>Ensuring that pharmacological interventions are only used when nonpharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.</u> • <u>If substance abuse is suspected, the facility has the right to increase monitoring and supervision of residents.</u> • <u>Facility can restrict or initiate supervised visitation, if a visitor(s) are deemed a danger to resident and other residents.</u> • <u>Can ask for Voluntary drug testing or voluntary inspections, if concerns for illegal drugs, weapons or other unauthorized items.</u> • <u>Can refer to local law enforcement for suspicion of crime.</u> • <u>Refusal to accept or non-adherence of a behavioral plan contract cannot be the sole basis for a denial of admission or transfer or discharge.</u> <p><u>Schizophrenia:</u></p> <p><u>Schizophrenia is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.</u></p> <p><u>Schizophrenia must be diagnosed by a qualified practitioner, using evidence-based criteria and professional standards, such as the Diagnostic and Statistical Manual of Mental Disorders - Fifth edition (DSM-5), and documented in the resident's medical record. Symptoms of Schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and diminished expression or initiative. Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts. Hallucinations include a person hearing voices, seeing things, or smelling things others can't perceive</u></p>	<p>involved and <i>communicate and coordinate</i> with the psychiatric consultant, as with any other consultant service.</p> <p>If a provider, including a psychiatric consultant, is not adhering to professional practices, address these deviations. Be prepared to discuss the process for recognizing and addressing deviations from professional standards during the survey process.</p>
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	Behavioral Health Services (continued)	<p>Based on the comprehensive assessment of a resident, the facility must ensure that all residents, including residents who display or are diagnosed with mental or psychosocial adjustment difficulty, receive appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental health and psychosocial well-being.</p> <p>A resident whose assessment does not reveal or who does not have a diagnosis of a mental disorder or psychosocial adjustment difficulty will not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that the pattern was unavoidable.</p> <p>If rehabilitative services such as physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for a mental disorder and intellectual disability are required in the resident's comprehensive plan of care, the facility must provide them.</p> <p>While individuals who provide services for residents with behavior and psychiatric issues do not have to have specific degrees or certifications, the facility must have enough staff with the appropriate competencies and skill sets to provide nursing and related services to residents who need such services.</p> <p>The requirements regarding medications are intended to promote the safe and effective use of medications including but not limited to psychopharmacological medications and discourage the inappropriate use of these medications.</p> <p>When these methods are not clinically contraindicated for the resident, non-pharmacological or behavioral interventions are required in an attempt to reduce or eliminate the unnecessary use of psychopharmacological medications.</p>	

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Care plan, comprehensive-Develop/ Implement	CFR483.21(b)(1)(3) <u>Comprehensive Care Plans</u> TN: F656 CFR 483.21(b)(2)(i)-(iii) TN: F657	<p>F656-The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being, as required under §483.24, §483.25, or §483.40, and (ii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. (iv)In consultation with the resident and the resident’s representative(s)—</p> <p>(A) The resident’s goals for admission and desired outcomes. (B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must— (iii) Be culturally-competent and trauma-informed.</p> <p>F657-A comprehensive care plan must be— (i) developed within 7 days after completion of the comprehensive assessment. (ii) prepared by an interdisciplinary team, that includes but is not limited to—(A) the attending physician, (B) a registered nurse with responsibility for the resident, (C) a nurse aide with responsibility for the resident, (D) a member of food and nutrition services staff (E) to the extent practicable, the participation of the resident and the resident’s representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan, (F) other appropriate staff or professional in disciplines as determined by the resident’s needs or as requested by the resident. (iii) reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p>	<p><u>AP</u>: Help other interdisciplinary team members understand the <i>functional and psychosocial impact of medical issues</i> so that they can develop a more pertinent resident-centered care plan. Guide staff in developing a <i>baseline and</i> a more <i>comprehensive care plan</i> that is <i>consistent with</i> the resident’s <i>medical condition and prognosis</i>. Help staff identify a resident’s <i>discharge potential</i>.</p> <p><u>MDIR</u>: Inform the medical practitioners about the content, purpose, and application of the <i>comprehensive resident assessment</i> and how they can use the information to guide implementation of a resident-centered care plan. Review care plans selectively for <i>medical input</i> related to baseline and comprehensive care plans, including <i>correlation</i> between medical findings and the overall plan and specific interventions.</p>

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<p>Care planning, resident notification</p> <p>Right to be Informed and Make Treatment Decisions</p>	<p>CFR483.10(c)(1)(4)(5) <u>Planning and Implementing Care</u> TN: F552</p> <p>re: Informing of condition; refer to</p> <p>CFR483.10(c)(2) TN: F553 re: Right to Participate in Planning Care</p>	<p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care; the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p><u>Health information and services must be provided in ways that are easy for the resident and/or the resident's representative to understand. This includes, but is not limited to, communicating in plain language, explaining technical and medical terminology in a way that makes sense to the resident, offering language assistance services to residents who have limited English proficiency, and providing qualified sign language interpreters or auxiliary aids if hearing is impaired. This does not mean that a facility is required to supply and pay for hearing aids.</u></p> <p><u>The physician or other practitioner or professional must inform the resident or their representative in advance of treatment risks and benefits, options, and alternatives. The information should be communicated at times it would be most useful to them, such as when they are expressing concerns, raising questions, or when a change in treatment is being proposed. The resident or resident representative has the right to choose the option he or she prefers.</u></p> <p><u>Discussion and documentation of the resident's choices regarding future health care may take place during the development of the initial comprehensive assessment and care plan and periodically thereafter.</u></p> <p>A facility must allow residents to express their wishes and choices regarding their health care and other matters, and to participate in related decisions. If they are incapable of doing so, the staff and practitioner should communicate with someone who is authorized under state law and regulations to act on their behalf.</p>	<p><u>AP: Discuss medical issues</u> with residents or, as appropriate, their legal representatives, including relevant <i>risks and benefits</i>. Collaborate with staff to <i>present clinical information</i> in a form and language suited to the individual. To help maximize resident participation, <i>identify and address</i> any medical conditions or medication-related adverse consequences that may be adversely affecting a resident's <i>alertness and cognition</i>. Clarify the resident's medical <i>condition and prognosis</i>. Periodically <i>review</i> the staff's <i>overall care plan</i> approaches, including their relevance to underlying medical causes. Review and document the <i>medical rationale</i> for continuing medical <i>interventions</i>, including medications.</p> <p>Collaborate with staff to <i>define</i> a resident's <i>decision-making capacity</i> (DMC).</p> <p>Help the facility <i>maximize resident participation</i> in decision making and care planning, to the extent possible.</p> <p>MDIR: Help the facility implement <i>appropriate procedures to define DMC</i>. <i>Advise</i> as needed <i>regarding determining DMC</i> in challenging situations.</p>

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Change notification	CFR483.10(g)(14)(i)-(iv) <u>Resident Rights</u> TN: F580	<p>A facility must immediately inform the resident; consult with the resident's physician, and notify, consistent with his or her authority the resident's representative(s) when there is: (a) an accident involving the resident which results in injury and has the potential for requiring physician intervention; (b) a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (c) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (d) a decision to transfer or discharge the resident from the facility.</p> <p>When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15(c)(2) is available and provided upon request to the physician.</p> <p>The facility must also promptly notify the resident and the resident's representative, if any, when there is: (a) a change in room or roommate assignment as specified in 483.10(e)(6) or (b) a change in resident rights under Federal or State law or regulations as specified in 483.10(e)(10). (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p>	<p><u>AP:</u> Respond appropriately and in a timely fashion when notified of a significant <i>acute problem or condition change</i>. <i>Assess</i> residents in a <i>timely</i> fashion, based on their medical stability and symptoms. Help staff identify and manage <i>adverse consequences related to medications and treatments</i>.</p> <p><i>Communicate</i> with residents and families about medical issues, as appropriate.</p> <p>Use condition change notifications as an opportunity to provide <i>feedback to staff</i> and educate, explain the <i>rationale for decisions</i>, and identify the need for <i>monitoring</i>, including when there is no change in the diagnostic/treatment plan.</p> <p>Inform the medical director when the <i>information provided by staff</i> about condition changes and symptoms is not accurate, pertinent, timely, thorough, or well organized.</p> <p><u>MDIR:</u> Guide the facility in identifying and implementing effective approaches <i>to triage clinical issues and notify</i> attending physicians of changes in condition as well as identifying reasonable <i>expectations for physician response</i>. Guide and inform the staff about optimal <i>ways to communicate</i> information to medical practitioners in order to make the best use of a physician's time and expertise.</p> <p>As part of QA activities, review <i>unplanned hospital transfers and unexpected deaths</i>. Review for whether the physicians are <i>seeking, identifying, and managing adverse consequences</i> related to medications and treatments.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Compliance and Ethics Program</p>	<p>Compliance and ethics program CFR483.85</p> <p>TN: F895</p> <p>NOTE: [§483.85 and all subparts will be implemented beginning November 28, 2019 (Phase 3)]</p>	<p>Beginning on November 28, 2019, the operating organization for each facility must have in operation a compliance and ethics program that meets the requirements of this section.</p> <p>Compliance and ethics program means, with respect to a facility, a program of the operating organization that—</p> <p>§483.85(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and</p> <p>§483.85(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.</p> <p>High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.</p> <p>§483.85(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components, which can be found at 483.85(c)(1)-(8) and 483.85(d) (1)-(3) and 483.85 (e).</p> <p><u>To ensure that facilities have in operation an effective compliance and ethics program that uses internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements to deter criminal, civil and administrative violations under the Act and promote quality of care for nursing home residents.</u></p> <p>Each “operating organization” must have a "compliance and ethics program;" that is, a program that has been reasonably designed, implemented, and enforced so that it is effective in preventing and detecting criminal, civil, and administrative violations under the 6102 and 6401(a) of the Affordable Care Act. There must be someone to oversee the entire program, a contact person to whom suspected violations can be reported, an alternate way to report violations anonymously, and disciplinary standards that set out the consequences for committing violations for the organization's entire staff, as well as contractors and volunteers. The organization must communicate the standards, policies, and procedures in the compliance and ethics program to everyone. Steps must be taken to achieve compliance with the program's standards, policies, and procedures. Standards, policies, and procedures must be enforced through appropriate disciplinary mechanisms. The organization must respond appropriately to violations and prevent further similar violations. The compliance and ethics program must be</p>	<p>AP: Comply with the standards, policies, and procedures in the facility’s compliance and ethics program. Report any violations or concerns to the appropriate facility leadership and/or responsible compliance officers. Follow up with the medical director regarding any concerns or questions regarding the compliance and ethics programs and participate to the extent possible in any improvement activities.</p> <p>MDIR: Collaborate with the facility management to establish a written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations. Help the facility oversee compliance with its compliance and ethics programs. Help communicate the standards, policies, and procedures in the compliance and ethics program to the facility’s medical practitioners.</p> <p>Help the organization ensure that reasonable steps are taken to achieve compliance with the program's standards, policies, and procedures.</p> <p>Help the facility enforce the standards, policies, and procedures through appropriate disciplinary mechanisms.</p> <p>Help the facility review and revise, as needed, its compliance and ethics program at least annually.</p>

		<p>reviewed annually and revised as needed. There must be a mandatory annual training on the program. The facility assessment developed under §483.70(e) must be used to develop and maintain the compliance programs. There must be an ongoing, comprehensive QAPI program to address the full range of care and services provided by the facility and which addresses all of the systems of care and management practices (§483.75(b)(1)). The information and data that is collected or that arises out of the compliance and ethics programs must be integrated into the QAPI program.</p>	
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Consent, resident rights	CFR483.10(a) <u>Resident Rights</u> TN: F550	<p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>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.</p> <p>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.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>A legally appointed representative may exercise the rights of a person who is adjudicated incompetent or who is determined by appropriate processes to lack decision making capacity, whether or not legal proceedings have occurred. References to “resident” in the Interpretive</p>	<p><u>AP</u>: Help determine each resident’s <i>decision-making capacity</i> (DMC). Help the facility <i>maximize resident participation</i> in decision making, to the extent possible. Help identify and address <i>treatable medical conditions and medication-related adverse consequences</i> that affect cognition, level of consciousness, and otherwise influence DMC. Advocate for the resident’s <i>right to participate in decision making</i> and for identifying and incorporating a resident’s <i>wishes and goals</i> into clinical decision making. Refer conflicts to a facility <i>patient care advisory committee</i> or a comparable process.</p> <p><u>MDIR</u>: Guide the facility to identify and implement an <i>effective process to evaluate and document DMC</i>. Guide the staff and practitioners in the proper evaluation and management of <i>medical conditions and medication-related issues</i> that affect mental status and medical decision-making capacity. Review for whether physicians are <i>determining DMC</i> correctly and collaborating with staff in challenging situations.</p> <p>As part of QA activities, help identify whether the facility and the practitioners are effectively addressing decision-making capacity, supporting residents’ <i>right to participate in decision making</i>, and incorporating a resident’s <i>wishes and goals</i> into treatment decisions. Help the facility establish and implement an effective mechanism such as a facility <i>patient care advisory committee</i> or a comparable process to address these issues and <i>help address conflicts</i>.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		Guidelines also refer to legal surrogates. State laws and regulations specify procedures for certifying incapacity and selecting appropriate substitute decision makers.	
Dental Services	42CFR483.55 Dental Services TN: F790-791	<p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>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.</p> <p>A facility must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;</p> <p>Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.</p> <p><u>A dentist must be available for each resident. The dentist can be directly employed by the facility or the facility can have a written contractual agreement with a dentist. The facility may also choose to have a written agreement for dentist services from a dental clinic, dental school or a dental hygienist all of whom are working within Federal and State laws and under the direct supervision of a dentist.</u></p> <p>The facility must help a resident who requests assistance in scheduling a dental appointment and arrange transportation and referrals for dental services, as needed. Referral for dental services should occur in 3 business days or less from the time the loss or damage to dentures is identified unless the facility can show documentation of extenuating circumstances that resulted in the delay. The facility should document efforts to ensure that the resident is able to eat and drink adequately while awaiting the dental services</p>	<p><u>AP:</u> Perform a basic <i>oral and dental screening</i> evaluation for each resident post-admission and periodically thereafter; for example, as part of at least some routine visits. Do an oral examination as part of the evaluation of anyone with <i>chewing, eating, or swallowing problems</i>, especially when there are proposals to restrict food and fluid consistency or when persistent or progressive weight loss or anorexia are present.</p> <p>For a resident with dental problems affecting eating, check that staff are obtaining a <i>timely dental evaluation</i> and that the resident is taking adequate food and fluids to try to <i>avoid major complications</i> while awaiting the dental evaluation.</p> <p><u>MDIR:</u> As part of QA activities, help identify whether the staff and practitioners are providing or obtaining timely and appropriate <i>oral and dental assessments and care</i>. Perform select case reviews to see if these issues are being addressed adequately in <i>residents at risk</i> or who are having significant eating, chewing, swallowing, and weight loss issues. Review and discuss whether pertinent <i>diet orders</i> are in place, if needed, for individuals with significant dental problems and that the staff and practitioners are paying attention to <i>adequate nutritional intake</i> until dental services are obtained.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Transfer and Discharge	<p>CFR §483.15(c) §483.15(c)(1)(i-ii)</p> <p>TN: F627</p>	<p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. . . ; or (F) the facility ceases to operate.</p> <p>The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) the basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) in the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—</p> <p>(A) the resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) a physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C)</p>	<p><u>AP:</u> Help the facility <i>identify</i> situations where it is <i>not feasible to continue to care</i> for a resident in the facility; for example, because their needs cannot be met or their safety is endangered. Help the staff address issues to the extent possible to try to <i>minimize transfers</i> that are not medically necessary. Help staff identify and <i>match</i> resident needs <i>to available resources and staff</i> in the facility; for example, a resident who needs a more controlled and supervised environment to address confrontations with other residents. Consistent with facility policy, help identify individuals who do not need <i>special placement or restrictions</i>; for example, a resident who does not need isolation despite being colonized with a multi-drug resistant organism. Provide information and documentation that is needed to ensure <i>a safe and effective transition</i> of care. Provide a <i>timely discharge summary</i> with required and other relevant information. In case of an <i>involuntary discharge</i>, include information in the discharge summary about why the facility cannot meet the resident's needs. For discharges where the facility is unable to meet the current needs of the resident, prepare the <i>required information for discharge</i>, including specific items or services.</p> <p><u>MDIR:</u> Guide the staff and physicians about <i>appropriate ways to handle</i> complex and difficult <i>situations</i> (for example, infection control issues or changes in behavior or medical condition) in the facility, to minimize avoidable transfers and try to minimize the impact of necessary transfers.</p> <p>As part of QA activities, <i>review</i> cases selectively for the <i>appropriateness of resident transfers and discharges</i> and the steps taken to validate that they are needed and try to minimize their impact. Review for whether adequate and timely <i>discharge summaries</i> are being done, and whether physician discharge summaries identify a resident's clinical course while at the facility and are consistent with the facility's discharge summary.</p> <p>Support the facility in assuring decisions about readmission are based on current assessed needs and are aligned with the facility's capabilities as outlined in the Facility Assessment.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Trasnfer and Discharge (continued)</p>	<p>TN: F628</p>	<p>or (D) of this section.</p> <p>Use guidance at this Ftag to determine if noncompliance exists when evidence suggests a facility should not have transferred or discharged a resident at the time of discharge, or at all. These circumstances may include, but are not limited to, the following:</p> <p>When evidence in the medical record does not support the basis for discharge, such as:</p> <ul style="list-style-type: none"> • Discharge based on an inability to meet the resident’s needs, but there is no evidence of facility attempts to meet the resident’s needs, or no evidence of an assessment at the time of discharge indicating what needs cannot be met; • Discharge based on improvement of resident’s health such that the services provided by the facility are no longer needed, but documentation shows the resident’s health did not improve or actually declined; <p>F628: 483.15 (c)(2) Documentation Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident’s discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>The intent of this tag is to ensure the facility adheres to all of the applicable components of the process for transferring or discharging a resident which include documentation and information conveyed to the receiving provider, the notice of transfer or discharge, notice of bed-hold policy, and completing the discharge summary.</p>	

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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Discharge and Transfer</p> <p>(continued)</p>	<p>CFR483.10(e)(7)(i)-(iii)(8)</p> <p><u>Resident Rights: Right to Refuse Certain Transfers</u></p> <p>TN: F560</p>	<p>483.10(e)(7)- F560-The right to refuse to transfer to another room in the facility, of the purpose of the transfer is (i) to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, (ii) to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (iii) solely for the convenience of staff.</p> <p>A resident’s exercise of the right to refuse transfer does not affect the individual’s eligibility or entitlement to Medicare or Medicaid benefits.</p> <p>Transfer or discharge should be documented in the record and appropriate communication to the receiving setting should be provided. A facility that cannot meet the needs of the resident should document those specific needs that they could not meet.</p> <p>Information that is to be part of the transfer includes: Contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, special instructions or precautions for ongoing care, and the resident’s comprehensive care plan goals.</p> <p>If the resident is out for longer than the anticipated period, the resident needs to know if they cannot be readmitted to the facility and the reasons for this.</p> <p>This also applies to room changes if they are in a distinct part of the facility.</p> <p>The discharge summary must include the medications as well as a recapitulation of the resident’s day, the final summary of the resident’s status, and the post-discharge plan of care.</p> <p>It may be appropriate to send a physician’s previously documented history and physical and progress notes along with consultations and lab tests supplemented by nursing documentation of the events leading to the transfer.</p> <p>To demonstrate that any of the permissible circumstances for a facility to initiate a transfer or discharge have occurred, the medical record must contain documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge.</p> <p>For some circumstances, the resident’s physician must document information about the basis for the transfer or discharge. If discharge is due to the inability to meet the resident’s needs, physician documentation must include: the specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.</p> <p>Documentation of the transfer or discharge may be completed by a non-physician practitioner</p>	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		(NPP) in accordance with State law.	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Food Safety requirements	CFR §483.60(i)(1)(2) <u>Food Procurement, Store / Preparation / Serve-Sanitary</u> TN: F812	<p>The facility must—</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities;</p> <ul style="list-style-type: none"> i. This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. ii. 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. iii. This provision does not preclude residents from consuming foods not procured by the facility. <p>(2) Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p><u>The food procurement requirements for facilities are not intended to restrict resident's choice. All residents have the right to accept food brought to the facility by family or visitor(s) for any resident.</u></p> <p>Nursing home residents risk serious complications from foodborne illness as a result of their compromised health status. Unsafe food handling practices represent a potential source of pathogen exposure for residents. Sanitary conditions must be present in health care food service settings to promote safe food handling. CMS recognizes the U.S. Food and Drug Administration's (FDA) Food Code and the Centers for Disease Control and Prevention's (CDC) food safety guidance as national standards to procure, store, prepare, distribute, and serve food in long term care facilities in a safe and sanitary manner.</p> <p>Effective food safety systems involve identifying hazards at specific points during food handling and preparation, and identifying how the hazards can be prevented, reduced or eliminated. It is important to focus attention on the risks that are associated with foodborne illness by identifying critical control points (CCPs) in the food preparation processes that, if not controlled, might result in food safety hazards. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices</p>	<p><u>AP:</u> Advise the facility about <i>medications and medical conditions</i> that are <i>related to appetite and weight</i>. Be aware of <i>weight loss and anorexia</i> in residents and help staff identify pertinent interventions.</p> <p><u>MDIR:</u> Guide the facility to develop and implement <i>policies and procedures</i> for <i>safe handling of food</i>, including food brought to residents from outside sources or grown on the premises.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Infection control	CFR483.80(a)(1),(a)(2),(a)(4),(e), and (f) Infection Control TN: F880	<p>A facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (a)The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <ul style="list-style-type: none"> (1) a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; (2)written standards, policies, and procedures for the program, which must include, but are not limited to: (i) a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) when and to whom possible incidents of communicable disease or infections should be reported; (iii) standard and transmission-based precautions to be followed to prevent spread of infections; (iv) when and how isolation should be used for a resident; including but not limited to: a) the type and duration of the isolation, depending upon the infectious agent or organism involved, and b) requirement that the isolation should be the least restrictive possible for the resident under the circumstances; (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) the hand hygiene procedures to be followed by staff involved in direct resident contact. (4) a system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility. <p>(e) Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	<p><u>AP:</u> Identify residents who need specific <i>infection control measures</i>. Help staff identify the <i>most appropriate</i> and <i>least restrictive</i> possible measures for those residents.</p> <p><i>Limit antibiotic use</i> to residents who have clinically significant symptoms and signs of an active infection or legitimate need for prophylaxis or empirical treatment, and try to minimize complications related to antibiotic use.</p> <p><i>Communicate</i> with the staff and facility Infection Preventionist (Coordinator) as needed, related to diagnosis and treatment of clinically significant infections; for example, those due to a multidrug-resistant organism.</p> <p>Perform <i>hand hygiene</i> and <i>clean equipment</i> (e.g., stethoscope) before and after physical contact with residents.</p> <p><u>MDIR:</u> Help the facility implement and refine an appropriate <i>infection prevention and control program</i> and related policies and procedures to prevent and manage the spread of infections and the proper use of antibiotics.</p> <p>Guide <i>physician involvement</i> in the infection control process, including related physician roles and responsibilities. Guide the facility about policies and procedures for <i>vaccination</i> of residents and staff, <i>surveillance</i>, and <i>isolation precautions</i>, based on relevant guidelines.</p> <p>Advise the facility on using <i>standardized definitions</i> for infection surveillance. Guide the facility in recognizing, containing, monitoring, and reporting <i>infectious outbreaks</i> and the management of residents involved in such outbreaks.</p> <p>Help the facility establish the frequency and mechanism for <i>giving prescribing practitioners feedback</i> regarding antibiotic resistance data, their antibiotic use and their compliance with facility antibiotic use protocols.</p> <p>Observe and discuss whether staff are using <i>isolation and precautions</i> appropriately.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		<p><u>The intent of this regulation is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program (IPCP) in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will:</u></p> <ul style="list-style-type: none"> • <u>perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection;</u> • <u>prevent and control outbreaks and cross-contamination using transmission-based precautions;</u> • <u>use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions, as indicated;</u> • <u>implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination; and</u> • <u>properly store, handle, and transport linens to minimize contamination.</u> • <u>Routinely clean/disinfect frequently touched surfaces (including privacy curtains) in common area/residents room.</u> • <u>Clean and disinfect resident care equipment (BP Cuff, rehab therapy equipment and blood glucose meters.</u> <p>The IPCP program must follow accepted national standards and include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. The program should also establish policies for the staff's infection control practices and precautions, and oversee an active training program to ensure compliance.</p> <p>The facility must maintain a separate record of infections by resident, including the onset date, causative agent, origin or site of the infection, and cautionary measures to try to prevent spread; and maintains a record of incidents and corrective actions related to infections. The program should review these data regularly and analyze trends and problems.</p> <p>The facility must designate an Infection Preventionist who is responsible for the IPCP and who has received specialized training in infection prevention and control and who has the IPCP assigned as a major responsibility.</p> <p>The facility must review its IPCP annually and update the program as necessary.</p>	<p>Help the facility identify <i>communicable illnesses and outbreaks that must be reported</i> to state agencies, consistent with applicable laws and regulations.</p> <p>As part of QA activities, review <i>infection control reports</i> and <i>analyze pertinent data</i> for trends and problems; for example, facility-specific antibiotic utilization review and bacteriology laboratory antibiotic susceptibility profiles. Advise the physicians on using such information to select <i>empiric antibiotics</i>, including in the face of critical illness.</p>

		<p>Isolation should only be to control the spread of infection and be the least restrictive possible to maintain the resident’s psychosocial well-being.</p> <p>Enhanced Barrier Precautions (EBP) EBP are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following:</p> <ul style="list-style-type: none"> • Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or • Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 	
	F887 483.80 Infection Control	<p>§483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:</p> <ul style="list-style-type: none"> (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; Advance Copy (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: <ul style="list-style-type: none"> (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. 	

		<p>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:</p> <p>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;</p> <p>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and</p> <p>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN)</p>	
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		The IPCP must also include an antibiotic stewardship program that includes antibiotic use protocols and systems for monitoring antibiotic.	
Laboratory services	CFR483.50(a)(1)(i) Laboratory Services TN: F770	<p>The facility must provide or obtain clinical laboratory services to meet the needs of residents'. The facility is responsible for the quality and timeliness of those services. If the facility provides its own laboratory services, the services must meet the applicable requirement specified in 42 CFR Part §493.</p> <p><u>If a facility provides its own laboratory services or performs any laboratory tests directly (e.g., blood glucose monitoring, etc.) the provisions of 42 CFR Part §493 apply and the facility must have a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility.</u></p> <p><u>Facilities collecting and/or preparing specimens and not performing testing are not considered to be providing laboratory services and do not need to meet the requirements of 42 CFR Part §493.</u></p> <p><u>Surveyors should only verify that the facility has a current CLIA certificate and not attempt to determine compliance with the requirements in 42 CFR part 493; rather, refer questions or concerns to CLIA surveyors.</u></p> <p>The facility must only provide or obtain these services when ordered by physician, a physician assistant, nurse practitioner, or clinical nurse specialist acting in accordance with state law, scope of practice, and facility policy.</p> <p>It is expected that test results are documented, reported, and addressed in a timely fashion.</p> <p>Various practitioners (ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist) may receive laboratory and radiology and other diagnostic results.</p>	<p><u>AP:</u> Order <i>pertinent clinical laboratory, radiology, and other diagnostic services</i> to support diagnosis, treatment, prevention, and assessment. <i>Interpret</i> the clinical significance of test results <i>and act on those results</i> as clinically indicated. Document the <i>clinical rationale</i> for actions taken or not taken, when otherwise not apparent. Review, sign, and date (or otherwise indicate review) of <i>reports of test results</i>.</p> <p><u>MDIR:</u> Advise the facility about the <i>quality and timeliness</i> of its lab and diagnostic testing services. Guide the facility in appropriately <i>requesting, obtaining, interpreting, documenting, and reporting</i> laboratory and diagnostic test <i>results</i>. Help the facility identify requirements for laboratory, radiology, and other diagnostic testing services (for example, bladder scanners or other <i>testing and special studies</i>), and also what may not be necessary. Help the facility define <i>appropriate notification guidelines</i> related to test results.</p> <p>As part of QA activities, review individual cases to determine whether lab and diagnostic testing is <i>timely, appropriate, and correctly reported and interpreted</i>, and that appropriate actions have been taken.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medical director, required duties	CFR483.70(h)(1)(2) <u>Administration</u> TN: F841 TN: F839	<p>The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.</p> <p><u>If a facility has not designated a physician to serve as a Medical Director refer that citation under F841.</u></p> <p><u>If the medical director does not hold a valid license to practice in the State where the nursing home is located refer to F839 - §483.70(f) Staff qualifications. The facility must designate a physician to serve as medical director (unless waived per §488.56(b) by CMS).</u></p> <p>The Medical Director must be licensed in the state where the facility is located.</p> <p>“Resident care policies” refers to the facility’s overall goals, directives, and governing statements that direct the delivery of care and services to residents consistent with current professional standards of practice.</p> <p>The medical director’s “coordination role” means that the medical director is responsible for assuring that the facility is providing appropriate care as required. This involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and the medical care of residents. It also includes having a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate. When the medical director identifies or receives a report of possibly inadequate medical care, including drug irregularities, he or she is responsible for evaluating the situation and taking appropriate steps to try to correct the problem. This may include any necessary consultation with the resident and his or her physician concerning care and treatment. The medical director’s coordination role also includes assuring the support of essential medical consultants as needed. A medical director whose sole function is to approve resident care policies does not meet this requirement.</p> <p><u>The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility. This may be included in the medical director’s job description or through a separate facility policy. Facilities and medical directors have flexibility on how all the duties will be</u></p>	<p>MDIR: Help the facility develop and implement appropriate <i>resident care policies and procedures</i> for all aspects of clinical services.</p> <p>Guide and coach the staff and practitioners to follow a systematic care delivery process that incorporates valid approaches to clinical reasoning and problem solving.</p> <p>Help ensure timely and pertinent attending physician visits, management of medical and psychiatric issues, and follow-up of problems such as acute changes of condition.</p> <p>Guide, coach, and educate the staff and practitioners about appropriate medical care and the assessment, diagnosis, and management of medical and psychiatric symptoms, syndromes, and conditions seen in the facility’s resident population.</p> <p>Ensure that all attending physicians have on-call coverage available. Provide backup coverage when on-call coverage is not available.</p> <p>Communicate and intervene as needed with attending physicians regarding their practices and performance, both generally and related to care of specific residents. Document actions taken when physicians fail to perform or practice appropriately.</p> <p>Contribute to the required annual facility assessment regarding the facility’s capabilities and its population. Help the facility align staff and medical practitioner skills needed for all aspects of clinical services identified for the resident population during the facility assessment.</p> <p>Document participation in the facility’s quality improvement activities. Assess the quality and appropriateness of care via case reviews and other methods.</p>
Medical director, required duties			

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medical director, required duties		<p><u>performed. However, the facility must ensure all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. For example, some, but not all, duties may be conducted remotely using various technologies (e.g., phone, email, fax, telehealth, etc., that is compliant with all confidentiality and privacy requirements).</u></p> <p><u>It is important that the medical director's responsibilities require that he/she be knowledgeable about current professional standards of practice in caring for long term care residents, and about how to coordinate and oversee other practitioners.</u></p> <p><u>If the medical director is also an attending physician, there should be a process to ensure there are no concerns with the individual's performance as a physician (i.e., otherwise, the medical director is monitoring his/her own performance). If there are concerns regarding his/her performance, the facility's administration should have a process for how to address these situations.</u></p> <p><u>While medical directors who work for multi-facility organizations, such as corporate or regional offices, may be involved in policy development, the facility's individual policies must be based on the facility's unique environment and its resident's needs, and not based on a broad, multi-facility structure.</u></p> <p><u>Although the medical director is not required to sign policies, the facility must be able to show that the development, review, and approval of resident care policies included the medical director's input.</u></p> <p><u>Medical director responsibilities must include:</u></p> <ul style="list-style-type: none"> <u>• Implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care.</u> <u>• Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. (Refer to F868).</u> <u>• Addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities.</u> <u>• Active involvement in the process of conducting the facility assessment (Refer to F838).</u> 	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medical director, required duties		<p><u>Note: Having a designee does not change or absolve the Medical Director's responsibility to fulfill his or her role as a member of the QAA committee, or his or her responsibility for overall medical care in the facility.</u></p> <p><u>In addition, the medical director responsibilities should include, but are not limited to:</u></p> <ul style="list-style-type: none"> • <u>Administrative decisions including recommending, developing, and approving facility policies related to residents care. Resident care includes the resident's physical, mental, and psychosocial well-being;</u> • <u>ensuring the appropriateness and quality of medical care and medically related care;</u> • <u>assisting in the development of educational programs for facility staff and other professionals;</u> • <u>Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents. Refer to Infection Control requirement at §483.80;</u> • <u>cooperating with facility staff to establish policies for assuring that the rights of individuals (residents, staff members, and community members) are respected;</u> • <u>supporting and promoting person-directed care such as the formation of advance directives, end-of-life care, and provisions that enhance resident decision making, including choice regarding medical care options;</u> • <u>identifying performance expectations and facilitating feedback to physicians and other health care practitioners regarding their performance and practices;</u> • <u>discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care, for example, physicians assigning new psychiatric diagnoses and/or prescribing psychotropic medications without following professional standards of care; and</u> • <u>assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners (e.g., nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law.</u> 	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medical records; Resident Records	CFR483.75(i)(1) Administration Resident-identifiable information TN: F842 TN: F843	<p>The facility must maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.</p> <p>Medical records must be retained for the period of time required by State law; or five years from the date of discharge when there is no requirement in State law or, for a minor, three years after a resident reaches legal age under State law. The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by law or by transfer to another health care institution.</p> <p>The medical record must contain the resident's comprehensive plan of care, results of diagnostic testing, and the progress notes from physicians and other licensed professionals.</p>	<p><u>AP</u>: Provide <i>timely, legible, and pertinent documentation</i> and orders that addresses key aspects of medical care and quality of life and resident choice. Provide a pertinent clinical rationale for all significant medical decisions.</p> <p><u>MDIR</u>: Guide physicians regarding desirable and required content, frequency, legibility, pertinence, timeliness, and other <i>attributes of medical documentation</i>. Perform <i>clinical record reviews</i> to identify how well physicians comply with expectations. Promote <i>confidentiality of clinical records</i> and other medical information. Advise the facility about the <i>content, organization, and storage</i> of the clinical record and about <i>access to</i> such <i>information</i>.</p>
Medical records, privacy and confidentiality	CFR483.10(h)(1)-(3)(i)(ii) <u>Resident Rights: Personal Privacy and Confidentiality of Records</u> TN: F583	<p>The resident has the right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. The resident has a right to secure and confidential personal and medical records. The resident has the right to refuse the release of personal and medical records except as provided at 483.70(i)(2) or other applicable federal or state laws.</p> <p>The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p>	<p><u>AP</u>: Recognize the resident's <i>privacy and confidentiality rights</i> related to documentation and sharing information with others. Follow pertinent <i>laws and regulations</i> related to such issues. Help the facility <i>discuss and explain information in the clinical record</i> as needed for authorized outsiders such as ombudsmen and surveyors.</p> <p><u>MDIR</u>: Guide the facility in implementing <i>policies and practices</i> that <i>protect individual rights</i>, including <i>confidentiality</i> of records and related information. Help the staff and practitioners <i>discuss and explain information in the clinical record</i> as needed, including for authorized outsiders such as ombudsmen and surveyors.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Medications, appropriate and unnecessary</p> <p>Drug Regimen is Free From Unnecessary Drugs</p>	<p>CFR483.45(d)(e) Pharmacy Services</p> <p>TN: F757</p>	<p>F757 Unnecessary Drugs—Each residents’ drug regimens must be free from unnecessary drugs. An unnecessary drug is any drug when used—in excessive dose (including duplicate drug therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p><u>The intent of these requirements is to ensure each resident’s entire drug/medication regimen is managed and monitored to promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being. The regulations and guidance are not intended to supplant the judgment of a practitioner in consultation with facility staff, the resident, and his/her representatives and in accordance with professional standards of practice. However, surveyors are expected to investigate the basis for decisions and interventions affecting residents. For example, a resident’s medical record should contain documentation that demonstrates how the practitioner arrived at their decision(s) in accordance with the professional standards of practice.</u></p> <p>The comprehensive assessment for medication management involves evaluating a resident's physical, behavioral, mental, and psychosocial signs and symptoms to identify any underlying medical conditions. This includes assessing the benefits and risks of medications and considering the resident's treatment preferences and goals. The evaluation and rationale for treatment choices should be documented in the resident's medical record.</p> <p>Key points include ensuring that medication changes are not solely due to:</p> <ul style="list-style-type: none"> • Medical conditions expected to improve with treatment or discontinuation of offending medications. • Environmental stressors that can be addressed. • Psychological stressors that can be resolved. <p>Circumstances warranting evaluation include:</p> <ul style="list-style-type: none"> • Irregularities in the pharmacist's medication review. • New medication orders as emergency measures. 	<p><u>AP: Prescribe all medications</u> only for pertinent indications, and in doses and for a duration that are intended to maximize benefit and minimize risks. Provide <i>clinically pertinent justification</i> for prescribing medications that are higher risk or are suspected of causing adverse consequences, especially when reasonable lower risk alternatives may be available. Identify, document, and review with staff and the resident the <i>goals of treatment and parameters for monitoring</i> a medication’s efficacy and safety.</p> <p><u>Effectiveness of the medications and potential adverse consequences should be documented after a medication is initiated or the dose is changed.</u></p> <p>Authorize and write <i>appropriate, timely, and legible orders</i>. Ensure that any as-needed (<i>PRN</i>) orders have a valid basis and include the indication(s), specific circumstance(s) for use, and the desired frequency of administration.</p> <p>Respond appropriately to <i>consultant pharmacist reviews</i> and follow recommendations or indicate clinical reasons for modifying or declining to follow recommendations.</p> <p><u>MDIR:</u> Review with the staff and practitioners <i>safe prescribing principles</i>, the <i>proper use of medications</i> in general and specific medications, including those for individuals with <i>behavior and psychiatric issues</i>, including (but not limited to) dementia.</p> <p>Help the facility implement <i>appropriate policies and practices</i> regarding medication prescribing.</p> <p>Inform physicians of <i>requirements related to medications</i>, including providing clinically pertinent documentation.</p> <p>Help implement Antibiotic Stewardship, including antibiotic use protocols, monitoring of antibiotic use and feedback and education to prescribing providers.</p> <p>Help staff identify ways to help <i>influence prescribing</i> by improving assessment and reporting of information to physician.</p> <p>Establish <i>strict controls</i> in the facility about who can write orders</p>

		<ul style="list-style-type: none"> • Admission or re-admission with unclear medication indications. • New or worsening changes in the resident's condition. <p>Regarding treatment of behavior and psychiatric symptoms related to dementia, antipsychotic medications should not be used if the only indications are one or more of the following: wandering; poor self-care; restlessness; impaired memory; mild anxiety; insomnia; inattention or indifference to surroundings; sadness or crying alone that is not related to depression or other psychiatric disorders; fidgeting; nervousness; or uncooperativeness (e.g. refusal of care).</p> <p>When antipsychotic medications are used, there needs to be clear identification of target behaviors with periodic review of documentation for continued need for the medication, review for potential side effects and a plan for gradual dose reduction if not contraindicated. If dose reduction is contraindicated, there needs to be a pertinent explanation documented. There should be documentation of discussions of risk versus benefit with the resident and or responsible party.</p> <p>Psychotropic medications are defined as antipsychotics, antidepressants, anxiolytics, and hypnotics. These medications require careful documentation of clinical rationale for use and response to use. Gradual dose reductions (GDR) must be attempted unless clinical contraindicated. If GDR is clinically contraindicated, the reason for this needs to be documented.</p> <p>Other medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication listed in §483.45(c)(3), unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice and in accordance with §483.45(d)(4). Categories of medications which affect brain activity include antihistamines, anti-cholinergic medications and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect, and muscle spasms or stiffness. The requirements pertaining to psychotropic medications apply to these types of medications when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication.</p> <p>483.45(e)(4-5) Use of PRN antipsychotic medications is limited to 14 days. If the prescriber believes ongoing PRN antipsychotic medication is clinically appropriate, they will need to reevaluate every 14 days and write a new order. Other psychotropic medications such as antidepressants, anxiolytics and hypnotics can have the order extended if the practitioner documents the rationale for the extended time period and indicates a specific duration.</p>	<p>and when verbal (telephone) orders are (or are not) appropriate.</p> <p>Advise the facility about setting limits on who can recommend to, or request any medications from, the practitioner.</p> <p>Interact with attending physicians about responses to medication irregularities and identified or suspected adverse consequences.</p> <p>Review and help implement consistent adherence to the care delivery process in managing all medical and psychiatric symptoms and conditions. Guide the staff and practitioners in the proper use of clinical reasoning and problem solving and good diagnosis as a foundation for prudent medication use for all medical and psychiatric symptoms and conditions.</p> <p>As part of QA activities, review the timeliness and appropriateness of pharmacy services, including consultant support, and of physician responses to consultant pharmacist recommendations.</p> <p>Advise and guide the facility about the quality of its medication utilization and monitoring, including appropriate use and monitoring of psychopharmacological medications.</p>
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medications, drug regimen review	CFR483.45(c)(1)(2)(4)(5) Pharmacy Services TN: F756	<p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The review must include a review of the resident's medical chart. The pharmacist must report any irregularities to the attending physician and the facility's medical director and the director of nursing, and these reports must be acted upon.</p> <ol style="list-style-type: none"> 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. 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. 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. <p>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.</p> <p><u>The intent of this requirement is that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON).</u></p> <p><u>The review must include the medication administration record (MAR), orders, progress notes (including consultant notes), RAI, lab/diagnostic tests, any documentation of expressions/indications of distress and/or change in condition, QM/QI reports, and should include observation of whether there is progress towards the therapeutic goal.</u></p>	<p><u>AP:</u> Review all <i>consultant pharmacist reports and comments</i>, and sign and date the report or comment. Modify orders as needed to <i>address</i> adverse consequences and clinically significant treatment <i>concerns</i>. Alternatively, provide a <i>clinically pertinent rationale</i> for not modifying a current regimen or dose, especially if it is despite risks or suspected or actual adverse consequences. <i>Monitor</i> the <i>progress</i> of symptoms and the presence of risks, discuss clinical issues with the nursing staff, and evaluate patients in more detail, as indicated.</p> <p><u>MDIR:</u> Support the availability of adequate and appropriate <i>pharmacy services</i> to the facility residents. As part of QA activities, review the timeliness and appropriateness of <i>provider pharmacy</i> and <i>consultant pharmacist support</i>. Communicate with the consultant pharmacist to ensure that physicians receive <i>clinically pertinent consultations</i> and that they <i>respond appropriately</i> to recommendations.</p> <p>Review a summary of <i>trends in pharmacist comments</i> concerning medication utilization, individual physician prescribing practices, and responses to consultant pharmacist communications, and address significant concerns as needed.</p> <p>Guide and educate the staff and practitioners regarding <i>selection and prescribing of medications</i> for the facility's population, problematic medications, medication-related adverse consequences, and appropriate approaches to diagnosing and managing medical and psychiatric symptoms and issues, based on pertinent literature and regulatory guidelines. As part of QA activities, perform case reviews to identify <i>medication-related issues</i> as well as the identification and management of <i>medication-related adverse consequences</i> above and beyond those noted by the consultant pharmacist. Intervene as needed with attending physicians to <i>address suspected and identified adverse medication consequences</i> that have a significant adverse impact on residents.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Medications, errors	CFR483.45(f)(1)(2) Pharmacy Services TN: F759-F760	<p>The facility must ensure that its medication error rates are not five percent or greater; and residents are free of any significant medication errors.</p> <p><u>“Significant medication error” means one which causes the resident discomfort or jeopardizes his or her health and safety. Criteria for judging significant medication errors as well as examples are provided below. Significance may be subjective or relative depending on the individual situation and duration, e.g., constipation that is unrelieved because an ordered laxative is omitted for one day, resulting in a medication error, may cause a resident slight discomfort or perhaps no discomfort at all. However, if this omission leads to constipation that persists for greater than three days, the medication error may be deemed significant since constipation that causes an obstruction or fecal impaction can directly jeopardize the resident’s health and safety</u></p>	<p><u>AP:</u> Write <i>legible and complete orders</i>, using only approved abbreviations and following principles of safe order writing. At the time that a verbal order is given, verify that <i>staff understand the order</i> correctly. Order medications judiciously to try to <i>minimize the number and frequency of doses</i> given to residents.</p> <p><u>MDIR:</u> Educate and inform the physicians and staff about <i>medication-related indications, benefits, and risks</i> for the population. Encourage the <i>judicious use of medications</i> including limiting doses and frequency of administration, whenever possible. As part of QA activities, review cases focusing on <i>appropriateness and clarity of physician orders</i>, and whether <i>prescribing in the facility</i> is consistent with principles for prescribing for the population and the indications and risks of individual medications. Guide the facility to strictly <i>limit</i> those who can take and write <i>verbal orders</i> as well as regarding other safe ordering practices. Review compliance with <i>signing verbal/telephone orders</i>.</p>
Medications, self-administration	CFR483.10(c)(7) <u>Resident Rights</u> TN: F554	<p>The resident has the right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p> <p><u>If a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) (as defined in §483.21(b), F657, Comprehensive Care Plans) to determine that it is safe before the resident exercises that right. A resident may only self-administer medications after the IDT has determined which medications may be self-administered.</u></p> <p><u>When determining if self-administration is clinically appropriate for a resident, the IDT should at a minimum consider the following:</u></p> <ul style="list-style-type: none"> • <u>The medications appropriate and safe for self-administration;</u> • <u>The resident’s physical capacity to swallow without difficulty and to open medication bottles;</u> • <u>The resident’s cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; The resident’s capability to follow directions and tell time to know when medications need to be taken;</u> • <u>The resident’s comprehension of instructions for the medications they are taking.</u> 	<p><u>AP:</u> Help the staff decide if a resident can <i>self-administer medications</i> safely. Be alert to situations where a resident may be taking medications from a personal supply or <i>taking medications improperly or excessively</i>, and intervene as needed.</p> <p><u>MDIR:</u> Guide the facility in developing and implementing <i>appropriate approaches</i> to evaluating residents who wish to self-administer medications. Guide the facility in effectively <i>monitoring residents who self-administer</i> to look for the inappropriate or excessive medication use. Identify whether physicians have made <i>adequate interventions</i> to address such issues; especially, those that have resulted in adverse consequences.</p>

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		<p><u>including the dose, timing, and signs of side effects, and when to report to facility staff.</u></p> <ul style="list-style-type: none"> • <u>The resident’s ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.</u> • <u>The resident’s ability to ensure that medication is stored safely and securely.</u> 	
Nursing Services	CFR 483.35 TN: F725 F726	<p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).</p> <p>“Providing care” for nursing staff is defined as including assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs. [§ 483.35(a)(4)] Facilities must identify, document, and maintain any training, certification, and similar records in an existing personnel file or training record for direct care personnel.</p> <p>Minimum knowledge, competency and skills are required for all nursing personnel, including nursing assistants and registry/temporary personnel. [§ 483.35(d)(2), § 483.35(a)(3)]. There are specific and detailed requirements as to nurse aide experience and qualifications [§ 483.35(d)]. The facility must do an annual performance review of nurse aides, and provide appropriate education and training based on outcome of these reviews. [§ 483.35(d)(7)]</p>	<p><u>AP:</u> Discuss periodically with the medical director the <i>nature, characteristics, and needs</i> of the patients and help identify any <i>gaps</i> and other concerns related to facility staffing and services.</p> <p><u>MDIR:</u> Help the facility assess its <i>services and staffing</i> (including the performance and practices of staff) and the population’s <i>characteristics and needs</i>, and guide the facility in determining areas for improvement.</p>
Paid Feeding Assistants- Food and Nutrition Services	CFR 483.60(h)(1)-(3) <u>Food and Nutrition Services</u> TN: F811	<p>A facility may use a paid feeding assistant if (i) the feeding assistant has successfully completed a State-approved training course that meets the requirements and (ii) the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN)). In an emergency, a feeding assistant must call a supervisory nurse for help.</p> <p>A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. Complicated feeding problems include, but are limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the interdisciplinary team’s assessment and the resident’s latest assessment and plan of care. Appropriateness for this</p>	<p><u>AP:</u> Help the facility identify residents who can be fed safely by a <i>paid feeding assistant</i>. Identify and address <i>treatable medical causes</i> of impaired eating, anorexia, and weight loss. Help staff monitor for and address <i>complications related to eating and feeding</i>.</p> <p><u>MDIR:</u> Guide the facility in developing and implementing policies and procedures regarding the <i>use of paid feeding assistants</i>. Guide and oversee the facility’s practices regarding identifying and addressing <i>factors</i> such as medications and medical</p>

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		<p>program should be reflected in the comprehensive care plan.</p> <p><u>The intent is to ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. The use of paid feeding assistants is intended to supplement certified nurse aides, not substitute for nurse aides or licensed nursing staff. The regulation requires that paid feeding assistants must work under the supervision of an RN or LPN, and they must call the supervisory nurse in case of an emergency. Therefore, a facility that has received a waiver and does not have either an RN or LPN available in the building cannot use paid feeding assistants during those times.</u></p>	<p>conditions <i>that affect appetite and nutritional status</i>.</p> <p>As part of QA activities, guide the facility in assessing its <i>approaches</i> to nutrition, anorexia, weight loss, and assisting residents who need help in eating.</p>
Pharmacy Services	CFR483.45 TN: F755	<p>The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who—</p> <ul style="list-style-type: none"> • §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. • §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and • §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. • Disposal methods for controlled medications must involve a secure and safe method to prevent diversion and/or accidental exposure. 	<p><u>AP: Prescribe opioids and other controlled drugs judiciously and monitor residents</u> receiving these medications for evidence of efficacy, continued indications, and adverse consequences. Identify and report to nursing management any suspicions about <i>possible drug diversion</i> or evidence of possible <i>impairment of staff</i> that might suggest possible drug use.</p> <p><u>MDIR: Review policies and procedures to ensure emergency drugs are available for residents.</u></p> <p>Advise and guide the staff and practitioners about the <i>benefits and risks of opioids</i> and other <i>controlled substances</i> and the need for <i>judicious prescribing</i> and <i>careful handling, including disposal</i>, of these medications.</p> <p>Promote and guide responsible and careful <i>assessment, documentation, and reporting of pain</i> and <i>detailed, objective monitoring</i> of residents receiving opioids for evidence of efficacy and adverse consequences. Identify and report to nursing management any <i>suspicions</i> about possible <i>drug diversion</i> or evidence of possible impairment of staff that might suggest possible drug use.</p> <p>Help the facility ensure that <i>medication errors are recognized and reported</i> appropriately.</p>

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Physical environment	CFR 483.90 Smoking Policy TN:F926	<u>Smoking Policy</u> §483.90(i) (5). Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety, including but limited to non-smoking residents.	<u>AP</u> : Help the facility manage <i>residents who smoke</i> , including efforts to get a resident to limit or stop smoking. <u>MDIR</u> : Advise the facility regarding <i>policies and procedures</i> about managing residents who smoke, including efforts to limit or stop smoking.

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Physician care and responsibility</p> <p>Resident Care Supervised by a Physician</p>	<p>CFR483.30 <u>Physician services</u></p> <p>TN: F710</p>	<p>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.</p> <p>Physician Supervision. The facility must ensure that—The medical care of each resident is supervised by a physician; Another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p><u>Supervising the medical care of residents means participating in the resident's assessment and care planning, monitoring changes in a resident's medical status, and providing consultation or treatment when contacted by the facility. It also includes, but is not limited to, prescribing medications and therapy, ordering a resident's transfer to the hospital, conducting required routine visits or delegating to and supervising follow-up visits by NPPs.</u></p> <p><u>It is the responsibility of the facility to ensure that another physician supervises the care of residents when the attending physician is unavailable. The attending physician may designate another physician to act on his/her behalf when unavailable. If the attending physician is unavailable and does not designate another physician to act on his/her behalf, or the designated physician is unavailable, the facility must have a physician available who will supervise the care of the attending physician's residents.</u></p> <p><u>There may be examples of physician orders in the medical record that would not impact a resident's medical care, such as instructions to contact a family member or providing date/time of an order; concerns related to these types of orders do not fall under the category of a physician's supervision of medical care and would not be cited here</u></p> <p><u>If surveyors identify deficiencies in those areas, they are instructed to ask:</u></p> <ul style="list-style-type: none"> • <u>Is there evidence that the attending physician supervises the resident's medical care? If not, what did the facility do?</u> • <u>If the physician makes a change to the residents' plan of care, e.g. orders a new medication or changes a medication, is there evidence that the physician reevaluated the effectiveness of the intervention and the resident's response? NOTE: the timing of the reevaluation may vary depending upon the type of change, type of medication.</u> • <u>If staff reported a change in medical status to the physician, how did the physician respond?</u> 	<p>AP: <i>Evaluate, diagnose, and manage</i> residents' medical and psychiatric symptoms and conditions. Review the resident's risk factors, functional and psychosocial status, and quality of life with the resident and staff. Respond promptly to notification of significant changes in medical condition. Assess and manage acute illness in a timely fashion, at the facility if possible. Authorize transfer of residents with acute medical problems who cannot be treated adequately in the facility. At required visits, review residents' medical stability, medications, active medical and psychiatric symptoms and conditions, overall condition and prognosis, and treatment plan, and their progress and problems in maintaining or improving their physical, mental, and functional status. Also review high-risk or problem-prone areas (e.g., impaired nutritional status or skin breakdown). Write, sign, and date a progress note that reflects these reviews and patient assessments. Review periodically the continued pertinence of the entire medication regimen. Review medications for possible tapering or discontinuation. Guide and coach staff and other health care professionals in establishing and validating diagnoses and the indications and pertinence of all medical interventions. Inform a facility of backup and alternate coverage.</p> <p>Oversee any tasks that are delegated to other health care professionals (e.g., dietary and therapy orders) and scrutinize any orders written by others.</p> <p>Ensure after hours call coverage and communicate on-call schedule to facility.</p> <p>MDIR: Clarify physician expectations and guide and direct their performance. As part of QA activities, review attending physician performance and practice, as well as compliance with these diverse requirements. Clarify the components of a pertinent physician visit and medical review. Collaborate with other facility leadership to ensure that all disciplines stay within the scope of their practice and that the physicians do not delegate anything outside of the scope of other disciplines' capabilities, such as diagnosing complex or multiple causes of medical symptoms.</p> <p>Clarify procedures and limits for all order writing in the facility.</p>

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		<ul style="list-style-type: none"> • <u>If the attending physician was unavailable and could not respond, did the facility have a physician available to supervise the medical care of the resident? How did this physician respond?</u> • <u>When a NPP performs a delegate physician visit, and determines that the resident's condition warrants direct contact between the physician and the resident, does the physician follow up promptly with a personal visit?</u> <p>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 [483.30]. The physician must sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications [483.30(b)(3)] and write, sign, and date progress notes at each visit [483.30(b)(2)]. The facility must ensure that every resident is under supervised by a physician [483.30(a)(1)] and another physician supervises the medical care of residents when their attending physician is unavailable [483.30(a)(2)] and the facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency [483.30(d)]. Routine regulatory visits must occur once every 30 days for the first 90 days, then at least every 60 days thereafter [483.30(c)(1)], with a 10-day grace period [483.30(c)(2)]. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist [483.30(c)(4)].</p> <p>Any required physician task in a NF (excluding tasks which the regulations specify must be performed personally by the physician), may also be performed by a NP/PA/CNS who is not an employee of the facility but who is working in collaboration with a physician [483.30(f)].</p> <p>The attending physician can delegate writing dietary orders to a qualified dietitian or other clinically qualified nutrition professional § 483.30(e)(2) and may delegate to a qualified therapist the task of writing therapy orders § 483.30(e)(3), to the extent that these professionals are permitted to perform these tasks under state law. A NP/PA/CNS cannot delegate these order-writing tasks. The physician is not obligated to delegate these orders and is ultimately responsible for any order writing done by those of other disciplines.</p> <p>Anyone who writes an order that is delegated by a physician must stay within the scope of their practice.</p>	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Physician Visits; Frequency (see table on page 91)	CFR483.30(c) <u>Physician Services</u> TN: F712	<p>Frequency of Visits-Physician visits must conform to the following schedule: (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.</p> <p>(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.</p> <p>The timing of a physician visit is based on the admission date of the resident. Visits must be made within the first 30 days, and then at 30-day intervals up until 90 days after the admission date. Visits must then be at 60-day intervals. Although the visit can occur within 10 days of the required date, a visit that occurs past the due date will not affect the next due date. However, surveyors are unlikely to scrutinize physician visits unless there is indication of inadequate medical care. “Must be seen” means that a physician must make actual face-to-face contact with the resident. This direct contact is not required at the time of admission, since the decision to admit an individual to a nursing facility generally involves physician contact during the period immediately preceding the admission. However, that does not preclude a physician visit upon, or soon after admission, for an individual whose condition requires additional medical evaluation.</p>	<p><u>AP:</u> Make all required visits in a timely fashion. After admission, visit a resident at least every 30 days for the first 90 days and at least every 60 days thereafter. Make scheduled visits no later than 10 days after the scheduled date, and other visits as a resident’s condition warrants. If collaborating with a nurse practitioner or physician assistant, make required alternate visits.</p> <p><u>MDIR:</u> Implement appropriate policies and procedures regarding physician visits. As part of QA activities, review attending physician compliance with visit requirements.</p>

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Physician availability for emergency care, Available 24 hours	CFR483.30(d) Physician Services TN: F713	<p>The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.</p> <p><u>If a resident's attending physician is unavailable, the facility should attempt to contact the covering for the attending physician before assuming the responsibility of contacting another physician. Arranging for physician services may include assuring resident transportation to a hospital emergency room or other medical facility if the facility is unable to meet the particular medical need at the facility. The provision of transportation does not remove the facility's responsibility to have a physician available, 24 hours a day, to respond to emergencies that do not require medical care in an alternative setting.</u></p>	<p><u>AP:</u> Provide a facility with current information about <i>practice location</i>, backup <i>coverage</i>, <i>contact information</i>, etc.</p> <p><u>MDIR:</u> Ensure that all physicians have arranged for <i>timely and cooperative backup coverage</i> and have provided their contact and emergency backup information. <i>Provide backup</i> for the facility when a physician and his/her backup coverage are unavailable. As part of QA activities, address concerns and problems with coverage and availability as needed.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Quality of care	CFR483.25 <u>Quality of Care</u> TN: F684	<p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that resident receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>F684 includes, but is not limited to, care of a resident with dementia, diabetes, renal disease, fractures, congestive heart failure, non-pressure-related skin ulcers (arterial ulcers, venous ulcers, and diabetic neuropathic ulcers), pain, fecal impaction, hospice services, dialysis services, and end-of-life care.</p> <p><u>A resident approaching the end of life must receive, and the facility must provide, the necessary care and services to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</u></p> <p><u>In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:</u></p> <ul style="list-style-type: none"> • <u>An accurate and complete assessment (see §483.20);</u> • <u>A care plan that is implemented consistently and based on information from the assessment;</u> • <u>Evaluation of the results of the interventions and revising the interventions as necessary.</u> <p><i>(Continued on next page)</i></p>	<p><u>AP:</u> Adequately evaluate, diagnose, and <i>manage medical and psychiatric conditions</i> and risk factors consistent with relevant evidence, protocols, and guidelines. Document enough information and conclusions about each resident's condition and progress to <i>clarify the medical basis for the medical plan and the overall plan of care</i>. Order appropriate tests, consultations and evaluations as medically indicated.</p> <p>Confirm that staff <i>implement medical orders</i> consistently and correctly.</p> <p>Ensure that <i>specific medical conditions and symptoms</i> are being monitored and addressed appropriately and that a resident's individual <i>goals and values</i> are <i>respected</i>.</p> <p>Periodically after admission, assess and address <i>risk factors for clinical and functional deterioration</i>, such as unrelieved pain. Alert staff to them, and document significant concerns in progress notes.</p> <p>Periodically document a resident's <i>prognosis</i>, potential for improvement, and <i>medical causes of functional impairment or decline</i>, including reasons for clinically unavoidable deterioration. Review with a resident and/or health care agent for whether <i>palliative or hospice care</i> is appropriate at a given time.</p>

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Quality of Care	CFR483.25 <u>Quality of Care</u> TN: F684	<i>(Continued from previous page)</i> 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.	<u>MDIR:</u> Help develop and/or implement policies and procedures to recognize, assess, diagnose, manage, and monitor diverse clinical issues.
Pain Management	Pain Management CFR 483.25(k) TN: F697	<u>Based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident’s choices, related to pain management.</u> <i>Opioids for Pain Management are appropriate treatment options for acute pain as well as chronic pain in some residents. However, because of potential for harm from opioids, prescribers should consider using alternative pain management approaches, and prescribe the lowest effective dosage for the shortest amount of time, while monitoring for effectiveness and any adverse effects.</i> <i>When treating pain in a resident with an addiction history or opioid use disorder (OUD), strategies must be used to relieve pain while also considering the OUD or addiction history. These strategies may include continuation of medication assisted treatment (MAT), non-opioid pain medications, and non-pharmacological approaches.</i> <i>Provide the necessary monitoring and supervision for a resident with known substance use disorder and history of using illicit substances when outside of the facility.</i> <i>(Continued on next page)</i>	Guide staff regarding appropriate policies and procedures related to the medical and psychiatric aspects of care planning and resident assessment . Help review for whether these activities facilitate the provision of care and services to help residents attain and maintain the highest practicable level of physical, mental, and psychosocial well-being . As part of QA activities, review for whether the staff and practitioners adequately evaluate, diagnose, manage, and monitor medical and psychiatric conditions and risk factors consistent with relevant evidence, protocols, and guidelines, including specific medical conditions and problems such as anorexia, falls, behavior issues, and pain. Review the clarity and pertinence of attending physician documentation and orders , including whether physician documentation adequately covers a resident’s prognosis, potential for improvement, and medical causes of functional impairment or decline, including reasons for clinically unavoidable deterioration. Help review whether staff are consistently implementing orders correctly. Educate and inform individual physicians regarding clinical practices to improve care. Review for whether medical practitioners respect residents’ goals and values and use diagnostic tests and consultations appropriately. Review for appropriate initiation, use, and oversight of palliative and/or hospice care .

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	CFR 483.40 Behavioral health services CFR 483.45 Pharmacy Services CFR 483.95 Training requirements, behavioral health	<p><u>Care and Services for a Resident with Dementia</u></p> <p>The facility is expected to assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident living with dementia, their family, and/or representative. The facility must provide resources necessary for an individual resident to be successful in reaching person-centered care plan goals that are achievable. The goals should promote the highest practicable level of functioning for residents living with dementia.</p> <p><u>While there is no specific investigative protocol for care of a resident living with dementia, the surveyor may use the checklist entitled, “Review of Care and Services for a resident with Dementia” to help investigate the care and services provided to a resident with a diagnosis of dementia.</u></p> <p><u>For residents living with dementia who are receiving one or more psychopharmacological agents, also review guidance at F757, Unnecessary Drugs. Prescribers should consider the following:</u></p> <ul style="list-style-type: none"> • <i>Evaluate the resident for psychosocial harm related to side effects of medications, such as, sedation, lethargy, agitation, mental status changes, or behavior changes.</i> • <i>Immediate release forms of opioids are preferred over long-acting forms to reduce overdose risk for residents living with dementia, unless clinically indicated.</i> • <i>Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotics should not substituted for another psychotropic medication unless there is documented clinical indication consistent with clinical standards of practice.</i> • <i>Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented.</i> <p>Note: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure.</p>	<p>AP: Review and verify appropriate <i>diagnosis and treatment</i> for all individuals with <i>behavior issues and psychiatric symptoms and diagnoses</i>. Evaluate all such symptoms, focusing on ruling out and addressing <i>underlying medical and medication-related causes</i>. Obtain <i>consultative support</i> as needed but <i>remain intimately involved</i> in the ongoing management and monitoring of such individuals. Collaborate with staff to provide <i>appropriate medical and nonpharmacological interventions</i> for individuals with behavior and psychiatric symptoms, including (but not limited to) neuropsychiatric conditions such as dementia. Prescribe all medications judiciously with awareness of indications and contraindications and monitor for <i>adverse consequences</i> related to medications and address appropriately. Obtain <i>appropriate input</i> from residents or a substitute decision maker regarding the treatment goals and plan.</p> <p>MDIR: Help develop and implement appropriate <i>policies and procedures</i> related to the care of individuals with <i>behavior and psychiatric diagnoses and symptoms</i>, regardless of diagnosis. Educate and inform the staff and practitioners about the appropriate <i>evaluation and management of behavior and psychiatric conditions</i>. Educate and inform the staff and practitioners about the need to assess each resident’s total current <i>medication regimen as a potential cause</i> of behavior and psychiatric symptoms, as well as the appropriate <i>indications for medications and other interventions</i> used to treat psychiatric and symptoms and address behavior issues.</p> <p>As part of QA activities, review the <i>performance</i> of the staff and practitioners in various aspects of <i>assessing, managing, and monitoring</i> individuals with behavior and psychiatric symptoms, including (but not limited to) medication management.</p>

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Quality of care; ADLs (continued)	CFR483.24(a)(1)(b)(1)-(5)(i)-(iii) <u>Activities of daily living</u> TN: F676 TN: F677	<p>F676–Based on the comprehensive assessment of a resident and consistent with the resident’s needs and choices, the facility must provide the necessary care and services to ensure that a resident’s abilities in activities of daily living do not diminish unless an individual’s clinical condition demonstrates that the decline was unavoidable. This includes the facility ensuring that: to bathe, dress groom, and oral care, transfer and ambulate, including walking, toilet, eat (including meals and snacks), and to use speech, language or other functional communication systems.</p> <p>F677–A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p><u>The existence of a clinical diagnosis shall not justify a decline in a resident’s ability to perform ADLs unless the resident’s clinical picture reflects the normal progression of the disease / condition has resulted in an unavoidable decline in the resident’s ability to perform ADLs. Conditions which may demonstrate an unavoidable decline in the resident’s ability to perform ADLs include but are not limited to;</u></p> <ul style="list-style-type: none"> • <u>The natural progression of a debilitating disease with known functional decline;</u> • <u>The onset of an acute episode causing physical or mental disability while the resident is receiving care to restore or maintain functional abilities; and</u> • <u>The resident’s or his/her representative’s decision to refuse care and treatment to restore or maintain functional abilities after efforts by the facility to inform and educate about the benefit/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The decision to refuse care and treatment must be documented in the clinical record. Documentation must include interventions identified on the care plan and in place to minimize or decrease functional loss that were refused by the resident or resident’s representative and any interventions that were substituted with consent of the resident and/or representative to minimize further decline.</u> 	<p><u>AP:</u> Periodically <i>review</i> a resident’s <i>function</i> and help identify significant trends (e.g., progress, stability, or decline) in function. Identify <i>medical and psychiatric risk factors</i> for potential decline in ADL function, such as active medical conditions and adverse medication consequences.</p> <p>Address <i>treatable causes of functional impairment and decline</i> that impact on function before attributing decline to irreversible problems such as dementia, aging, or progression of untreatable comorbid conditions. <i>Remain involved</i> in assessing impact of medical issues affecting function and do not just order therapy referrals; for example, help staff clarify the details and causes of falls and other problems for which therapy referral is made.</p> <p><u>MDIR:</u> Help ensure that attending physicians adequately assess, evaluate, and address <i>risk factors and medical factors</i> (including medications in all categories) that affect function, condition change, and functional decline. Review for whether <i>physicians remain</i> adequately <i>involved</i> in identifying and addressing causes and assessing progress, and do not simply order therapy referrals.</p>
Quality of care; Vision on hearing (continued)	CFR483.25(a)(1)(2) <u>Vision and hearing</u> TN: F685	To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	<u>AP:</u> Perform basic <i>vision and hearing screening</i> as part of the history and physical exam. Address <i>medical causes</i> of impaired vision and hearing. Authorize an adequate <i>vision and hearing evaluation</i> , as indicated. Consider how <i>impaired vision and hearing</i> may affect behavior, mood, falls, function, and other

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		<p><u>The facility is responsible for helping residents and their representatives locate and use available resources to obtain needed services. This includes helping make appointments and arranging transportation to obtain needed services.</u></p> <p>Residents must receive proper treatment and assistive devices to try to maintain vision and hearing abilities. Facilities must provide access to vision and hearing services, but do not have to provide assessments or actual services on site.</p>	<p>possible <i>complications</i>.</p> <p>MDIR: Help the facility identify services to assess and address <i>sensory impairments</i> and try to prevent sensory decline where possible. Review for whether <i>physicians</i> are helping <i>identify and address</i> the impact of <i>impaired vision and hearing</i> on behavior, mood, falls, function, quality of life, and other possible complications.</p>
Quality of care; Skin Integrity—Pressure Ulcers (continued)	<p>CFR483.25(b)(1)(i)(ii)</p> <p><u>Pressure ulcers</u></p> <p>TN: F686</p>	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers from developing unless the individual’s clinical condition demonstrates that they were unavoidable. A resident with pressure ulcers will receive necessary evaluation, including staging, treatment, and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing.</p> <p><u>The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and service consistent with professional standards of practices to:</u></p> <ul style="list-style-type: none"> • <u>Promote the prevention of pressure ulcer/injury development</u> • <u>Stage PU/PIs to determine the damage to the skin and underlying tissue.</u> • <u>Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and</u> • <u>Prevent development of additional pressure ulcers/injury.</u> 	<p>AP: Identify and address <i>risk factors</i>, including medical comorbidities and medication-related adverse consequences, for development or impaired healing of pressure ulcers. Determine staging of the damaged tissue and order appropriate <i>preventive and treatment measures</i>. For more complicated or poorly healing wounds, review with staff whether the <i>care plan</i> for managing these patients addresses key issues. Document appropriate <i>medical explanations</i> for the development of pressure ulcers or worsening of pressure ulcers in individuals, especially where healing was anticipated. Follow the <i>status of existing pressure ulcers</i> until resolved. Periodically evaluate in more depth patients with <i>complex, non-healing, or recurrent</i> ulcers.</p> <p>MDIR: Help the facility identify and implement appropriate <i>protocols to prevent and manage</i> pressure ulcers. Review <i>incidence and causes</i> of pressure ulcers, as part of the quality assurance process. Review whether physicians are addressing <i>pertinent medical conditions and risk factors</i>. Review and <i>assess patients with pressure ulcers</i> when questions arise about the current treatment plan or complications arise and the attending physician is not involved adequately.</p>
Quality of care; Incontinence (continued)	<p>CFR483.25(e)(1)-(3)</p> <p><u>Urinary incontinence</u></p>	<p>The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless their condition does not permit them to maintain continence.</p> <p>Residents admitted with an indwelling catheter or incontinence must receive appropriate treatment and services to try to restore as much normal bladder function as possible.</p>	<p>AP: Define the <i>category</i>, and help identify and address <i>treatable causes</i>, of incontinence and other urologic issues. Evaluate risks for <i>complications</i> of incontinence and those related to any indwelling catheter. Identify <i>opportunities to discontinue indwelling catheters</i>. Document pertinent information about the</p>

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	TN: F690	<p>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.</p> <p>The intent of this requirement is to ensure that:</p> <ul style="list-style-type: none"> • <u>Maintain bladder continence and/or bowel function in continent residents</u> • <u>Restore bladder continence and/or bowel function as possible, based on a comprehensive assessment and clinical condition</u> • <u>Prevent urinary tract infections to the extent possible</u> • <u>Provide timely continence care to residents</u> • <u>Ensure that a resident is not catharized unless required by their clinical condition</u> • <u>Ensure that a urinary catheter is removed as soon as possible unless the catheter is necessary because of the residents' clinical condition</u> 	<p><i>causes of incontinence</i> and the <i>potential</i> for at least some <i>improvement in continence</i>. Order appropriate <i>prevention and treatments</i>. As indicated, obtain <i>urologic testing</i> to help diagnose and manage incontinence and other urologic problems. Use medications cautiously to <i>treat urinary incontinence</i>, especially in residents who are susceptible to their side effects.</p> <p><u>MDIR</u>: Review <i>continence management and catheter use</i> as part of quality assurance activities. Help implement protocols to <i>identify and address causes</i> of incontinence. Review for whether physicians adequately <i>assess and manage bowel and bladder incontinence</i> and for appropriate <i>assessment and diagnostic efforts</i> and <i>prudent medication use</i>.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Quality of care; Mobility (continued)	CFR483.25(c)(1)-(3) <u>Mobility</u> TN: F688	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable, and a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. To review the impact of the physical, mental, and/or psychosocial aspects of the resident's ability to maintain, improve or prevent avoidable decline in range of motion and mobility, the surveyor must review the provision of care and services and implementation of interventions under this tag.</p> <p><u>The intent of this regulation (F688) is to ensure that the facility provides the services, care and equipment to assure that 1) a resident maintains, and/or improves to his/her highest level of range of motion (ROM) and mobility, unless a reduction is clinically unavoidable; and 2) a resident with limited range of motion and mobility maintains or improves function unless reduced Range of Motion (ROM)/mobility is unavoidable based on the resident's clinical condition.</u></p> <p>Residents who enter a facility without limitations in range of motion (ROM) should not develop such limitations unless clinically unavoidable. Residents with limited ROM should receive appropriate assessment and treatment to try to improve ROM or prevent further decline.</p>	<p><u>AP:</u> Identify and address <i>medical causes</i> of decreased mobility and ROM, and help staff try to <i>minimize related complications</i> such as falls or decreased ability to eat. Document <i>medical conditions that cause unavoidable decline</i> in mobility and range of motion (e.g., Parkinson's disease and stroke). Authorize appropriate <i>preventive measures and interventions</i> and also identify when interventions (e.g., additional therapy) are unlikely to be helpful.</p> <p><u>MDIR:</u> As part of quality assurance activities, review <i>medical issues related to mobility and movement</i>.</p>
Quality of care; Treatment for Mental / Psychosocial Concerns (continued)	CFR483.25(b) <u>Behavioral Health Services</u> TN: F741-743 F838	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.</p> <p>The behavioral health care needs of those with a SUD or other serious mental disorder should be part of the facility assessment under (F838) and the facility should determine if they have the capacity, services, and staff skills to meet the requirements as discussed in F741.</p>	<p><u>AP:</u> Review and verify appropriate <i>diagnosis and treatment</i> for all individuals with <i>behavior issues and psychiatric symptoms</i>. Evaluate all such symptoms, focusing on ruling out and addressing <i>underlying medical and medication-related causes</i>. Obtain consultative support as needed, but <i>remain intimately involved</i> in the ongoing management and monitoring of such individuals.</p> <p>Collaborate with staff to authorize and provide <i>appropriate medical and nonmedical interventions</i> for individuals with behavior and psychiatric symptoms. <i>Prescribe medications judiciously</i> with awareness of indications and contraindications, and monitor for <i>adverse consequences</i> related to medications and address</p>

		<p><u>Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (PTSD) require specialized care and services to meet their individual needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.</u></p> <p>Surveyors should be aware that all residents are screened for possible serious mental disorders or intellectual disabilities and related conditions prior to admission to determine if specialized services under Preadmission Screening and Resident Review (PASARR) requirements are necessary. If the resident does not qualify for specialized services under PASARR, but requires more intensive behavioral health services (e.g., individual counseling), the facility must demonstrate reasonable attempts to provide for and/or arrange for such services. This would include ensuring that the type(s) of service(s) needed is clearly identified based on the individual assessment, care plan and strategies to arrange such services (F644).</p>	<p>appropriately. Obtain appropriate <i>input from residents</i> or a substitute decision maker regarding the treatment goals and plan.</p> <p><u>MDIR:</u> Help develop and implement appropriate <i>policies and procedures</i> related to the care of individuals with behavior and psychiatric symptoms, regardless of diagnosis. Educate and inform the staff and practitioners about the <i>appropriate evaluation of behavior and psychiatric symptoms</i> and <i>clinically pertinent approaches</i> to managing such conditions and symptoms. Educate and inform the staff and practitioners about the essential assessment of each resident's <i>existing medication regimen</i> as a potential cause of behavior and psychiatric symptoms as well as the appropriate <i>indications for medications</i> and <i>other interventions</i> used to manage these situations.</p>
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Quality of Care; Trauma Informed Care	483.25(m) TN: F656 F699, F 726, F742	<p>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>Person-centered care includes cultural competency, meaning being respectful and responsive to the health beliefs, practices and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious or social groups. It also includes trauma-informed care practices to recognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions. Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others.</p>	<p><u>AP:</u> Review and verify <i>appropriate diagnosis and treatment</i> for all individuals with behavior issues and psychiatric symptoms. <i>Evaluate</i> all such <i>symptoms</i>, focusing on clarifying the issues and on ruling out and addressing <i>underlying medical and medication-related causes</i>. Obtain <i>consultative support</i> as needed, but remain intimately involved in the <i>ongoing management and monitoring</i> of such individuals. Collaborate with staff to provide appropriate <i>medical and nonmedical interventions</i> for individuals with behavior and psychiatric symptoms. <i>Prescribe medications judiciously</i> with awareness of indications and contraindications, and <i>monitor for adverse consequences</i> related to medications and address appropriately. Obtain appropriate input from residents or a substitute decision maker regarding the treatment goals and plan.</p> <p><u>MDIR:</u> Help develop and implement appropriate <i>policies and procedures</i> related to the care of individuals with <i>behavior and psychiatric conditions and symptoms</i>, regardless of diagnosis. Educate and inform the staff and practitioners about appropriate <i>evaluation and management of behavior and psychiatric conditions</i> and clinically <i>pertinent approaches</i> to managing such conditions and symptoms. Educate and inform the staff and practitioners about <i>appropriate indications</i> for medications and other interventions.</p> <p>As part of QA activities, help review the <i>performance of the staff and practitioners</i> in various aspects of assessing, managing, and monitoring individuals with behavior symptoms and psychiatric disorders.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
<p>Quality of care (continued)</p> <p>Nutrition</p>	<p>CFR483.25(g)(4) CFR483.25(g)(5)</p> <p><u>Tube Feeding Management / Restore Eating Skills</u></p> <p>TN: F693</p>	<p>Based on a resident’s comprehensive assessment, the facility must ensure that 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 use of enteral feeding was clinically indicated and consented to by the resident.</p> <p>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.</p> <p><u>A decision to use a feeding tube has a major impact on a resident and his or her quality of life. It is important that any decision regarding the use of a feeding tube be based on the resident’s clinical condition and wishes, as well as applicable federal and state laws and regulations for decision making about life-sustaining treatments.</u></p> <p><u>“Enteral feeding” (also referred to as “tube feeding”) is the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum.</u></p> <p><u>“Feeding tube” refers to a medical device used to provide liquid nourishment, fluids, and medications by bypassing oral intake. There are two basic categories, nasogastric and gastrostomy. The type of feeding tube used must be based on clinical assessment and needs of the resident since there are various kinds of feeding tubes within each category.</u></p>	<p><u>AP:</u> Identify and address a resident’s <i>nutritional risk factors</i> and <i>causes of anorexia and weight loss</i> (e.g., gastritis, medication side effects, depression). Help staff identify and address <i>factors affecting nutritional status</i> and appropriate interventions for <i>underlying causes</i>.</p> <p>Help staff review and address <i>treatable causes of impaired nutrition</i> before proposing tube feeding, and review <i>risks, benefits and alternatives</i> to a feeding tube with the resident and/or surrogate decision maker. After seeking and ruling out treatable causes, document <i>when weight loss</i> is <i>unavoidable</i>. Educate families about the <i>risks and limitations of feeding tubes</i> in individuals with advanced dementia and other end-stage conditions. Keep in mind that tube feeding is <i>rarely “clinically necessary”</i> for residents with weight loss or eating difficulties.</p> <p>Periodically reevaluate the <i>adequacy, appropriateness, rate, and other parameters</i> for any tube feedings, and modify as needed. Periodically review the possibilities for <i>liberalizing oral intake</i> in individuals who have altered diets or alternate routes of feeding. Monitor weights and <i>progress in appetite and food consumption</i> to determine whether tube feedings or altered diets are achieving</p>

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			<p>the desired response and are still needed.</p> <p><u>MDIR:</u> Help the facility identify appropriate <i>policies and procedures</i> for assessing and addressing nutritional issues. Help the facility identify appropriate approaches to <i>considering, managing, and monitoring tube feeding</i>. As part of QA activities, review for <i>adequate evaluation and management</i> of causes of <i>anorexia and weight loss</i>. Educate attending physicians and nurse practitioners as to <i>risks, benefits, indications, and contraindications</i> for enteral feeding.</p>
Quality of care (continued)	<p>CFR483.25(d) <u>Accidents</u></p> <p>TN: F689</p>	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><u>“Accident” refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction).</u></p> <p>The facility must maintain the environment as free as possible of accident hazards; and provide residents with adequate supervision and assistive devices to try to prevent accidents.</p> <p>Inappropriate physical restraints may be considered an accident hazard (See 483.12 re restraint use). Facilities are required to attempt appropriate alternatives before installing/ using bed rails, and if a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails.</p> <p><i>Electronic Cigarettes: Facilities must balance resident safety with a resident’s right to use these devices while also considering the rights of residents who do not want to be exposed to second-hand aerosol.</i></p>	<p><u>AP:</u> Identify and address a resident’s <i>risks for accidents and injury</i>, including falls. Seek, identify, and address <i>factors</i> such as the medication regimen <i>that affect injury risks</i>, including (but not limited to) falls. Identify and address <i>medical causes</i> of impaired alertness, gait, mobility, and balance. Authorize appropriate <i>evaluation and assistive devices</i> for residents, as needed.</p> <p><u>MDIR:</u> Review <i>trends and patterns</i> in incidents and accidents and discuss findings as part of the QA/RM process. Review for whether physicians <i>address medical issues</i> (including medications) that affect fall and other injury risk. Help the facility identify <i>accident hazards and risks</i>.</p>

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		<p><u>483.60 (e) (1) F808 Therapeutic diets must be prescribed by the attending physician</u></p> <p>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. An attending physician may delegate prescribing of therapeutic diets to a nutrition professional; however, the attending physician remains responsible for the resident's care.</p>	<p>AP: If the choice is made to delegate prescribing of therapeutic diets, <i>clarify the parameters</i> for such activity, including limits (for example, limits related to ordering lab tests or diagnosing causes of anorexia). Continue to <i>assess and manage medical issues</i> related to weight and nutrition. Do not allow those of other disciplines to make medical decisions about causation and treatment that <i>exceed their clinical capabilities</i>.</p> <p>MDIR: Help identify and implement policies related to <i>any order writing by those of other disciplines</i>, including expectations for <i>oversight and communication</i> between the attending physician and the dietician. Be aware of the <i>qualifications and experience</i> of the facility dietician. Review cases for adherence to <i>limits</i> on <i>order writing</i> by dietitians. As part of QA activities, <i>review</i> residents for whom the attending physician has <i>delegated</i> the <i>prescribing</i> of therapeutic diets and check that this has not led to problematic resident outcomes.</p>
Quality of care (continued)	<p>CFR483.25(g) <u>Nutrition/ Hydration Status Maintenance</u></p> <p>TN: F692</p>	<p>483.60 (d)- Food and Drink</p> <p>Each resident receives and the facility provides: food prepared by methods that conserve nutritive value, flavor, and appearance; food and drink that is palatable, attractive, and at a safe and appetizing temperature.</p> <p>A facility must ensure that a resident is offered sufficient fluid intake to maintain proper hydration and health.</p> <p><u>"Sufficient fluid" means the amount of fluid needed to prevent dehydration and maintain health. The amount needed varies for each resident and may fluctuate as the resident's condition fluctuates (e.g., diarrhea or fever).</u></p> <p>The facility must comprehensively assess each resident's hydration status.</p> <p>A facility must identify risk factors placing the resident at risk for dehydration, try to reduce those risk factors, and try possible alternatives, if the resident does not tolerate oral liquids.</p>	<p><u>AP:</u> Periodically discuss or evaluate a resident's <i>hydration status</i>. Consider <i>risk factors</i> for dehydration and order <i>interventions</i> (e.g., additional fluid, decreased diuretic dose) as indicated. Identify and document <i>medical issues</i> (e.g., stroke, coma, or delirium) that may <i>cause or contribute</i> to fluid and electrolyte imbalance. Identify and address <i>treatable causes</i> of fluid/electrolyte imbalance (e.g., fever, diarrhea, diuretics, diet consistency restriction, and poorly controlled diabetes). Monitor <i>laboratory parameters of hydration</i> status (e.g., BUN, creatinine and electrolytes) as indicated, and guide staff to identify whether abnormal results imply a clinical risk or problem. Review with staff when <i>fluid and electrolyte imbalance</i> may be <i>causing symptoms</i> such as confusion or behavior changes. Try to balance <i>diuretic use</i>, when needed to treat medical problems, with preventing excess volume depletion. Order <i>fluids as indicated</i>, for example, for those with fever, delirium, or diarrhea. Consider <i>oral rehydration solutions or subcutaneous fluid infusion</i></p>

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			<p>(hypodermoclysis) as alternatives to IV rehydration. Follow closely the progress of residents considered at significant risk for fluid and electrolyte imbalance, including dehydration, and those with impaired hydration status.</p> <p>When some degree of relative volume depletion is medically advisable (e.g., with heart failure), document the reason for use of diuretics and that burdens versus benefits of treatment have been considered and discussed. When dehydration is medically unavoidable (e.g., poor oral intake despite offering adequate fluids), and when goals of care do not include artificial hydration, document that dehydration is an expected outcome as a resident's condition declines.</p> <p><u>MDIR:</u> Help the facility implement medically valid approaches to evaluate and address hydration issues, including maintaining and monitoring fluid and electrolyte balance and correcting imbalances. Review whether physicians seek and address medical causes of hydration risk and fluid and electrolyte imbalance. Help the facility identify when hydration issues require a physician's involvement. As part of QA activities, identify whether hydration issues are being identified and managed appropriately.</p>
Quality of care (continued)	<p>CFR483.25(h) <u>Special needs</u></p> <p>Parenteral Fluids 483.25(h) TN: F694</p> <p>Respiratory / Tracheostomy Care and Suctioning 483.25(i) TN: 695</p>	<p>A facility must ensure that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses.</p> <p>F694: Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <ul style="list-style-type: none"> For facilities who offer IV therapy, the facility must develop and implement resident care policies based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuance of an IV, as well as for the prevention of infection at the site to the extent possible 	<p><u>AP:</u> Order special services that are indicated, based on individualized resident assessment, including related parameters (e.g., size of device, frequency of treatment) for use and monitoring, for aspects of care including: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. Periodically review with staff the impact of treatments (e.g., suctioning, ostomy changes) on the resident, and review for ongoing indications. Check periodically for any complications of devices and treatments. Authorize medically necessary podiatric services.</p> <p><u>MDIR:</u> Help the facility ensure availability of appropriate special</p>

		F695: Respiratory Care, including tracheostomy care and tracheal suctioning.	
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	Prostheses 483.25(j) TN:F696	<p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>F696: The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p>	<p><i>services.</i> As part of QA activities, perform some case reviews for appropriate <i>ordering, indications, and documentation</i> related to special services and treatments.</p>
Quality assurance and performance improvement	CFR483.75 QAPI TN: F865 <u>§483.75</u>	<p>Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:</p> <ul style="list-style-type: none"> • §483.75(a)(1) maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; • §483.75(a)(2) present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)] • §483.75(a)(3) present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and • §483.75(a)(4) present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. <p><u>There requirements are intended to ensure that long-term care facilities (including multi-unit chains) implement a comprehensive QAPI program which addresses all the care and unique services a facility provides.</u></p>	<p><u>AP:</u> Provide care that is consistent with pertinent evidence-based protocols and guidelines in order to help <i>optimize care practices and patient outcomes</i>. Follow the <i>approaches recommended throughout this Synopsis</i>. Review <i>information</i> from reliable references and from the medical director <i>regarding quality of care issues</i>. <i>Modify practices</i> as indicated based on <i>QA reviews</i> and other information from <i>authoritative references and other sources</i>. <i>Support</i> the facility's <i>performance improvement activities</i>.</p> <p><u>MDIR:</u> Establish a relevant <i>medical QA program</i> for the practitioners, and help the facility implement an appropriate <i>facility-wide QA program</i> that covers <i>key clinical and operational issues</i> (including, but not limited to, high risk, high volume and/or problem-prone areas in the facility assessment such as specific units, programs, departments and the facility's population). Identify <i>areas for review and data collection</i>, covering clinical care, quality of life, and resident choice. <i>Review and analyze collected information</i>, and <i>give feedback</i> about performance. Give all direct care staff and medical practitioners <i>pertinent information</i> including evidence-based approaches derived from the medical and geriatrics literature. Help develop and/or implement useful <i>quality indicators</i> for clinical conditions, patient safety, coordination of care, and quality of life. Serve on the facility <i>Quality Assessment and Assurance (QA&A) committee</i>. Guide the facility's development and implementation</p>

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		<p>QAPI is a type of quality management program which takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. An interdisciplinary approach encompasses all managerial, and clinical services, which includes care and services provided by outside (contracted or arranged) providers and suppliers.</p> <p>The purpose of a QAPI program is to ensure continuous evaluation of facility systems with the objectives of:</p> <ul style="list-style-type: none"> • Ensuring care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards where available; • Preventing deviation from care processes, to the extent possible; • Identifying issues and concerns with facility systems, as well as identifying opportunities for improvement; and • Developing and implementing plans to correct and/or improve identified areas. <p>Program and Documentation</p> <p>Each facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.</p> <p>The facility must maintain and be able to provide documentation and evidence of its ongoing QAPI program, which meets the requirements of §483.75.</p> <p>Demonstration of compliance includes, but is not limited to:</p> <ul style="list-style-type: none"> • Evidence of systems and reports demonstrating identification, reporting, investigation, analysis and prevention of adverse events; • Data collection and analysis at regular intervals; and • Documentation demonstrating development, implementation and evaluation of corrective actions or performance improvement activities. <p>Upon the request of a State Survey Agency, Federal surveyor or CMS, the facility must present evidence, including documentation, of its ongoing QAPI program's implementation and the facility's compliance with requirements.</p>	<p>of <i>resident care policies</i> and its approaches to <i>coordination of medical care</i>. Make <i>recommendations</i> to the administrator, DON, practitioners, and staff to help <i>improve care and operations</i>. Participate in the facility's overall <i>problem-solving efforts</i> whenever possible.</p>

<p>Quality compliance- Professional standards of</p>	<p>CFR483.70(b) and CFR483.21(b)(3) (i)-(iii)</p> <p><u>Compliance with federal, state, and local laws and professional standards</u></p> <p>TN: F836</p> <p>TN: F658-659</p>	<p>A facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles pertinent to professionals providing services in a facility.</p> <p><u>TN658: §483.21(b)(3) Comprehensive Care Plans:</u> The services provided or arranged by the facility, as outlined by the comprehensive care plan, must (i)meet professional standards of quality and (ii) be provided by qualified persons in accordance with each resident’s written plan of care, (iii) be culturally- competent and trauma-informed.</p> <p><u>INTENT:</u> To assure that ALL services, as outlined by the comprehensive care plan, being provided meet professional standards of quality.</p> <p><u>“Professional standards of quality” means that care and services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may emanate from a professional organization, licensing board, accreditation body or regulatory agency. Recommended practices to achieve desired resident outcomes might also be found in the clinical literature.</u></p> <p><u>CMS focuses on mental disorders particularly schizophrenia and the proper diagnostic criteria and supported documentation in the resident’s medical record. Mental disorders are diagnosed by practitioners using evidence-based criteria, such as the DSM, and must be supported by comprehensive documentation in the resident’s medical record. This includes evaluations of the resident’s physical, behavioral, mental, and psychosocial status, ruling out other medical conditions or substance effects, and noting any distress or functional changes. Insufficient documentation examples include diagnoses mentioned without supporting evidence, or notes in medical records without comprehensive evaluations. Proper documentation must show symptoms consistent with DSM criteria, comprehensive assessments, and the impact on the resident’s function. Surveyors review records and interview staff to ensure compliance with professional standards.</u></p> <p>When surveyors identify a pattern of residents with new diagnoses lacking sufficient documentation, they can cite non-compliance at a minimum scope of pattern (e.g., Level 2 = "E," Level 3 = "H," or Level 4 = "K"). They should also discuss findings with their state agency for potential referrals to respective state boards. Insufficient documentation for a new schizophrenia diagnosis represents non-compliance at F658, and if antipsychotic medication is involved, compliance with F605 should be evaluated. Examples include residents withdrawing from social activities due to medication side effects or lack of gradual dose reduction attempts. Surveyors should also review F605, F641, F644, and F841 to assess the medical director’s oversight of medical care.</p>	<p><u>AP:</u> Become familiar with <i>information</i> regarding desirable <i>care of the facility’s population</i>, including (but not limited to) <i>management of medical and psychiatric conditions</i>. Provide appropriate <i>medical care</i> for the population and the setting. Provide <i>clinically pertinent documentation</i> that explains the basis for medical diagnoses, decisions, conclusions, and orders.</p> <p><u>MDIR:</u> Clarify physicians’ <i>clinical responsibilities and practice and performance expectations</i>. Inform physicians in detail about <i>appropriate approaches</i> to managing the conditions and problems of long-term care residents and post-acute patients. Review attending physician <i>practice and performance</i> and give them <i>feedback</i> about their performance and practice relative to expectations. Inform the staff and management about effective <i>communication with physicians</i>, discussing medical issues with them, and identifying, documenting, and reporting any concerns about their performance and practice.</p>
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Quality of life	<p>CFR483.10(f)(4)(i i)-(v)</p> <p><u>Resident Rights: Right to Receive/Deny Visitors</u></p> <p>TN: F563</p> <p>CFR483.10(f)(4)(i)(A)-(G)</p> <p><u>Immediate Access to Resident</u></p> <p>TN: F562</p>	<p>F563-The resident has the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. The facility must provide immediate access to any resident by immediate family and other relatives of the resident, subject to the resident’s right to deny or withdraw consent at any time; the facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident’s right to deny or withdraw consent at any time. The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time; and the facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.</p> <p>F562-The facility must provide immediate access to any resident by representative of the Secretary of the Department of Health and Human Services, the State, the resident’s individual physician, the State long term care ombudsman, or the agencies responsible for the protection and advocacy of individuals with developmental disabilities or mental illness.</p>	<p><u>AP</u>: Help the staff address any concerns related to visitors, including the impact of family and others on the resident and staff and on the care provided to the resident.</p> <p><u>MDIR</u>: Help the facility develop and implement policies and procedures related to visitors and communications with others. Help the facility identify and address situations where visitors or other individuals from outside who interact with the residents may affect the safety and well-being of the residents and staff.</p>

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		<p><u>F563: Visitation Considerations During a Communicable Disease Outbreak Facilities may need to modify their visitation practices when there are infectious outbreaks or pandemics to align with current CMS guidance and CDC guidelines that enables maximum visitation, such as by:</u></p> <ul style="list-style-type: none"> • <u>Offering options for outdoor or virtual visitation, or indoor designated visitation areas</u> • <u>Providing adequate signage with instructions for infection prevention, i.e. hand hygiene, cough etiquette, etc.</u> • <u>Ensuring access to hand hygiene supplies</u> • <u>Taking other actions that would allow visitation to continue to occur safely in spite of the presence of a contagious infection</u> • <u>Contacting their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of communicable disease transmission during an outbreak</u> <p><u>During an infectious disease outbreak, while not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors. In these cases, before visiting residents who are on TBP, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to principles of infection prevention.</u></p> <p><u>Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, consistent with §483.10(f)(4)(v), placed by the facility based on recommendations of CMS, CDC, or the local health department. With the consent of the resident, facilities must provide 24-hour access to other non-relative visitors, subject to reasonable clinical and safety restrictions. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life</u></p> <p><u>F562: The facility must provide immediate access to the resident by the resident's physician, representative, and various state and federal officials and organizations as outlined in the regulation, which would include state and federal surveyors. Surveyors are considered representatives of the Secretary and/or the State. Facility staff cannot prohibit surveyors from talking to residents, family members, and resident representatives.</u></p>	

<p>Quality of life and environment (continued)</p>	<p>CFR 483.10 (e)(4)-(6)</p> <p><u>Choose/Be Notified of Room/Roommate Change</u></p> <p>TN: 559</p>	<p>The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement; the right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement; and [§483.10(e)(6)] the right to receive written notice, including the reason for the change, before the resident’s room or roommate in the facility is changed.</p> <p><u>Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.</u></p> <p><u>There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents are not able to share a room if one of the residents has a different payment source for which the facility is not certified (if the room is in a distinct part of the facility, unless one of the residents elects to pay privately for his or her care) or one of the individuals is not eligible to reside in a nursing home.</u></p>	<p><u>AP:</u> Help the staff identify, define, and address issues related to <i>room location, room sharing</i>, and related issues, including the impact on a resident’s quality of life and psychosocial function and the impact of the resident on others.</p> <p><u>MDIR:</u> Advise the staff about <i>policies and procedures</i> regarding <i>resident placement and room sharing</i>, and as needed, help the staff and practitioners identify, define, and address issues related to room location, room sharing, and related issues.</p>
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Quality of life (continued)	CFR §483.10(a)(1)(2)(b)(1)(2) <u>Resident Rights: Dignity</u> TN: F550 & F557	<p>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. The facility must protect and promote the rights of the resident.</p> <p>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.</p> <p>F557-The resident has a right to be treated with respect and dignity, including: The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</p> <p><u>"Dignity" means that in their interactions with residents, staff helps the resident maintain and enhance his/her self-esteem and self-worth; for example, grooming, wearing their own clothes appropriate to the time of day and individual preferences; labeling clothing; promoting resident independence and dignity in dining; respecting residents' private space and property; maintaining an environment in which there are no signs posted in residents' rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status); maintaining resident privacy of body including keeping residents sufficiently covered; and refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered or refusing to comply with a resident's request for toileting assistance during meal times.</u></p>	<p><u>AP:</u> <i>Examine and otherwise interact</i> with residents in a private area, to the greatest extent possible, and by respecting their dignity. Discuss clinical information in a way and location that ensures <i>confidentiality</i>.</p> <p><u>MDIR:</u> Help the facility implement policies and practices that <i>promote dignity and respect resident rights</i>. As part of QA activities, review and discuss <i>situations and issues</i> related to privacy, dignity, and resident rights.</p>
Quality of life (continued)	CFR §483.10(f)(1)-(3)(8) <u>Resident Rights: Self Determination</u> TN: F561	<p>The resident has the right to, and the facility must promote and facilitate, resident self-determination through support of resident choice, including but not limited to the right to (f)(1) choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plans of care; (f)(2) make choices about aspects of his or her life in the facility that are significant to the resident; and (f)(3) interact with members of the community and participate in community activities both inside and outside the facility. The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p>	<p><u>AP:</u> Ask the resident and staff about <i>resident choices</i> regarding desired wake, sleep, bathing and eating times, as they relate to the medical plan of care and orders such as medication choices and times. <i>Limit restrictions</i> (e.g., modified diets and food consistency) outside of essential medical indications and try to <i>liberalize treatments</i> to reflect the resident's personal needs, abilities, and preferences. Try to <i>avoid orders that require</i> nocturnal <i>awakenings</i> (e.g., medications or vital signs every 6 hours). Work with staff to <i>reduce unnecessary interventions</i> (e.g., frequent blood sugar measurement) as much as possible.</p>

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		<p><u>It is important for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed. Additionally, a resident's needs and choices for how he or she spends time, both inside and outside the facility, should also be supported and accommodated, to the extent possible, including making transportation arrangements.</u></p> <p><u>Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans. This includes, but is not limited to, choices about the schedules that are important to the resident, such as waking, eating, bathing, and going to bed at night. Choices about schedules and ensuring that residents are able to get enough sleep is an important contributor to overall health and well-being. Residents also have the right to choose health care schedules consistent with their interests and preferences, and information should be gathered to proactively assist residents with the fulfillment of their choices. Facilities must not develop a schedule for care, such as waking or bathing schedules, for staff convenience and without the input of the residents.</u></p> <p><u>If a facility changes its policy to prohibit smoking (including electronic cigarettes), it should allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents. The smoking area may be an outside area provided that residents remain safe. Residents admitted after the facility changes its policy must be informed of this policy at admission. (See §483.10(g)(1) and §483.10(g)(16)) For further explanation of safety concerns, refer to §483.25(d), F689. For information on smoking policies, refer to §483.90(i)(5), F926.</u></p>	<p><u>MDIR:</u> Help the staff and practitioners <i>recognize and incorporate resident choices</i> about activities and daily schedule into the overall plan of care, to the greatest extent possible; for example, bedtime, diet, food consistency, medication administration times, mealtimes, and choice of roommate.</p>

<p>Quality of life (continued)</p>	<p>CFR §483.10(e)(3) <u>Accommodation of Needs</u></p> <p>TN: F558</p>	<p>The resident has a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.</p> <p><u>“Reasonable accommodations of resident needs and preferences” means the facility’s efforts to individualize the resident’s physical environment.</u></p> <p><u>This includes the physical environment of the resident’s bedroom and bathroom, as well as individualizing as much as feasible the facility’s common living areas. The facility’s physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident’s own needs and preferences.</u></p> <p>The facility is responsible for evaluating each resident’s needs and preferences and for ensuring that the environment accommodates the resident to a reasonable extent and does not endanger the health or safety of individuals or other residents, regarding such tasks as opening and closing drawers; turning faucets on and off; having toiletry articles easily within reach while using the sink; opening and closing bedroom and bathroom doors; easily accessing areas of their room and bath, operating room lighting; using bathroom facilities as independently as</p>	<p><u>AP:</u> Periodically review with staff a resident’s <i>function and quality of life</i>. Help the staff identify services to allow the resident to <i>maintain</i> as much <i>independence</i> in the environment as possible.</p> <p><u>MDIR:</u> Help the facility <i>implement practices</i> that <i>accommodate resident needs and preferences</i>, try to optimize function and quality of life, and protect and enhance resident rights.</p>
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		<p>possible with access to assistive devices (such as grab bars within reach) if needed; performing other desired tasks such as turning a table light on and off and using the call bell; and accommodating preferences for furniture arrangement; providing reasonably sufficient electric outlets, comfortable bedroom seating, and task lighting that is sufficient and appropriate for the resident's chosen activities.</p> <p>The facility should also ensure that furniture and fixtures in common areas frequented by residents accommodate physical limitations and enhance residents' abilities to maintain their independence, such as being able to arise from living room furniture.</p> <p>The facility should provide seating with appropriate seat height, depth, firmness, and with arms that assist residents to rise to a standing position.</p> <p>Staff interactions with residents should take into account the physical limitations of the resident, assure communication, and maintain respect; for example, getting down to eye level with a resident who is sitting, speaking so a resident with limited hearing can read lips, and using a hearing amplification device such as a pocket-talker if the resident has such a device. Residents who use glasses, hearing aids, or similar devices should have them in use (except when the resident refuses), clean, and functional.</p>	
Quality of life (continued)	CFR §483.10(e)(6) <u>Choose / be Notified of Room / Roommate Change</u> TN: F559	<p>A resident has a right to be treated with respect and dignity including—</p> <ul style="list-style-type: none"> • (e)(6) Receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. <p><u>A resident's preferences should be taken into account when considering moving a resident to a new room or changing roommates.</u></p> <p><u>The resident should be supported when a roommate passes away by providing time to adjust before moving another person into the room. The length of time needed to adjust may differ depending upon the resident. Facility staff should provide necessary social services for a resident who is grieving over the death of a roommate.</u></p>	<p><u>MDIR:</u> Help the facility <i>implement practices</i> that accommodate resident <i>needs and preferences</i>, try to optimize <i>function</i> and <i>quality of life</i>, and protect and enhance <i>resident rights</i>.</p>
Quality of life (continued)	CFR §483.10(i) <u>Resident Rights</u>	<p>The resident has a right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. The facility must provide—</p>	<p><u>MDIR:</u> Advise the facility about <i>implementing practices</i> that help to create a <i>homelike environment</i> that meets their personal, social, functional and medical needs.</p>

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	<u>Safe Environment</u> TN: F584	<p>(i)(1) A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p><u>A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The intent of the word “homelike” in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible.</u></p> <p>Examples might include minimizing the use of overhead paging, medication carts, bed and chair alarms, use of dining trays and institutional signage.</p> <p>A “homelike environment” de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment.</p> <p>Although the regulatory language at this tag refers to “safe,” “clean,” “comfortable,” and “homelike,” for consistency, the following specific F-tags should be used for certain issues of safety and cleanliness:</p> <p>For issues of safety of the environment, presence of hazards and hazardous practices, use §483.25(d), Accidents F689;</p> <ul style="list-style-type: none"> • For issues of fire danger, use §483.90(a) Life Safety from Fire F895; • For issues of cleanliness and maintenance of common living areas frequented by residents, use §483.10(i)(2), Housekeeping and Maintenance F584; • For issues of cleanliness of areas of the facility used by staff only (e.g., break room, medication room, laundry, kitchen, etc.) or the public only (e.g., parking lot), use §483.90(i) F921 Other Environmental Conditions; • For issues of uncomfortable lighting, use §483.10(i)(5), F584 Adequate and Comfortable Lighting; • For issues of uncomfortable temperature, use §483.10(i)(6), F584 Comfortable and Safe Temperature Levels; and • For issues of uncomfortable noise levels, use §483.10(i)(7), F584 Comfortable Sound Levels. 	

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Quality of life (continued)	CFR §483.10(i)(5) <u>Lighting</u> TN:F584	<p>The facility must provide—</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas</p> <p><u>“Adequate lighting” means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform.</u></p> <p><u>“Comfortable lighting” means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their need or enhance independent functioning.</u></p>	<p><u>AP:</u> Identify and notify staff when lighting may be affecting a resident’s risks (e.g., falls), function, and quality of life.</p> <p><u>MDIR:</u> Advise the facility about lighting, especially as it relates to visual impairment, fall risk, and other aspects of resident safety and function.</p>
Rehabilitation services, special; Provide	CFR483.65(a)(1)(2) <u>Specialized rehabilitation services</u> TN: F825	<p>A facility must provide specialized rehabilitative services including, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for a mental disorder if a resident needs these services so that the needs of the resident are met and support the resident in attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.</p> <p>If specialized services such as, but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, 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.</p> <p><u>Specialized rehabilitative services by qualified personnel must be provided under the written order of a physician.</u></p>	<p><u>AP:</u> Order pertinent therapy assessments and treatments. Review and manage medical conditions and medications affecting function. Certify medical necessity of therapy services appropriately and in a timely fashion, based on pertinent regulations and guidelines.</p> <p><u>MDIR:</u> Guide the staff and practitioners about factors that affect function and successful rehabilitative efforts, including medical conditions and medication-related effects and adverse consequences. Guide the staff and practitioners in integrating medical care with rehabilitative activities; for example, by addressing medical causes of falls, swallowing disorders, and decline in function. Guide the physicians about the appropriate indications for, and utilization of, therapy services.</p>
Resident rights, exercise of	CFR483.10(a)(1)(2)(b)(1)(2) <u>Resident Rights</u> TN: F550	<p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>(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.</p> <p>(a)(2) The facility must provide equal access to quality care regardless of diagnosis,</p>	<p><u>AP:</u> Address medical conditions and clinical risk factors, as feasible, to help optimize function, decision-making capacity, quality of life, and the resident’s participation in planning care, engaging in activities, and making decisions. Evaluate decision-making capacity adequately. Evaluate and address conditions and other factors that impact cognition and decision making capacity.</p> <p><u>MDIR:</u> Help the facility implement policies and procedures that</p>

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		<p>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.</p> <p>§483.10(b) Exercise of Rights</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p><u>All residents have rights guaranteed to them under Federal and State laws and regulations. This regulation is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.</u></p>	<p>preserve and protect resident rights. Review whether the staff and practitioners are identifying and addressing <i>adverse consequences</i> of medications and treatments that could <i>impair function and decision making capacity</i>. Review for <i>appropriate physician practices</i> in evaluating decision making capacity and managing medical conditions that affect level of consciousness, cognition and function. Help the facility <i>identify situations</i> that enhance or impede <i>exercise of</i> an individual's <i>rights</i>.</p>
Resident rights Abuse	CFR483.12 Freedom from Abuse, Neglect, and Exploitation TN:F600	<p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. The facility must—</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p><u>This also includes the right not to be deprived of goods or services that are needed to attain or maintain physical, mental, and psychosocial well-being.</u></p> <p>“Abuse,” is defined at §483.5 as the willful infliction of injury, unreasonable confinement,</p>	<p><u>AP:</u> Help evaluate situations of <i>possible abuse or neglect</i>. Report <i>concerns</i> about possible abuse or neglect, per facility policy and in accordance with state and federal reporting requirements. Examine <i>residents who may have been abused</i>, or arrange to have them evaluated, and document and report findings. Help objectively assess and document the <i>cognitive capacity and reliability</i> of individuals who allege abuse.</p> <p><u>MDIR:</u> Guide the facility in implementing appropriate protocols to <i>prevent, identify, manage, document, and report abuse and neglect</i>.</p>

		<p>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.</p> <p>“Neglect” means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility’s indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.</p>	
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Resident rights; Choosing an attending physician	CFR483.10(d)(1)-(5) <u>Resident Rights: Choice of attending physician</u> TN: F555	<p>The resident has the right to choose his or her attending physician. The physician must be licensed to practice, and if the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.</p> <p>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.</p> <p>(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.</p> <p>(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.</p> <p>A facility must help a resident choose a personal physician, as needed. If a resident's chosen physician fails to meet requirements, the facility has the right, after informing the resident, to seek alternate physician coverage. Facilities should make a reasonable effort to get a physician to correct performance problems, where possible, before insisting on replacing the physician.</p>	<p><u>MDIR:</u> Help the facility ensure that each resident has an <i>attending physician</i>. Inform the facility's physicians, administrator, staff, residents, and families about <i>requirements and expectations</i> for physician licensure, performance and practice. Help the facility identify and manage situations where physician <i>practice and performance are problematic</i>, including when a change in attending physician is needed.</p> <p>When formal <i>credentialing and privileging</i> procedures are utilized, participate in <i>evaluation of physicians</i> and other practitioners when they are applying and periodically thereafter.</p>
Resident rights Informing	CFR483.10(c)(1)(4)(5)	The resident has the right to be informed of, and participate in, his or her treatment, including:	<u>AP:</u> Document pertinent information about <i>discussions with residents/families</i> , including important issues that were covered and the basis for any decisions that were made. Attempt to verify

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resident about condition	<p>Planning and Implementing Care: <u>Right to be informed / Make treatment decisions</u></p> <p>TN: F552</p>	<ul style="list-style-type: none"> • (c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition • (c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care • (c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. <p>A facility must inform residents (or their legal representatives) about their “total health status” (including functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments) in a language they understand.</p>	<p>that <i>residents or legal representatives understand</i> what they have been told and what they have agreed to; for example, by having them restate information in their own words.</p> <p><u>MDIR:</u> Help the staff and practitioners identify <i>ways to communicate information effectively</i> with residents and families. Help the facility ensure that the staff and practitioners respect <i>rights to receive information and make decisions</i> about care.</p>
Resident rights, Privacy of resident	<p>CFR483.10(h)(1)-(3)(i)(ii) <u>Resident Rights</u> <u>Privacy and Confidentiality</u></p> <p>TN: F583</p>	<p>The resident has the right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>The facility must respect the resident’s right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in</p>	<p><u>AP:</u> Conduct medical <i>interviews and examinations</i> in a way that respects <i>privacy and confidentiality</i>, as well as when <i>discussing the resident</i> with other individuals, in <i>documentation</i> about the individual, and in choosing individuals to give specific <i>medical information and opinions</i>.</p> <p><u>MDIR:</u> Guide the staff and practitioners in identifying and implementing appropriate practices related to <i>privacy and confidentiality</i>.</p>

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		<p>accordance with State law.</p> <p>A resident must have privacy, including when receiving medical care and treatment. This does not require a private room. Only authorized staff directly involved in care should be present when treatments are given; others should be present only with the resident's consent. A resident has the right to confidentiality of personal and clinical records.</p> <p>Residents should have reasonable access to and privacy for communication with email and internet-based video communication.</p>	
Restraints (physical and chemical), use of	<p>CFR483.10(e)(1) 483.12(a)(2) Resident Rights-Respect and Dignity TN: F604</p> <p>Respect and Dignity CFR483.10(e) TN: F605</p> <p>CF 483.45(c)(d)(e)</p>	<p>T604: The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with 483.12(a)(2).</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>The facility must—</p> <p>§483.12(a)(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.</p> <ul style="list-style-type: none"> • <u>"Physical restraint" is defined as any manual method, physical or mechanical device, equipment or material that meets all of the following criteria: is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his /her body.</u> <p>"Chemical restraint" refers to any drug used for discipline or that makes it more convenient (i.e., less effort) for staff to care for a resident, and not required to treat medical symptoms. This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety. In these instances, a medication would be deemed not required to treat a resident's symptoms, because a</p>	<p><u>AP:</u></p> <p>Limit <i>use of restraints</i>. Prior to authorizing use of a restraint, help <i>identify and address underlying causes</i> of the symptoms (e.g., behavior, falls) for which a restraint is being considered. Help <i>objectively identify medical symptoms</i> that justify the use of a restraint, target symptoms or objectives for treatment, and potential complications (e.g., incontinence, pressure sores, contractures, etc.) for which staff should monitor. Confirm that any restraints are being used to <i>stabilize or improve</i> an individual's <i>function and well-being</i>. Review periodically the need for continuing restraint <i>use over time</i>, the feasibility of <i>alternatives</i>, and possible <i>complications</i> of their use (e.g., skin condition, functional status).</p> <p><u>MDIR:</u></p> <p>Help the facility implement <i>policies and procedures</i> for the appropriate use of restraints, including valid <i>alternative approaches</i> to managing the conditions and symptoms that lead to consideration of restraint use.</p> <p>As part of QA activities, help review the <i>facility's restraint use</i> and <i>physician participation</i> in helping staff minimize their use and prevent related complications.</p>

safer alternative should be used. For example, if a nonpharmacological intervention should be used or attempted and is not clinically contraindicated, but a medication is administered and has the effect consistent with the definition of convenience (defined below), the medication would be classified as a chemical restraint.

- Convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest.

The comprehensive assessment must demonstrate that specific medical symptoms require use of restraints and document how these are expected to help. The care plan should contain a plan to try to reduce restraint use, where possible. The care plan must address any decline in function or overall status resulting from using a restraint. A capable resident, or the legal representative of an incapable resident, may refuse these interventions. A restraint may be used for brief periods to allow emergency medical treatment to proceed, unless the resident, family, or legal representative has refused the treatment, and this is documented.

Resident's Right to be Informed In accordance with the requirements at §483.10(c), residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred. A written consent form may serve as evidence of a resident's consent to psychotropic medication, but other types of documentation are also acceptable. If a psychotropic medication has been initiated or increased, and there is not documentation demonstrating compliance with the resident's right to be informed and participate in their treatment, noncompliance with §483.10(c) exists and F552 must be cited.

TN605: Includes CFR from TN604 in addition to §483.45(c-e):

- **A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.**
- **Unnecessary drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used— (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be**

AP: Prior to initiating or increasing psychotropic medications, discuss the benefits, risks and alternatives with the resident and/or their family/representative and document this conversation in the medical record, along with the resident/family/representative's preference.

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Establish a facility process to inform residents and their family/representative and allow them to participate in treatment decisions before psychotropic medications are initiated or increased.

Establish a quality assurance plan to monitor that residents rights to be informed and participate in treatment decisions are honored.

		<p>reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <ul style="list-style-type: none"> • Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; • Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; • Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and • PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. • PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. <p>The intent of these requirements is to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Also, residents must only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated. Additionally, medication should only be used to treat resident's medical symptoms and not used for discipline or staff convenience, which would be deemed a chemical restraint.</p> <p>The regulations and guidance are not intended to supplant the judgment of a practitioner in consultation with facility staff, the resident, and his/her representatives and in accordance with professional standards of practice. Rather, the regulations and guidance are intended to ensure psychotropic medications are used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). However, surveyors must review the resident's medical record for evidence which supports and documents the clinical indication for psychotropic medication use.</p>	
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Social services, medically related	CFR483.40(d) TN: F745	<p>The facility must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.</p> <p><u>Examples of medically related social services include, but are not limited to the following:</u></p> <ul style="list-style-type: none"> · <u>Advocating for residents and assisting them in the assertion of their rights within the facility</u> · <u>Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs;</u> · <u>Assisting with informing and educating residents, their family, and/or representative(s) about health care options and ramifications;</u> · <u>Transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);</u> · <u>Providing or arranging for needed mental and psychosocial counseling services.</u> 	<p><u>AP:</u> Advise and guide staff about <i>medical factors influencing psychosocial issues</i> such as end-of-life care, advance directives, decision making capacity, discharge, prognosis, etc. Provide pertinent medical information and documentation to facilitate <i>subsequent placement and access to services</i>.</p> <p><u>MDIR:</u> Help the facility implement appropriate <i>policies and procedures</i> related to these issues (e.g., consent, advance directives, discharge planning), to <i>facilitate exercise of resident rights</i> and enable compliance with applicable laws and regulations.</p>
Training Requirements	CFR 483.95 TN: F940, F941, F942, F943 [NOTE: §483.95 will be implemented beginning November 28, 2019 (Phase 3)]	<p>A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to— (a) <i>Communication</i>. A facility must include effective communications as mandatory training for direct care staff.</p> <p>(b) <i>Resident's rights and facility responsibilities</i>. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10, respectively.</p> <p>(c) <i>Abuse, neglect, and exploitation</i>. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on—</p> <p>(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.</p>	<p><u>AP:</u> Use patient care situations as an opportunity to <i>educate and inform</i> staff, residents, and families about the appropriate care and management of diverse clinical situations and medical conditions.</p> <p><u>MDIR:</u> Advise the facility on the <i>content of its training</i>, especially concerning <i>clinical issues, overall resident care, and clinical practices</i>. Provide <i>information</i> to the staff and practitioners about medical, psychiatric, and other clinical issues, and give <i>training</i> as appropriate.</p>

		<p>(3) Dementia management and resident abuse prevention.</p> <p>(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.</p> <p>(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).</p> <p>(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at § 483.85—</p> <p>(1) An effective way to communicate that program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.</p> <p>(2) Annual training if the operating organization operates five or more facilities.</p> <p>(g) Required in-service training for nurse aides. In-service training must—</p> <p>(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.</p> <p>(2) Include dementia management training and resident abuse prevention training.</p> <p>(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.</p> <p>(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160.</p> <p>(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at § 483.40 and as determined by the facility assessment at § 483.70(e)</p>	
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SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
Transfer agreement	CFR483.70(j)(1)(2) Administration TN: F843	<p>The facility must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that: (i) 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; and (ii) medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can 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).</p> <p>483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.</p>	<p><u>AP</u>: Help the facility address issues related to the <i>transfer</i> of individual residents <i>to and from other settings</i>; for example, providing medical information to local hospitals or other settings, medical stability of admissions, and possibly avoidable rehospitalization.</p> <p><u>MDIR</u>: Help the facility address issues related to the <i>transfer</i> of residents <i>to and from other settings</i>; for example, adequacy of discharge information from local hospitals, medical stability of admissions, and preventing avoidable hospitalization.</p>

SUBJECT	REGULATION /TAG #	REQUIREMENT / INTERPRETATION*	RECOMMENDATIONS FOR ATTENDING PHYSICIANS (AP) / NPPs AND MEDICAL DIRECTORS (MDIR)
		<p><u>Facilities must have written transfer agreements with one or more hospitals to transfer residents, when transfer is medically appropriate, as determined by the attending physician.</u></p> <p>A practitioner other than the attending physician may determine that a hospital transfer is medically appropriate in an emergency situation.</p>	

**Table 1: Authority for Non-Physician Practitioners to Perform Visits,
Sign Orders and Sign Medicare Part A Certifications/Re-certifications
when Permitted by the State (as of February 2023)**

	Initial Comprehensive Visit	Admission Orders*	Other Required Visits & Orders^	Other Medically Necessary Visits & Orders+	Certification/ Recertification ±
SNFs					
PA, NP & CNS employed by the facility	May not perform	May not provide	May perform alternate visits and sign	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform	May not provide	May perform alternate visits and sign	May perform and sign	May sign as permitted under State laws.
NFs					
PA, NP & CNS employed by the facility	May not perform	May not provide	May not perform or sign	May perform and sign	Not applicable
PA, NP & CNS not a facility employee	May perform	May provide*	May perform and sign	May perform and sign	

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

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

+ Medically necessary visits are independent of required physician visits §483.30(c)(1) and may be performed prior to the initial comprehensive visit as permitted under state laws.

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



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**Any questions, please contact:
PALTmed
9891 Broken Land Parkway, Suite 101, Columbia, MD 21044 or at
(410) 740-9743
paltmed.org**