



The National
CONSUMER VOICE
for Quality Long-Term Care
formerly NCCNHR



Center for
Medicare Advocacy

The Updated CMS Nursing Facility Regulations

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Objectives

- Understand the important changes made by the new federal regulations.
 - E.g., some improvements in eviction protections.
- Recognize how advice to clients may change due to the new regulations.
 - E.g., More emphasis on person-centered planning and discharge planning.
- Begin developing advocacy strategies based on the new regulations.
 - E.g., Easier to challenge arbitration agreements and financial guarantees.

First Major Update Since 1991

- Why the revision now? CMS cites:
 - Changes in nursing facility residents.
 - Changes in nursing facilities.
 - Need to implement provisions of Affordable Care Act and other federal laws.

Implemented in Three Phases

- Nov. 28, **2016** -- most regulations effective, particularly those that continue existing requirements.
- Nov. 28, **2017** – additional regulations effective (including behavioral health); Surveyor's Manual includes new guidance; use of new survey process begins.
- Nov. 28, **2019** – implementation of new programs such as Quality Assurance and Performance Improvement (QAPI), and Compliance and Ethics Programs.

Admission:

No Pre-Dispute Arbitration Agreements

- Not allowed because arbitration has negative impact on quality of care.
 - 42 C.F.R. § 483.70(n)
 - Post-dispute arbitration OK.
- AHCA has filed legal challenge.
 - Court granted injunction pending appeal

No Financial Guarantees

- Facility cannot require **or request** third-party financial guarantee.
 - 42 C.F.R. § 483.15(a)
 - Does not address situations where agent takes on responsibility re: resident's money and Medicaid application.
 - CMS says they will “further investigate this concern.”

More Enforcement on Admission Agreements

- “The terms of an admission contract ... must not conflict with the requirements of these regulations.”
 - 42 C.F.R. § 483.10(g)(18)(v)
 - This is a positive step – admission agreements often conflict with relevant law.

Person-Centered Care

- “Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”
 - 42 C.F.R. § 483.5.

Addressing Resident Preferences

- Resident has the “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.”
 - 42 C.F.R. § 483.10(e)(3).

Initial Care Planning

- Baseline care plan required within 48 hours of admission.
- Must include at least:
 - Initial goals.
 - MD orders.
 - Dietary orders.
 - Therapy services.
 - Social services.
 - PASARR recommendation (if applicable).
 - 42 C.F.R. § 483.21(a).

Comprehensive Care Plan

- Within 7 days of assessment.
- Interdisciplinary team includes, “[t]o 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.”
 - 42 C.F.R. § 483.21(b).

Interdisciplinary Team

- Must also include:
 - Attending MD.
 - RN with responsibility for resident.
 - CNA with responsibility for resident.
 - Member of food and nutrition staff.
 - Other appropriate staff, based on resident's need or **as requested by resident.**

Care Plan Contents

- Services needed for resident's highest practicable well-being.
- Resident's goals and desired outcomes.
- Resident's preference and potential for future discharge.
- Discharge plans, as appropriate.
 - 42 C.F.R. § 483.21(b).

Discharge Planning

- Each resident must have discharge plan, which must be updated as needed.
- Resident and/or resident's representative must be involved.
- If discharge to community is determined to be not feasible, facility must document who made the determination and why.
 - 42 C.F.R. § 483.21(c).

Resident representative

1) An individual chosen by the resident OR

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries)

To act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

Legal representative

Court appointed guardian or conservator

Resident representative

- Can only exercise the authority given by resident, State or Federal law or court
 - Facility cannot give them “more” authority
- The resident retains the right to exercise those rights not delegated to a resident representative

Resident representative

- Must consider the resident's wishes and preferences when exercising the resident's rights
- Will be reported by the facility if there are concerns that a resident representative is making decisions or taking actions that are not in the resident's best interests

Self-determination

- Resident has explicit right to self-determination
- Facility now has an affirmative duty to promote and facilitate resident self-determination
 - Through support of resident choice

Self-determination

Includes:

- Choice of activities, schedules, healthcare, and *providers*
 - *Providers – New*
 - *Schedules*: Specifically calls out sleeping and waking times
- Right to make choices, interact with members of community; participate in activities inside and outside the facility
- Right to receive visitors
- Right to organize and participate in resident groups (family groups too)
- Right to manage his/her financial affairs

Visitation

- Expands some aspects of visitation right: residents have the right to receive visitors of their choosing at the time of their choosing; receive visitors whom they designate
- The facility must:
 - Ensure all visitors have full and equal visitation privileges (subject to resident preferences)
 - Not discriminate
- BUT visits from non-family visitors changed from “reasonable restrictions” to “*reasonable clinical and safety restrictions*”

Visitation

- The facility must:
 - Have visitation policy
 - Inform residents of their right to visitors, the policy and any restrictions

Resident Personal Funds and Property

Personal funds

- The facility must:
 - Act as a fiduciary of the resident's funds if the resident authorizes the facility to manage his/her funds
 - Continue to make financial records available quarterly and upon request

Personal funds

- The facility must:
 - Refund any deposit or charges already paid within 30 days if resident dies, is hospitalized or is transferred/discharged
 - Convey the resident's funds and a final accounting within 30 days upon discharge, eviction or death

Personal Property

- The facility must:
 - Provide reasonable care for resident's personal property
 - Not waive its liability for loss of resident property
 - Have a policy indicating circumstances when loss or damage of dentures is the facility's responsibility and residents won't be charged for replacement of lost/damaged dentures

Access to records

- Resident has access to “personal and medical records”
 - (before: access to *all* records)
- Must be provided in a form and format requested by resident
- No longer have to inspect records before obtaining copies
- Facility may impose a “reasonable cost-based fee”



Grievances

- Current rights expanded
- Right to voice complaints without discrimination or reprisal and *without fear of discrimination or reprisal*
- Complaints can be filed *orally, in writing, anonymously*
- Complaints can be voiced to the facility *and to agencies/entities that hear grievances*
- Type of complaints now include complaints related to the *behavior of staff and “other concerns regarding their LTC facility stay.”*

Grievances

New!

- The facility must have a grievance policy; provide to resident upon request
- Residents have the right to:
 - Be given contact information for the grievance official and contact information of independent entities where grievances can be filed
 - Have the complaint reviewed within a reasonable expected time frame
 - Receive a written decision

Grievance Official

Role:

- Overseeing the grievance process
- Receiving and tracking grievances
- Conducting any necessary investigations by the facility
- Maintaining confidentiality
- Issuing written grievance decisions to the resident
- Coordinating with state and federal agencies as necessary in light of specific allegations

Written decisions

- Must include
 - The date the grievance was received
 - A summary statement of the resident's grievance
 - The steps taken to investigate the grievance
 - A summary of the pertinent findings or conclusions regarding the resident's concern(s)
 - A statement as to whether the grievance was confirmed or not confirmed
 - Any corrective action taken or to be taken by the facility as a result of the grievance
 - The date the written decision was issued

Quality of Life

- Current, § 483.15
 - (a) Dignity
 - (b) Self-determination and participation
 - (c) Participation in resident and family groups
 - (d) Participation in other activities
- New, § 483.24
 - (a) not titled (includes CPR)
 - (b) Activities of daily living
 - (c) Activities

Quality of Life

(e) Accommodation of
needs

(f) Activities

(g) Social services

(h) Environment

Quality of Life: What's the Same?

- CMS retained separate Requirements of Participation (RoPs) for Quality of Care and Quality of Life (withdrawing the proposal to combine the RoPs into a single RoP)

Quality of Life: What's Changed?

- Many provisions moved to other Requirements of Participation (RoPs)
 - Dignity moved to resident rights, § 483.10(a)(1)
 - Self-determination moved to resident rights, § 483.10(f)(2)
 - Participation in resident and family groups moved to resident rights, § 483.10(f)(5)
 - Participation in other activities moved to resident rights, § 483.10(f)(5)

Quality of Life: What's Changed?

- Accommodation of needs moved to resident rights, § 483.10(e)(3)
- Activities moved to Quality of Life, § 483.24(c)
- Social services moved to Behavioral health services, § 483.40(d)
- Environment moved to resident rights, § 483.10(i)

Facilities must provide basic life support, including CPR, prior to arrival of emergency personnel, subject to physician orders and resident's advance directives, § 483.24(a)(3)

Major Concerns About Quality of Life RoP

- Reorganization is confusing
- Titles of current Quality of Life requirements are lost as sub-paragraphs in other RoPs
- Social services should not be solely part of Behavioral Health RoP

Quality of Care

Current Rules vs. New Rules

Current rules, § 483.25

- (a) Activities of daily living
- (b) Vision and hearing
- (c) Pressure sores
- (d) Urinary incontinence
- (e) Range of motion
- (f) Mental & psychosocial functioning
- (g) Naso-gastric tubes
- (h) Accidents

New rules, § 483.25

- (a) Vision and hearing
- (b) Skin integrity
- (c) Mobility
- (d) Accidents
- (e) Incontinence
- (f) Colostomy, urostomy, or ileostomy care
- (g) Assisted nutrition and hydration

Quality of Care

Current Rules vs. New Rules

Current

- (i) Nutrition
- (j) Hydration
- (k) Special needs
- (l) Unnecessary drugs
- (m) Medication errors
- (n) Influenza and pneumococcal immunizations

New

- (h) Parenteral fluids
- (i) Respiratory care
- (j) Prostheses
- (k) Pain management
- (l) Dialysis
- (m) Trauma-informed care
- (n) Bed rails

Quality of Care: What's the Same?

- CMS retained separate RoPs for Quality of Care and Quality of Life (withdrawing the proposal to combine the RoPs into a single RoP)

Quality of Care: What's Changed?

- Deletion, in some provisions, of preliminary language about resident without a problem at admission not developing the problem unless it was unavoidable for that person

Quality of Care: What's Changed?

- Many provisions moved to other RoPs
 - Activities of daily living moved to quality of life, § 483.24(b)
 - Unnecessary drugs (including antipsychotic drugs) moved to pharmacy, § 483.45(d)
 - Mental and psychosocial functioning moved to new RoP on behavioral health services, § 483.40(b)
 - Medication error moved to pharmacy services, § 483.45(f)
 - Influenza and pneumococcal immunizations moved to infection control, § 483.80(d)

Quality of Care: What's Changed?

- Addition of fecal incontinence, § 483.25(e)(3)
- Range of motion broadened to include mobility, § 483.25(c)
- Discussion of restraints moved (from Quality of Care RoP in proposed RoP) to Freedom from abuse, neglect, and exploitation, § 483.12(a)(2)

Deferred to “Subregulatory Guidance” or Future Rulemaking

- Colostomy, urostomy, ileostomy; parenteral fluids; prostheses; pain management; dialysis; bed rails; incontinence; alarms

Major Concerns About Quality of Care RoP

- Reorganization is confusing (e.g., why look to pharmacy services to find unnecessary drugs?)
- Refusal to add dementia-specific provisions in the RoPs, as commenters recommended

Specialized Rehabilitative Services

Current § 483.25

(a) Provision of services

(b) Qualifications

New § 483.65

(a) Provision of services

Qualifications are cross-referenced to other RoPs

Specialized Rehabilitative Services: What's Changed?

- Addition of respiratory therapy – facilities must provide or obtain respiratory therapy for residents who need it (p. 68782)
- Withdrew requirement from NPRM that outside provider be Medicare or Medicaid provider; instead, outside provider cannot be excluded from federally funded health care program (p. 68782)

Dental Services

Current § 483.55

New § 483.55

Assists residents in
obtaining routine and
24-hour emergency
dental care

Same

Separate rules for
Medicare and Medicaid

Same

Dental Services: What's Changed?

- For both Medicare and Medicaid, facility must
 - have policy identifying when loss or damage of dentures is its responsibility; may not charge resident for loss or damage in accordance with facility policy, § 483.55(a)(3), (b)(4)
 - Within 3 days, refer residents with lost or damaged dentures for dental services, § 483.55(a)(5), (b)(3); if delay, document how facility ensured resident could eat and drink adequately while waiting and reasons for delay

Dental Services: What's Changed?

- Arrange for transportation to dental services, if requested by resident, § 483.55(a)(4)(ii), (b)(2)(ii)

Dental Services: What's Changed?

- For Medicaid only, facility must assist residents who are eligible apply for reimbursement of dental services as an incurred medical expense under the Medicaid state plan, § 483.55(b)(5)

Antipsychotic Drugs: Current Rules

- Address “unnecessary drugs” as part of quality of care rules, § 483.25(l)
- Include subsection on antipsychotic drugs, § 483.25(l)(2):
 - Subsection (i) residents should not get antipsychotic drugs “unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record”
 - Subsection (ii) requires gradual dose reductions, behavioral interventions “unless clinically contraindicated, in an effort to discontinue these drugs”

Antipsychotic Drugs: What's Changed?

- “Unnecessary drugs” moved from quality of care regulations, current § 483.25(l), to pharmacy services, § 483.45
- New broader category of psychotropic drugs created; defined to include not only antipsychotic drugs, but also anti-depressants, anti-anxiety, and hypnotics. § 483.45(c)(3)(i)-(iv)
- Current protections for “unnecessary drugs” redesignated (i.e., § 483.25(l)(1) (i)-(vi)), using identical language at § 483.45(d)(1)-(6))
- Current protections for antipsychotic drugs (§ 483.25(l)(2)(i)-(ii)) repeated for **all** psychotropic drugs (§ 483.45(e)(1)-(2))

Psychotropic Drugs: What's Changed?

- New rules created for PRN (“as needed”) psychotropic drugs and different rules for PRN antipsychotic drugs
 - PRN orders for psychotropic drugs are limited to 14 days (unless the attending physician or prescribing practitioner documents rationale in the medical record and indicates the duration for the PRN order), § 483.45(e)(4).
 - PRN orders for antipsychotic 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”, § 483.45(e)(5)

Psychotropic Drugs: New Rules, Preamble

- Accepts comments to modify definition of psychotropic drugs, eliminating opioid analgesics and expansive “any other” language for drugs having similar effects, while reserving the right to add other drugs in Interpretive Guidelines. (pp. 68770, 68769)
- Declines comment to incorporate requirements from proposed rule published in 1992, 57 Fed. Reg. 4516 (Feb. 5, 2012). CMS says it did not re-propose these requirements because they were “too prescriptive.” (p. 68775)
- Accepts comment to extend PRN from 48 hours in proposed rules, describing 48-hour proposal as “burdensome for some facilities.” (pp. 68772-68774)

Drug Regimen Review: What's The Same?

Monthly review of each resident's drug regimen
by licensed pharmacist, § 483.60(c)(1)

Drug Regimen: What's Changed?

- Drug regimen review includes monthly review of medical record, § 483.60(c)(2)
- Adds medical director to list of people who are notified of irregularities identified by pharmacist, § 483.60(c)(4) (current rules require notification of attending physician and Director of Nursing)
- Physician must document review of pharmacist's report, changes made, rationale for not making changes, § 483.60(c)(4)(iii)

Drug Regimen: What's Changed?

- New requirement for facility to develop and maintain policies and procedures for monthly drug regimen review, § 483.60(c)(5)

Drug Regimen Review: Preamble

- Accepts comment to require pharmacist to review medical records monthly, not every six months (as CMS proposed). (p. 68767)
- Declines comment to require pharmacist's report of irregularities to be given to resident/resident's representative. (p. 68768)
- Affirms proposed rule's requirement that medical director be informed of irregularities identified by pharmacist. (p. 68769)
- Declines comment to require independence of consultant pharmacists. (p. 68769) (as CMS proposed, CMS-4157-P, 76 Fed. Reg. 63017, 63038-63041 (Oct. 11, 2011), but declined to make final, 77 Fed. Reg. 22701, 22101-22107 (Apr. 12, 2012))

Staffing

- Staffing levels/numbers
- Training

Staffing: Levels/numbers

NO required minimum staffing standard or increase in staffing levels

Activities, Social Services

No change in language (except qualifications)

Nursing, Food & Nutrition Services, Behavioral Health Services (completely new section)

Change

Sufficient staff:

- With appropriate competencies and skill sets
- As determined by resident assessments and individual plans of care
- Taking into consideration the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment

Facility Assessment

- Purpose: To determine what resources are needed to competently care for residents
- Assessment must be reviewed and updated:
 - As necessary but at least annually
 - Whenever there is any change or plans for a change requiring that would require major modification of the assessment

Facility Assessment

Resident population

- Number of actual residents
- Facility's resident capacity
- Care required by resident population taking into consideration
- Types of diseases
- Conditions
- Physical and cognitive disabilities
- Overall acuity
- Staff competencies needed to the level of care and type of care needed for resident population
- Physical environment, equipment, services, other physical plant factors necessary to care for resident population
- Ethnic, cultural and religious factors

Facility resources

- Buildings and/or other physical structures
- Vehicles
- Equipment (medical and non-medical)
- Services provided
- All personnel and their education/training and competencies related to care
- Any type of arrangement/agreement with third parties for services or equipment
- Health information technology

Staffing: Training

The facility must develop, implement and maintain an effective training program for:

- All existing staff
- All new staff
- Contract employees
- Volunteers

Staffing: Training

Required topics include:

- Communication
- Resident' s rights and facility responsibilities
- Abuse, neglect, exploitation
- Dementia management and resident abuse prevention
- Quality assurance and performance improvement
- Infection control
- Compliance and ethics
- Behavioral health

Staffing: Training

Nurse aide in-service training

- Dementia management and resident abuse prevention

Freedom from Abuse, Neglect, and Exploitation

- New section 483.12 (formerly 483.13 Resident behavior and facility practices)
- Resident has the right to be free from abuse, neglect, misappropriation of resident property, and *exploitation*
- Free from physical or chemical restraints

**Italics indicates new language/requirement*

Cannot employ staff who are

- Found guilty by court of law of abuse, neglect, *exploitation, misappropriation of property*, or mistreatment
- Finding entered into the State nurse aide registry
- *Disciplinary action in effect by State licensure body against professional license*

Must report knowledge of “unfitness for service”

Facility must

- Prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property
- Investigate allegations
- *Include training for staff, volunteers, contractors*

Facility must

- *Coordinate with QAPI program*
- *Ensure reporting of crimes in accordance with section 1150B of the [Affordable Care] Act*
 - *Report to the State Agency and one or more law enforcement entities*
 - *Annually notify covered individuals of their reporting obligations*

Timeframes for reporting

- Immediately, but no later than 2 hours, if serious bodily injury
- Within 24 hours if no serious bodily injury

To:

- Administrator
- *State Agency and law enforcement officials (Suspicion of Crime requirements)*
- Other officials – State Survey Agency and *Adult Protective Services, if jurisdiction in LTC facilities*
– under State law

Report results of investigation to administrator and other officials (including State Survey Agency) within 5 working days

Transfer/Discharge

6 Reasons for Transfer/Discharge

- Resident's needs cannot be met
- Resident no longer needs the facility's services
- Safety of others is endangered *due to the clinical or behavioral status of the resident*
- Health of others is endangered
- Nonpayment – *but only if the resident does not submit the necessary paperwork for 3rd party reimbursement*
- Facility closes

New Requirements

- May not discharge while appeal is pending (unless health or safety of others is endangered)
- Copy of the discharge notice to the State Long-Term Care Ombudsman
- Additional documentation if facility claims discharge/transfer is necessary because it can't meet the resident's needs
 - What specific needs can't be met
 - What facility did to try to meet those needs
 - The services available at the receiving facility to meet the needs of the resident

Information for Receiving Facility or Provider

- Information to the receiving provider must include, at a minimum:
 - Practitioner contact info
 - Resident representative contact info
 - Advance Directive info
 - Special instructions or precautions for ongoing care
 - Comprehensive care plan goals
 - Other necessary info, including copy of the discharge summary

Right to Return to the Facility

- Bed Hold
 - Facility must provide written information about bed-hold policy
 - Facility must establish and follow a written policy permitting residents to return to the facility after hospitalized or placed on therapeutic leave
 - If bed-hold exceeded, resident can return to previous room or first available bed.

Right to Return

- If a resident had an expectation of returning and the facility determines s/he “cannot return to the facility,” the facility must comply with discharge requirements

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