

Federal Requirements of Participation for Nursing Homes

Summary of Key Changes in the Final Rule

Issued September 2016

Phase 2

On September 28, 2016, the Centers for Medicare & Medicaid Services (CMS) released updated federal nursing home regulations (Requirements of Participation for Long-Term Care Facilities). This is the first comprehensive revision to the regulations since they were issued in 1991. The updated rule (also referred to as the “final rule”) is being implemented in three phases: Phase 1 - November 28, 2016, Phase 2 - November 28, 2017, and Phase 3 - November 28, 2019.

This summary sheet is designed to provide an overview of key changes in regulations going into effect as part of Phase 2. The purpose of the summary is to highlight what is different (new or modified) between the prior rule and the final rule.

Changes in the rule are indicated in two ways:

NEW

means that the language is completely new.

MODIFIED

means that a prior regulation has been revised in some way. Some language has either been deleted or revised, or new language has been added. Instances where the content of the prior and final rule are the same, but there is a slight variation in phrasing, have not been included.

§483.10 RESIDENT RIGHTS

(g) Information and communication

MODIFIED

(4)(ii)-(iv) Residents must now be provided with information and contact information in writing and orally about:

- The Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program
- State and local advocacy organizations (if different from resident advocacy groups required in Phase 1)
- Medicare eligibility and coverage and Medicaid coverage (previous regulations required information about Medicaid eligibility to be furnished)

§483.12 FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

(b) The facility must develop and implement policies and procedures

NEW

(5) For the first time, the facility must have policies and procedures ensuring that any reasonable suspicion of a crime is reported by covered individuals to the state survey agency and one or more law enforcement entities.

Note:

- While these regulations are new, the Affordable Care Act made these reporting requirements mandatory effective March 2011 (under section 1150B of the Social Security Act)
- This requirement is separate and different from the requirement that allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, be reported to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law

Covered individuals are facility owners, operators, employees, managers, agents, or contractors.

Reporting timeframes:

- If there is bodily injury, the report must be made immediately, but no later than 2 hours after the suspected crime
- If there is no bodily injury, the report must be made no later than 24 hours after the suspected crime

Covered individuals must be informed annually about these reporting requirements.

In addition, the facility must:

- Prevent and prohibit retaliation against covered individuals for lawfully reporting
- Post a notice about employee rights related to reporting

§483.15 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS

(c) Transfer and discharge

(2) Documentation

NEW

(i) Requirements regarding documentation of the transfer/discharge have been expanded and strengthened.

Documentation in the resident's medical record must include the basis for the transfer or discharge.

If the reason for the proposed transfer/discharge is because the facility states it cannot meet the resident's needs, the facility must now also document:

- The specific need(s) that cannot be met
- What the facility has done to try to meet the resident's needs
- The services that are available in the receiving facility that will meet the resident's needs

This justification was not previously required.

NEW

(iii) The facility must provide the receiving institution or provider with very specific, detailed information about the resident. At a minimum, this information must include:

- Contact information of the practitioner responsible for the care of the resident
- Resident representative information, including contact information
- Advance Directive information
- All special instructions or precautions for ongoing care, as appropriate
- Comprehensive care plan goals
- All other information to ensure a safe and effective transition of care, including, if applicable, a copy of the resident's discharge summary

§483.21 COMPREHENSIVE PERSON-CENTERED CARE PLANNING

(a) Baseline care plans

NEW

(1) The facility is now required to develop and implement a “baseline care plan” within 48 hours of admission. The baseline care plan must include instructions and healthcare information so that the facility can properly care for the resident in a person-centered way.

The minimum healthcare information includes, but is not limited to:

- Initial goals based on admission order
- Physician orders
- Dietary orders
- Therapy services
- Social services
- PASARR recommendation, if applicable

NEW

(2) The facility can develop a comprehensive care plan instead of a baseline care plan if the plan is created within 48 hours of the resident's admission and meets all the requirements of a care plan.

NEW

(3) The facility must provide the resident and resident representative with a summary of the baseline care plan that includes, at a minimum:

- Initial goals
- Summary of medications and dietary instructions
- Services and treatments to be provided
- Any updated information from the comprehensive care plan

§483.35 NURSING SERVICES

MODIFIED

The facility must now have not only sufficient nursing staff, but staff with appropriate competencies and skills sets to assure resident safety as well as to attain or maintain the resident's highest level of well-being.

Sufficient staff with appropriate competences and skills sets is determined by resident assessments and individual care plans (previously required) and new language requiring the number, acuity, and diagnoses of the facility's residents to be taken into consideration as required by a newly mandated facility assessment required under §483.70(e).

§483.40 BEHAVIORAL HEALTH SERVICES

NEW

For the first time, the regulations have an entire section focused solely on behavioral health. CMS states that it has put these requirements in a separate section to emphasize the importance of behavioral health and ensure that facilities address these issues.

The vast majority of this section is implemented as part of Phase 2.

Behavioral health is described as encompassing a resident's whole emotional and mental well-being, including, but not limited to, the prevention and treatment of mental and substance use disorders.

The regulations stress the importance of behavioral health services by using virtually the same language now required under §483.24 Quality of life: 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.

NEW

(a) The facility must have sufficient staff who provide direct services to residents to assure resident safety and to attain or maintain each resident's highest level of well-being. Sufficient staff with appropriate competences and skills sets is determined by resident assessments, individual care plans, and taking into consideration the number, acuity, and diagnoses of the facility's residents as required by the facility assessment. Note: This language is similar to that of nursing services.

The appropriate staff competencies and skills sets include knowledge of, and appropriate training and supervision for:

NEW

(1) Caring for residents with mental and psychosocial disorders

NEW

(2) Implementing non-pharmacological interventions

NEW

(b)(3) Residents displaying or diagnosed with dementia must receive appropriate treatment and services to attain or maintain their highest level of well-being. This is the first-time language specifically about the care of individuals with dementia has been included in the actual regulations.

MODIFIED

(c) If the resident's care plan requires rehabilitative services, the facility must provide or obtain these services. Examples of such services are physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability. The services must be provided by a Medicare and/or Medicaid provider.

§483.45 PHARMACY SERVICES

NEW

(c)(2) The monthly drug regimen review conducted by the pharmacist must now include a review of the resident's medical chart.

(e) Psychotropic drugs

MODIFIED

(1)-(2) The regulations that previously applied just to antipsychotic drugs have been expanded to apply to the much broader category of psychotropic drugs. Now, psychotropic drugs may not be given to a resident unless they are "necessary to treat a specific condition as diagnosed and documented in the clinical record." Psychotropic drugs are subject to gradual dose reductions and behavioral intervention "in an effort to discontinue these drugs."

NEW

(3) Psychotropic drugs cannot be given under a PRN (as needed) order unless the drug is necessary to treat a specific condition documented in the resident's clinical record. PRN orders had not been addressed in the previous regulations.

NEW

(4) PRN orders for all psychotropic drugs except antipsychotic medications are limited to 14 days unless the attending physician or prescribing practitioner:

- Believes an extension is appropriate
- Documents the rationale for continuation
- Indicates the duration of the PRN order

NEW

(5) Antipsychotic drugs are treated differently. PRN orders for antipsychotics are good for 14 days, but cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the drug.

§483.55 DENTAL SERVICES

For Skilled Nursing Facilities (Medicare)

NEW

(a)(3) The facility must now have a policy identifying when loss or damage of dentures is its responsibility. The facility may not charge residents for loss or damage if it is determined to be the facility's responsibility in accordance with the facility policy.

MODIFIED

(a)(5) A time frame for referral and what the facility must do if that time frame is not met have been added. The facility must refer residents with lost or damaged dentures for dental services within 3 days. If the referral does not occur within 3 days, the facility will be required to document the reasons for the delay and how it ensured the resident could eat and drink adequately while waiting for dental services.

For Nursing Facilities (Medicaid)

NEW

(b)(3) Same as (a)(5)

MODIFIED

(b)(4) Same as (a)(3)

§483.60 FOOD AND NUTRITION SERVICES

NEW

(a) Staffing

The facility must now have sufficient staffing with the appropriate competencies and skill sets to carry out all the functions of food and nutrition services. Staffing includes: a qualified dietitian or other clinically qualified nutrition professional; a director of food and nutrition services if the dietitian/clinically qualified nutrition professional is not full-time; and support staff.

Similar to the requirements for nursing services and behavioral health services, sufficient staff with appropriate competencies and skills set is determined by resident assessments, and individual care plans, and takes into consideration the number, acuity, and diagnoses of the facility's residents as required by the facility assessment.

(2)(i)-(ii) The rule establishes qualifications that the director of food and nutrition services must meet. This person must:

- Be a certified dietary manager; or
- Be a certified food service manager; or
- Be nationally certified for food service management and safety by a national certifying body; or
- Have an associate's degree or higher in food service management or hospitality and meet state requirements if they exist

Individuals designated as director of food and nutrition services after November 28, 2016 must now meet these requirements.

§483.70 ADMINISTRATION

(e) Facility assessment

The facility must conduct and document a facility-wide assessment to determine what resources are needed to competently care for residents on a day-to-day basis and during emergencies. For instance, as noted in the sections on nursing services, behavioral health services, and food and nutrition services, the assessment must be used in determining the number of staff and the competencies and skills sets staff must have.

The assessment must be reviewed and updated:

- Whenever there is any change or plans for a change requiring major modification of the assessment
- As necessary, but at least annually

The assessment must address or incorporate:

(1) The facility's resident population, including:

- 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 for the level of care and type of care needed for the resident population
- The facility's physical environment, equipment, services, and other physical plant factors necessary to care for the resident population
- Ethnic, cultural, and religious factors (including activities and food and nutrition services)

NEW

(2) The facility's resources, including:

- 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

NEW

(3) A facility-based and community-based risk assessment

§483.75 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

This is a new requirement that requires each facility to have a Quality Assurance and Performance Improvement (QAPI) program. QAPI is a quality management system.

Most of this section will be implemented in Phase 3.

NEW

(a)(2) The facility must provide the state surveyors with its initial QAPI plan at the time of its annual survey.

§483.80 INFECTION CONTROL

(a) Infection prevention and control program

MODIFIED

(1) The facility must establish an infection prevention and control program that includes a system to prevent, identify, report, investigate, and control both infections and communicable diseases for residents and all those working, providing services in any capacity, volunteering, and visiting in the facility.

This system must be based on:

- Accepted national standards
- The facility assessment. This means that the system must take into consideration and address factors such as resident conditions and types of diseases, staff competencies, the physical environment, and other elements included as part of the facility assessment

NEW

(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

§483.90 PHYSICAL ENVIRONMENT

NEW

(h)(5) For the first time, facilities are required to have policies regarding smoking, smoking areas, and smoking safety. The policies must take into account nonsmoking residents and comply with applicable Federal, State, and local laws and regulations.

National Consumer Voice for Quality Long-Term Care
1001 Connecticut Ave, NW, Suite 632
Washington, DC 20036

www.theconsumervoice.org

