

A Closer Look at the Revised Nursing Facility Regulations

Quality of Care

Executive Summary

The substantive requirements for quality of care are retained in the revised regulations, and the Centers for Medicare & Medicaid Services (CMS) affirms the regulations' overriding goals: supporting person-centered care and enabling each resident to attain or maintain his or her highest level of well-being. Finding all of the requirements presents a challenge, however. CMS has significantly reorganized the quality of care provisions, moving some provisions to other regulatory sections, expanding the standards of the prior regulations, and adding several entirely new requirements.

Introduction

On September 28, 2016, CMS released revised nursing facility regulations. These regulations govern most aspects of nursing facility operations and apply nationwide to any nursing facility that accepts Medicare or Medicaid reimbursement, or both.

Acknowledgements

Justice in Aging, the National Consumer Voice for Quality Long-Term Care, and the Center for Medicare Advocacy created this issue brief in collaboration. This brief is the tenth of a series explaining important provisions of the revised regulations.

Quality of Care

As CMS recognizes, the quality of care regulations reflect one of the fundamental principles of the federal Nursing Home Reform Law: that each resident is entitled to receive care and services to attain and maintain the resident's "highest practicable physical, mental, and psychosocial well-being." What matters is what works for each resident; it is not sufficient that a facility's care and services work for most residents. CMS interprets the "highest practicable" language of the Reform Law to require, in regulations, that a resident not decline unless decline was medically unavoidable for that individual. In practice, a facility is out of compliance with quality of care requirements if it fails to implement the resident's care plan, which CMS views as the facility's determination of what care and services are needed, and must be provided, to enable the resident to achieve his or her highest practicable level of functioning.

The revised quality of care section (42 C.F.R. § 483.25) contains 14 specific subsections. Some subsections are identical to the prior subsections (although sometimes with new numbering); some are revised and may also include new language; some are completely new; and some have been moved elsewhere. While it may take some searching to find the new locations of the quality of care standards, they are *all* present in the revised regulations.

Subsections with Identical Language Are:

Two subsections use language that is **identical** to the prior quality of care provisions: **vision and hearing**, and **accidents**.

- **Vision and hearing** (now § 483.25(a)) requires facilities to provide treatment and assistive devices to residents and, if needed, to assist residents in making appointments and to arrange for transportation to practitioners.
- **Accidents** (now § 483.25(d)), as before, has two parts: the facility must ensure that the resident's environment is "free of accident hazards" to the extent possible, and provide "adequate supervision and assistance devices to prevent accidents."¹

Subsections with Revised Language Are:

- **Skin integrity** (now § 483.25(b)) addresses both pressure ulcers (as before) and foot care (new). The pressure ulcer language confirms, as before, that residents should not develop pressure ulcers "unless the individual's clinical condition demonstrates that they were unavoidable."

Entirely new language on **foot care** requires facilities to provide "proper treatment and care to maintain mobility and prevent complications from the resident's medical condition(s)."² Facilities must provide treatment for foot care, assist the resident in making necessary appointments, and arrange for transportation to appointments.

- **Mobility** (now § 483.25(c)) incorporates, but is more comprehensive than, the former language addressing solely range of motion. As before and with identical language, the regulation provides that a resident should not experience a decline in range of motion unless reduction is unavoidable. It also requires facilities to provide treatment and services "to increase range of motion and/or to prevent further decrease in range of motion."

Entirely new language requires facilities to provide "appropriate services, equipment, and assistance" to maintain or improve a resident's mobility so that the resident achieves "maximum practicable independence."

- **Incontinence** (now § 483.25(e)) also incorporates, but is more comprehensive than, the former language, which addressed only urinary incontinence. New language addressing urinary incontinence requires facilities to ensure that a resident who was continent on admission remains continent unless the resident's clinical condition makes continued continence not possible. If a resident is incontinent on admission, the facility, as before, must provide treatment and services to prevent urinary tract infections and (prior language) to restore "as much normal bladder function as possible" or (new language) to restore continence. Prior language about catheterization is continued: a resident should not be catheterized unless the resident's medical condition makes catheterization necessary.

Entirely new language addressing fecal incontinence requires facilities to provide treatment and services "to restore as much normal bowel function as possible."

¹ The accident provision is one of the most frequently-cited deficiencies for nursing facilities. The regulatory language requires facilities to keep the resident environment "as free of accident hazards as possible" and to provide "adequate supervision and assistance devices to prevent accidents." This regulatory provision often is cited when a resident wanders away from a facility.

² 42 C.F.R. § 483.25(b)(2).

- **Colostomy, urostomy, or ileostomy care** (now § 483.25(f)) was a subsection of Special Needs in the prior regulations. New language requires facilities to provide care “consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.”
- **Assisted nutrition and hydration** (now §483.25(g)) combines two separate provisions from the prior regulations: nutrition and hydration. As before, the regulation requires that each resident maintain “acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible.”

A notable change for both nutrition and hydration is that facilities now must “offer” “sufficient fluid intake” and “offer” “a therapeutic diet;” the prior regulation required that fluids and therapeutic diets be *provided*. CMS sets out two reasons for this change in language. First, the change reflects a resident’s right to refuse assisted nutrition or assisted hydration or both, although CMS affirms that such a refusal by a resident “does not absolve a facility of its responsibilities to provide adequate nutrition or permit the facility not to meet a resident’s nutritional needs.”³

Second, CMS further explains the change as responding to concerns that fluids have been placed in residents’ rooms “without ensuring that the resident was actually able to drink them.”⁴ While again affirming a resident’s right to refuse fluids, CMS also wants to ensure that a facility do more than place fluids in the resident’s room: “We would expect that the fluids actually be offered to the resident and assistance provided so that the resident can drink if they [sic] so desire.”⁵ Specifically offering the fluids and offering assistance in drinking them are key CMS concerns here.

This section includes two provisions relating to enteral feeding that continue, with some changes, requirements discussed in the prior regulations in reference to “naso-gastric tubes.” First, if a resident has been able to eat alone or with assistance, enteral feeding must be “clinically indicated and consented to by the resident.” The former regulation provided that a resident who could eat alone or with assistance should not be fed by a naso-gastric tube unless use of the tube was medically “unavoidable.” Although the prior language seems more protective of residents in limiting use of naso-gastric tubes, the requirements of consent and clinical indication are good additions. Second, a provision states that “oral eating skills” (called “normal eating skills” in the prior regulations) should be restored, if possible. As before, appropriate treatment and services related to enteral feeding are also necessary “to prevent complications of enteral feeding, including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.”

- **Parenteral fluids** (now at § 483.25(h)) is a separate subsection of the Quality of Care requirements; in the prior regulations, it was a subcategory of Special Needs. New language requires that parenteral fluids “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.”
- **Respiratory care, including tracheostomy care and tracheal suctioning** (now at § 483.25(i)) is a separate subsection of the Quality of Care requirements; in the prior regulations, it was a

3 81 Federal Register 68,688, 68,749 (2016).

4 81 Federal Register 68,688, 68,751 (2016).

5 *Id.*

subcategory of Special Needs. New language requires that respiratory care “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.”

Note that respiratory care is also listed in the rehabilitation services regulation (§ 483.65), specifying that facilities must provide rehabilitation services to residents who need them. Although the Rehabilitation Services regulation does not list which specific respiratory services must be provided, CMS indicates that facilities have broad obligations to provide all services that each resident needs.

- **Prostheses** (now at § 483.25(j)) is a separate subsection of the Quality of Care requirements; in the prior regulations, it was a subcategory of Special Needs. New language requires that a resident with a prosthesis be provided appropriate care and assistance, “consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.” The purpose is to ensure that the resident wears and can use the prosthesis.
- **Dialysis** (now at § 483.25(l)) was a subsection of Special Needs in the prior regulations. New language requires facilities to provide the care “consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.”

Three Entirely New Provisions are Added to the Quality of Care Requirements:

1. **Pain management** (now at § 483.25(k)) is a new subsection. New language requires facilities to provide the care “consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.” This is a significant addition to the Quality of Care requirements because pain is widely understood to be under-identified and under-treated in nursing facilities, especially for residents who have dementia and are unable to use words to communicate their pain.
2. **Trauma-informed care** (now at § 483.25(m)), a second entirely new subsection, requires facilities to ensure that residents “receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences.” The purpose of such care is “to eliminate or mitigate triggers that may cause re-traumatization of the resident.” CMS explains that “Holocaust survivors and survivors of war, disasters, and other profound trauma” have unique needs that facilities must address, and refers facilities to SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach,⁶ the National Association of Social Workers’ standards for cultural competency,⁷ and The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.⁸

Penny Shaw, a nursing home resident and active advocate for residents and all people with disabilities, explains in a recent blog post that moving into a nursing facility, in and of itself, can be highly stressful and traumatic for individuals.⁹ She reminds us that transfer trauma can apply to admission and other facets of nursing facility life and that physicians (and facilities) need to identify and address residents’ trauma in their assessments and care plans.

6 HHS Publication No. (SMA) 14-4884, available at <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>. SAMHSA is the Substance Abuse and Mental Health Services Administration.

7 <https://www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf>.

8 <https://www.thinkculturalhealth.hhs.gov/pdfs/enhancednationalclasstandards.pdf>.

9 Penny Shaw, “Nursing Home Resident Calls for Trauma-Informed Primary Care,” <http://www.primarycareprogress.org/blogs/16/659>.

3. **Bed rails** (now at § 483.25(n)) is the third new subsection. New language requires facilities to use “appropriate alternatives” before considering bed rails; to review risks and benefits of bed rails with the resident or resident representative; to “obtain informed consent prior to installation;” to assess the risk of entrapment prior to installation; to “ensure that the bed’s dimensions are appropriate for the resident’s size and weight;” and to follow manufacturers’ “recommendations and specifications for installing and maintaining bed rails.”

These comprehensive protections have not appeared in the regulations before.

Five Subsections Have Been Moved Elsewhere:

- Activities of daily living (now in Quality of Life, § 483.24(b)).
- Unnecessary drugs (now in Pharmacy Services, § 483.45(d)).
- Mental and psychosocial functioning (now in a new regulation on Behavioral Health Services, § 483.40(b)).
- Medication errors (now in Pharmacy Services, § 483.45(d), (f)).
- Influenza and pneumococcal immunizations (now in Infection Control, § 483.80(d)).

Effective Dates

Most quality of care provisions became effective on November 28, 2016. Provisions related to trauma-informed care become effective on November 28, 2019.

Finding the Regulations

The quality of care provisions are found at section 483.25 of Title 42 of the Code of Federal Regulations.

Tips for Residents and Advocates

Focus on the Facility's Duty to Meet Residents' Needs. The regulations reflect the core mandate of the federal Nursing Home Reform Law that care and services be provided to each resident to enable him or her to attain the highest possible physical, mental, and psychosocial well-being. Accordingly, residents and their representatives should use the regulations to advocate for the facility to provide whatever care and services each resident needs in order to reach the resident's highest level of well-being. A critical component of meeting residents' individual needs is a facility having enough staff to assist all residents individually as necessary. In addition, the regulations' new focus on, and repetition of, language related to "professional standards of practice" gives residents and representatives a new tool to use in advocating for care meeting high standards, as developed by staff's professional affiliations. Residents and representatives should challenge facilities' argument that they follow corporate policies when those policies conflict with professional standards of care.

Insist that the Facility Assist Residents in Maintaining the Ability to Walk. A resident's ability to walk gets special new attention, both in the foot care requirements (under skin integrity) and in the mobility requirements. The foot care standards require facilities to make sure that a resident who needs special care gets the necessary medical appointments made, along with transportation to those appointments. The mobility standards require facilities to provide "appropriate services, equipment, and assistance" to maintain or improve a resident's mobility. The goal is "maximum practicable independence." Retaining the ability to walk is identified as a central obligation. Residents and their advocates should use these standards to ensure that residents retain the ability to walk, to the extent possible.

Ensure that Residents Receive the Help They Need to Drink. The regulations also make clear that facilities must assist residents in drinking fluids. Placing a water pitcher in a resident's room, and ignoring whether the resident can reach it or hold it and actually drink, is not sufficient. Facilities must make sure residents get the assistance they need to drink and remain hydrated. Again, residents and their advocates can use the language of the revised regulation to ensure that residents get the assistance they need to remain hydrated.

Advocate for Adequate Pain Control. Residents have often been left in pain, or given antipsychotic drugs to quiet them when they cry out in pain. The new language gives residents and their advocates new tools to ensure that facilities are conducting appropriate assessments of residents' pain and developing and implementing care planning interventions to alleviate residents' pain. Remember that failure to follow a care plan is a violation of the quality of care requirements.

Recognize Residents' Trauma When Planning and Providing Care. As Penny Shaw has shown, trauma-informed care should reflect the trauma, for many residents, of admission and how facilities must assist each resident in making the transition to living in a nursing facility. Shaw suggests that ensuring that each resident feels safe and has a measure of choice and control over his or her life can help, as can an environment that is soothing, homelike, and open to the outside world. Residents and their representatives should stress the importance of professional social workers to address residents' psychosocial needs, at admission and throughout their stay. They can also use the regulatory language to support environmental changes that are comforting and comfortable for residents.

Be Cautious with Bed Rails. Bed rails are dangerous for many residents and can be the source of avoidable strangulation deaths. Ensuring that all other options are first explored, and that bed rails are not used unless a resident gives informed consent, can reduce the dangers associated with bed rails. The comprehensive regulatory language gives residents and their representatives numerous new tools to ensure that bed rails are used only when necessary, only with the informed consent of the resident, and only as authorized by the manufacturer.