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INFORMATIONAL LETTER #2002-17

DATE: September 3, 2002

TO: ALL HOSPITALS IN IDAHO PROVIDING SWING BED SERVICES

FROM: DEBBY RANSOM, R.N , R.H.I.T., Chief
Bureau of Facility Standards

SUBJECT: **REVISED APPENDIX T**
INTERPRETIVE GUIDELINES FOR SWING BEDS

Changes to Appendix T, the Interpretive Guidelines for Swing Beds, effective May, 2002, were issued by the Centers for Medicare and Medicaid Services (CMS)

Enclosed are copies of the regulations and guidance provided to surveyors. There are no new requirements, but the structure and numbering system has been revised.

Should you have any questions, please contact Sylvia Creswell, QMRP, Supervisor, Non-Long Term Care, at (208) 334-6626.

Debby Ransom

DEBBY RANSOM, R.N., R.H.I.T., Chief
Bureau of Facility Standards

DR/nah
Enclosures
cc: Idaho Hospital Association

APPENDIX T

INTERPRETIVE GUIDELINES

FOR

SWING BEDS

RECEIVED
JUL 30 2002
FACILITY STANDARDS

Surveyor Interpretive Guidelines for

Swing Beds

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TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A500	**§482.66 Special requirements for hospital providers of long-term care services ("swing-beds").** A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in §409.30 of this chapter, and be reimbursed as a swing-bed hospital, as specified in §413.114 of this chapter: (a) Eligibility. A hospital must meet the following eligibility requirements:	Interpretive Guidelines §482.66 The swing-bed concept allows hospitals to use their beds interchangeably for either acute-care or post-acute care. This allows greater flexibility in meeting fluctuating needs of the patient. Compliance with eligibility standards is assessed prior to the survey.
A501	(1) The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see §413.24(d)(5) of this chapter).	
A502	(2) The hospital is located in a rural area. This includes all areas not delineated as "urbanized" areas on the most recent census.	
A503	(3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.	
A504	(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A505	(b) Skilled nursing facility services. The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter. (1) Resident rights (§483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m)). (2) Admission, transfer, and discharge rights (§483.12(a)(1), (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7)). (3) Resident behavior and facility practices (§483.13). (4) Patient activities (§483.15(f)). (5) Social services (§483.15(g)). (6) Discharge planning (§483.20(l)). (7) Specialized rehabilitative services (§483.45). (8) Dental services (§483.55).	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A508	**§483.10 Resident rights** 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. A facility must protect and promote the rights of each resident, including each of the following rights: (b) Notice of rights and services. (3) 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;	Interpretive Guidelines §483.10 The intent of this requirement is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, during the resident's stay, and when the facility's rules changes. A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits. These rights include the resident's right to: o Be informed about what rights and responsibilities the resident has (§483.10(b)(3 through 6)); o Choose a physician (§483.10(d)); o Participate in decisions about treatment and care planning (§483.10(d)); o Have privacy and confidentiality (§483.10(e)); o Work or not work (§483.10(h)); o Have privacy in sending and receiving mail (§483.10(i)); o Visit and be visited by others from outside the facility (§483.10(j)(1)(vii and viii)); o Retain and use personal possessions (§483.10(l)); and o Share a room with a spouse (§483.10(m)). Interpretive Guidelines §483.10(b)(3) "Total health status" includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. Information on health status must be presented in language that the resident can understand. Communicating with the resident in language that the resident can understand includes minimizing the use of technical words, providing interpreters for non-English speaking residents, using sign language when needed, or other interventions, as appropriate. Survey Procedures and Probes §483.10(b)(3) Look for on-going efforts on the part of facility staff to keep residents informed. Look for evidence that information is communicated in a manner that is understandable to residents. Is information available when it is most useful to the residents such as when they are expressing concerns, raising questions, and on an on-going basis? Is there evidence in the medical record that the patient was informed of his rights, including the right to accept or refuse medical or surgical treatment?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A509	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph 8 of this section; and	Interpretive Guidelines §483.10(b)(4) "Treatment" is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. "Experimental research" is defined as development and testing of clinical treatments, such as an investigational drug or therapy, that involve treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research. "Advance directive" means a written instruction, such as living will or durable power of attorney for health care, recognized under state law, relating to the provisions of health care when the individual is incapacitated. A resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes. The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining resident permission. Survey Procedures and Probes §483.10(b)(4) If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? The requirement at §483.75(c) Relationship to Other HHC Regulations may apply, see 45 CFR Part 46, Protection of Human Subjects of Research). "Although these regulations at §483.75(c) are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds."

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A509 (Cont.)		NOTE: 42 CFR §483.10(b)(8) containing advance directive requirements, guidelines, procedures and probes is contained below. 42 CFR §483.10(b)(8) The facility must comply with the requirements specified in Subpart I of Part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. 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 individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care recognized under State law, relating to the provision of health care when the individual is incapacitated. Interpretive Guidelines §483.10(b)(8) This provision applies to residents admitted on or after December 1, 1991. The regulation at 42 CFR §489.102 specifies that at the time of admission of an adult resident, the facility must : o Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care; o Provide written information concerning his or her rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives; o Document in the resident's medical record whether or not the individual has executed an advance directive; o Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; o Ensure compliance with requirements of State law regarding advance directives; o Provide for educating staff regarding the facility's policies and procedures on advance directives; and o Provide for community education regarding issues concerning advance directives.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A509 (Cont.)		The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is also not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive, and state law allows the provider to conscientiously object. The sum total of the community education efforts must include a summary of the state law, the rights of residents to formulate advance directives, and the facility's implementation policies regarding advance directives. Video and audio tapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience. <u>Survey Procedures and Probes §483.10(b)(8)</u> Review the records of sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements. o Determine to what extent the facility educates its staff regarding advance directives. o Determine to what extent the facility provides education for the community regarding individual rights under State law to formulate advance directives.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A510	(5) The facility must-- (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. (6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	Interpretive Guidelines: §483.10(b)(5-6) If payment is not made by Medicare or Medicaid for services, the provider must fully inform the resident of any related charges both at the time of admission and prior to the time that changes will occur in their bills. Listed below are general categories and examples of items and services that the facility may charge to resident funds, if they are requested and agreed to by a resident. o Telephone o Television/radio for personal use o Personal comfort items including smoking materials, notions, novelties, and confections o Cosmetic and grooming items and services in excess of those for which payment is made o Personal clothing o Personal reading matter o Gifts purchased on behalf of a resident o Flowers and plants o Social events and entertainment offered outside the scope of the activities program o Non-covered special care services such as privately hired nurses or aides o Private room, except when therapeutically required for example, isolation for infection control o Specially prepared or alternative food requested

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A511	(d) Free Choice. The resident has the right to-- (1) Choose a personal attending physician;	Interpretive Guidelines §483.10(d)(1) The right to choose a personal physician does not mean that the physician must serve the resident. If the physician of the resident's choosing fails to fulfill a given requirement, such as frequency of physician visits, the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment. A facility may not place barriers in the way of residents choosing their own physician. If a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his/her choice in finding another physician. A resident can choose his/her own physician, but cannot have a physician who does not have swing bed admitting privileges. The requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges.
A512	(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	Interpretive Guidelines §483.10(d)(2) "Informed in advance" means that the resident receives information necessary to make a health care decision. The information should include his/her medical condition, changes in his/her medical condition, the benefits and reasonable risks of the recommended treatment, and reasonable alternatives. If there are any financial costs to the resident in the treatment options, they should be disclosed in advance and in writing to the resident prior to his/her decision.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A513	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	Interpretive Guidelines §483.10(d)(3) "Participates in planning care and treatment" means that the resident is afforded the opportunity to select from alternative treatments, to the level of his ability to understand. This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment. The resident has the right to participate in care planning and to refuse treatment. Survey Procedures and Probes §483.10(d)(3) Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes. If there appears to be a conflict between a resident's right and the resident's health or safety, determine if the facility attempted to accommodate both the exercise of the resident's rights and the resident's health, including exploration of care alternatives through a thorough care planning process in which the resident may participate. If a resident whose ability to make decisions about care and treatment is impaired, was he kept informed and consulted on personal preferences to the level of his ability to understand?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A514	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical 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; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when-- (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.	Interpretive Guidelines §483.10(e) "Right to personal privacy" means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include both visual and auditory privacy. Private space may be created flexibly and need not be dedicated solely for visitation purposes. For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility's administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents. Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual's consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services. Survey Procedures and Probes §483.10(e) Document any instances where you observe a resident's privacy being violated. Completely document how the resident's privacy was violated. Documentation Example: Resident #12 left without gown or bed covers and unattended on 2B Corridor at 3:30 p.m. February 25, 2001. Identify the responsible party, if possible.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A515	(h) Work. The resident has the right to-- (1) Refuse to perform services for the facility; (2) Perform services for the facility, if he or she chooses, when-- (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	Interpretive Guidelines §483.10(h)(1)-(2) All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident's desire for work is subject to medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated. The "prevailing rate" is the wage paid to workers in the community surrounding the facility for the same type, quality, and quantity of work requiring comparable skills. Survey Procedures and Probes §483.10(h)(1)-(2) Are residents engaged in work (e.g., doing housekeeping, doing laundry, preparing meals)? Pay special attention to the possible work activities of residents with mental retardation or mental illness. If a resident is performing work, determine whether it is voluntary, and whether it is described in the plan of care. Is the work mutually agreed upon between the resident and the treatment team?
A516	(i) Mail. The resident has the right to privacy in written communications, including the right to-- (1) Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.	Interpretive Guidelines §483.10(i)(1)-(2) "Promptly" means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours of regularly scheduled postal delivery and pickup service.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A517	(j) Access and Visitation Rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following: (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and (viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.	Interpretive Guidelines §483.10(j)(1)(vii)-(viii) The facility may set reasonable hours for visitation. If it would violate the rights of a roommate to have visitors in the resident's room, the facility must establish alternate areas in the facility for visiting. These areas could include the chapel, a suitable office area, a dining room, or a porch or patio area.
A518	(l) Personal Property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	Interpretive Guidelines §483.10(l) The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits. All residents' possessions must be treated with respect and safeguarded. The facility has the right to limit personal property due to space limitations in the facility or for safety considerations. Survey Procedures and Probes §483.10(l) If residents' rooms have few personal possessions, ask residents and families if-- o They are encouraged to have and to use personal items; o The facility informs them not to bring in certain items and for what reason; and o Their personal property is safe in the facility.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A519	(m) Married couples. 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.	Interpretive Guidelines §483.10(m) The requirement means that when a room is available for a married couple to share, the facility must permit them to share it if they choose.
A522	**§483.12 Admission, Transfer and Discharge Rights.** (a) Transfer and discharge-- (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.	Interpretive Guidelines §483.12(a)(1) The intent of the regulation on transfer and discharge provisions is to significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility to prevent dumping of high care or difficult residents. This requirement applies to transfer or discharges that are initiated by the facility, not by the resident.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A523	(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) 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; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered; (v) 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. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (vi) The facility ceases to operate.	Interpretive Guidelines §483.12(a)(2) If transfer is due to a significant change in the resident's condition, the facility must conduct the appropriate assessment, prior to any transfer or discharge to determine if a new care plan would allow the facility to meet the resident's needs. If the significant change in the resident's condition is an emergency, immediate transfer should be arranged. Survey Procedures and Probes §483.12(a)(2) During closed record review, determine the reasons for transfer/discharge. o Do records document accurate assessments and attempts through care planning to address the resident's needs through multidisciplinary interventions, accommodation of individual needs, and attention to the resident's customary routine? o Did the resident's physician document the record if the resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization) or the resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility? o Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered? o Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? o If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of this resident.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A524	(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-- (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.	Interpretive Guidelines §483.12(a)(3) Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy.
A525	(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-- (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. (ii) Record the reasons in the resident's clinical record; and (iii) Include in the notice the items described in paragraph (a)(6) of this section.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A526	(5) Timing of the Notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when-- (A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or (E) A resident has not resided in the facility for 30 days.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A527	(6) Contents of the Notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman; (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.	

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A528	(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	Interpretive Guidelines §483.12(a)(7) "Sufficient preparation" means the facility informs the resident where he or she is going and assures safe transportation. The facility should actively involve the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits by the resident to a new location; working with family; and orienting staff in the receiving facility to the resident's daily patterns. Survey Procedures and Probes §483.12(a)(7) During resident reviews, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.
A531	**§483.13 Resident behavior and facility practices.** (a) Restraints. 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.	Interpretive Guidelines §483.13(a) The intent of this requirement is for each person to reach his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. "Chemical Restraint" is defined as a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms. "Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents. "Convenience" is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interest. Medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. The facility must engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities).

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A531 (Cont)		Survey Procedures an d Probes §483.13(a) Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. Determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated. Did the team institute measures in the care plan to address reversal of any decline in health status? Determine the intended use of any restraints. Was the use for convenience or discipline?
A532	(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	Interpretive Guidelines §483.13(b) The intent of this regulation is to assure that each resident is free from abuse, corporal punishment, and involuntary seclusion. The facility is responsible for preventing abuse, but also for those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; and saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A532 (Cont.)		"Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. "Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment and restraints. "Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. "Involuntary seclusion" is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. Survey Procedures and Probes §483.13(b) Offsite, pre-survey review of complaints can focus the survey team's on-site review of actual incidents and predisposing factors to abuse or neglect and misappropriation of property. Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act, the nature of the abuse, and where and when it occurred. Ensure that the facility addresses that incident immediately. If the survey team's observations and resident's responses signal the presence of abuse, determine how the facility prevents and reports abusive behavior. If a resident is being temporarily separated from other residents, for less than 24 hours, as an emergency short-term intervention, answer these questions-- 1. What are the symptoms that led to the consideration of the separation? 2. Are these symptoms caused by failure to-- o Meet individual needs; o Provide meaningful activities; and o Manipulate the resident's environment?

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A532 (Cont.)		3. Can the cause(s) be removed? 4. If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation? 5. Does the facility use the separation for the least amount of time? 6. To what extent has the resident, surrogate or representative participated in care planning and made an informed choice about separation? 7. Does the facility monitor and adjust care to reduce negative outcomes, while continually trying to find and use less restrictive alternatives? 8. If residents are temporarily separated in secured units, staff should carry keys to these units at all times. 9. If the purpose of the unit is to provide specialized care for residents who are cognitively impaired (through a program of therapeutic activities designed to enable residents to attain and maintain the highest practicable physical, mental or psychosocial well-being) then placement in the unit is not in violation of resident rights, as long as the resident's individual care plan indicates the need for the stated purpose and services provided in the unit and the resident, surrogate, or representative has participated in the placement decision.
A533	(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must— (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	Interpretive Guidelines §483.13(c) The intent of this regulation is to assure that the facility has in place an effective system that prevents mistreatment, neglect and abuse of residents, and misappropriation of resident's property. "Misappropriation of resident's property" is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

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A534	(ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	Interpretive Guidelines §483.13(c)(1)-(4) The intent of this regulation is to prevent employment of individuals who have been convicted of abusing, neglecting, or mistreating individuals in a health care related setting. In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility should check all staff references and make reasonable efforts to uncover information about any past criminal prosecutions. "Found guilty...by a court of law" applies to situations where the defendant pleads guilty, is found guilty, or pleads nolo contendere. "Finding" is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents or misappropriation of their property. Any facility staff found guilty of neglect, abuse, or mistreating residents or misappropriation of property by a court of law, must have his or her name entered into the nurse aide registry, or reported to the licensing authority, as appropriate. Survey Procedures and Probes §483.13(c)(1)-(4) During Sample Selection-- 1. If the team has identified a problem in mistreatment, neglect or abuse of residents or misappropriation of their property, then request— o A copy of the facility's policies and procedures regarding abuse prevention: Note particularly the extent to which those policies concern the areas uncovered through complaints and/or previous survey; o Reports of action(s) by a court of law against employees; o Reports of alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident's property; o Reports of the results of these investigations; and o Records of corrective actions taken.

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A534 (Cont.)	(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	2. Spot check employment applications for questions about convictions or mistreatment, neglect or abuse of residents, or misappropriation of their property. Determine if applicants have answered these questions and if affirmative answers had resulted in rejections of employment candidates. 3. Contact the State Nurse Aide Registry or Board of Nursing, as appropriate. Determine if applicants with a finding concerning mistreatment, neglect, abuse of residents or misappropriation of their property have been rejected. 4. Ask for the results of any in-house investigations of mistreatment, neglect, or abuse of residents, misappropriation of their property, or injuries of unknown sources. o Was the administrator notified of the incident and when? o Did investigations begin promptly after the report of the problem? o Is there a record of statements or interviews of the resident, suspect (if one is identified), any eye witnesses and any circumstantial witnesses? o Was relevant documentation reviewed and preserved (e.g., dated dressing which was not changed when treatment recorded change)? o Was the alleged victim examined promptly (if injury was suspected) and the finding documented in the report? o What steps were taken to protect the alleged victim from further abuse (particularly where no suspect has been identified)? o What actions were taken as a result of the investigation? o What corrective action was taken, including informing the nurse aide registry, State licensure authorities, and other agencies (e.g., long-term care ombudsman; adult protective services; Medicaid fraud and abuse unit)?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A537	**§483.15 Quality of Life.** A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (f) Activities. (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who-- (i) Is a qualified therapeutic recreation specialist or an activities professional who-- (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or	Interpretive Guidelines §483.15(f) A "recognized accrediting body" refers to those organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professionals or registered occupational therapists. The activities program should be multi-faceted and reflect each individual resident's needs on their care plan. **In a Critical Access Hospital**, the services at §483.15(f) may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers, and visitors. Survey Procedures and Probes §483.15(f) Observe individual, group and bedside activities. 1. Are residents who are confined or choose to remain in their rooms provided with suitable in-room activities (e.g., music, reading, visits with individuals who share their interests)? Do any facility staff members assist the resident with activities? 2. If residents sit for long periods of time with no apparently meaningful activities, is the cause-- o The resident's choice; o Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities; o Lack of assistance with ambulation; o Lack of sufficient supplies and/or staff to facilitate attendance and participation in the activity programs; or o Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A537 (Cont)	(iv) Has completed a training course approved by the State.	3. For residents selected for review, determine to what extent the activities reflect the individual resident's assessment. 4. Review the activity calendar for the month prior to the survey to determine if the formal activity program: o Reflects the schedules, choices and rights of the residents; o Offers activities at hours convenient to the residents (e.g., morning, afternoon, some evenings and weekends); o Reflects the cultural and religious interests of the resident population; and o Would appeal to both men and women and all age groups living in the facility. 5. Review clinical records and activity attendance records of residents to determine if-- o Activities reflect individual resident history indicated by the comprehensive assessment; o Care plans address activities that are appropriate for each resident based on the comprehensive assessment; o Activities occur as planned; and o Outcomes/responses to activities interventions are identified in the progress notes of each resident. 6. If there are problems with provision of activities, determine if these services are provided by qualified staff.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A538	(g) Social Services. (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (3) Qualifications of social worker. A qualified social worker is an individual with-- A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and (ii) One year of supervised social work experience in a health care setting working directly with individuals.	Interpretive Guidelines §483.15(g) The intent of this regulation is to assure that all facilities provide for the medically-related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. A qualified social worker need not personally provide all of these services. It is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline. "Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services could include: o Making arrangements for obtaining needed adaptive equipment, clothing, and personal items; o Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning; o Assisting staff to inform residents and those they designate about the resident's health status and health care choices; o Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation); o Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements); o Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities); o Providing or arranging provision of needed counseling services; o Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions; o Finding options that meet the physical and emotional needs of each resident; o Meeting the needs of residents who are grieving; and o Assisting residents with dental/denture care, podiatric care; eye care; hearing services, and obtaining equipment for mobility or assistive eating devices. Where needed services are not covered by the Medicaid State Plan, facilities are still required to attempt to obtain these services.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A538 (Cont)		Survey Procedures and Probes §483.15(g) For residents selected for review -- o How do facility staff implement social services interventions to assist the resident in meeting treatment goals? o How do staff who are responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly? o How does the care plan link goals to psychosocial functioning/well being? o Has the staff responsible for social work established and maintained relationships with the resident's family or legal representative? o What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan? Look for evidence that social services interventions successfully address residents' needs and link social supports, physical care, and physical environment with residents' needs and individuality.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A541	**§483.20 Resident Assessment.** The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. (l) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes: (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	Interpretive Guidelines §483.20 The intent of this regulation is to provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status. The facility is expected to use resident observation and communication as the primary source of information when completing the assessment. In addition to direct observation and communication with the resident, the facility should use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, family members, or outside consultants and review of the resident's record. Items in (b)(2) of this section would include comprehensive assessments of a resident which were done within 14 days of admission; within 14 days of a significant change in the resident's physical or mental condition; or done on an annual review. These assessments need to be in the final discharge summary.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A544	**§483.45 Specialized rehabilitative services.** (a) Provision of services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must-- (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	Interpretive Guidelines §483.45(a) The intent of this regulation is to assure that residents receive necessary specialized rehabilitative services as determined by the comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psychosocial well being. Specialized rehabilitative services are considered a facility service and are included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services. A facility is not obligated to provide **specialized rehabilitative services** if it does not have residents who require these services. If a resident develops a need for these services after admission, the facility must either provide the services, or, where appropriate, obtain the service from an outside resource. For a resident with mental illness (MI) or mental retardation (MR) to have his or her specialized needs met, the individual must receive all services necessary to assist the individual in maintaining or achieving as much independence and self determination as possible. Specialized services for mental illness or mental regardation refers to those services to be provided by the State which can only be delivered by personnel or programs other than those of the nursing facility (NF) because the overall level of NF services is not as intense as necessary to meet the individuals needs. "Mental health **rehabilitative services** for MI and MR" refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff who come into contact with the resident who is mentally ill or who has mental retardation. These services are necessary regardless of whether or not they require additional services to be provided for or arranged by the State as specialized services. Mental health rehabilitative services for MI and MR may include, but are not limited to-- o Consistent implementation during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors; o Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness; o Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal);

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A544 (Cont.)		o Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management, and maintenance of the living environment; o Crisis intervention services; o Individual, group, and family psychotherapy; o Development of appropriate personal support networks; and o Formal behavior modification progress. <u>Survey Procedures and Probes §483.45(a)</u> Determine the extent of follow through with the comprehensive care plan. Verify from the chart that the resident is receiving frequency and type of therapy as outlined in the care plan. 1. <u>PHYSICAL THERAPY</u> o What did the facility do to improve the resident's muscle strength? The resident's balance? o What did the facility do to determine if an assistive device would enable the resident to reach or maintain his/her highest practicable level of physical function? o If the resident has an assistive device, is he/she encouraged to use it on a regular basis? o What did the facility do to increase the amount of physical activity the resident could do (for example, the number of repetitions of an exercise, the distance walked)? o What did the facility do to prevent or minimize contractures, which could lead to decreased mobility and increased risk of pressure ulcer occurrence?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A544 (Cont.)		2. OCCUPATIONAL THERAPY o What did the facility do to decrease the amount of assistance needed to perform a task? o What did the facility do to decrease behavioral symptoms? o What did the facility do to improve gross and fine motor coordination? o What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration? o What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards? 3. SPEECH, LANGUAGE PATHOLOGY o What did the facility do to improve auditory comprehension? o What did the facility do to improve speech production? o What did the facility do to improve expressive behavior? o What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiologic evaluation? o For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication? 4. REHABILITATIVE SERVICES FOR MI AND MR o What did the facility do to decrease incidents of inappropriate behaviors, for individuals with MR, or behavioral symptoms for persons with MI? To increase appropriate behavior? o What did the facility do to identify and treat the underlying factors behind tendencies toward isolation and withdrawal? o What did the facility do to develop and maintain necessary daily living skills?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A544 (Cont.)		o How has the facility modified the training strategies it uses with its residents to account for the special learning needs of its residents with MI or MR? o Questions to ask individuals with MI or MR-- --Who do you talk to when you have a problem or need something? --What do you do when you feel happy? Sad? Can't sleep at night? --In what activities are you involved, and how often?
A545	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	Interpretive Guidelines §483.45(b) Specialized rehabilitative services are provided for individual's under a physician's order by a qualified professional. Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional. Once a resident has met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will follow to maintain functional and physical status. "Qualified personnel" means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws. Health rehabilitative services for MI and MR must be implemented consistently by all staff unless the nature of the services is such that they are designated or required to be implemented only be licensed or credentialed personnel. Survey Procedures and Probes §483.45(b) o Determine if there are any problems in quality of care related to maintaining or improving functional abilities. Determine if these problems are attributable in part to the qualifications of specialized rehabilitative services staff. o Determine from the care plan and record that rehabilitative services are provided under the written order of a physician and by qualified personnel. If a problem in a resident's rehabilitative care is identified that is related to the qualifications of the care providers, it may be necessary to validate the care provider's qualifications. If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with MI or MR, how has the facility arranged for the necessary direct or staff training services to be provided?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A548	**§483.55 Dental services.** The facility must assist residents in obtaining routine and 24 hour emergency dental care.	Interpretive Guidelines §483.55 This requirement makes the facility directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents. They can satisfy this requirement by employing a staff dentist or having a contract/arrangement with a dentist to provide services. For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose an additional charge for the services. Medicaid residents may not be charged. For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well being.
A549	(a) Skilled nursing facilities. A facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; (2) May charge a Medicare resident an additional amount for routine and emergency dental services;	Interpretive Guidelines §483.55(a) "Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures). "Emergency dental services" includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity, appropriately treated by a dentist that requires immediate attention. "Prompt referral' means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A550	(3) Must if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (4) Promptly refer residents with lost or damaged dentures to a dentist.	Survey Procedures and Probes §483.55(a) Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them? Are residents missing teeth and may be in need of dentures? Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene? Are resident's dentures intact? Properly fitted? Interpretive Guidelines §483.55(b) NOTE: §483.55(b) Nursing Facilities does not usually apply to Medicare reimbursed swing-bed residents because Medicare swing-bed residents receive skilled nursing care comparable to services provided in a SNF not a NF. If a swing-bed resident is a NF level patient, apply standard §483.55(b) as appropriate.
A551	(b) Nursing facilities. The facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident: (i) Routine dental service (to the extent covered under the State plan); and (ii)Emergency dental services;	Interpretive Guidelines §483.55(b) "Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures). "Emergency dental services" includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity, appropriately treated by a dentist that requires immediate attention. "Prompt referral' means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A552	(2) Must, if necessary, assist the resident (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (3) Must promptly refer residents with lost or damaged dentures to a dentist.	Survey Procedures and Probes §483.55(b) Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them? Are residents missing teeth and may be in need of dentures? Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene? Are resident's dentures intact? Properly fitted?