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INFORMATIONAL LETTER #2002-20

DATE: December 16, 2002

TO: ALL IDAHO CRITICAL ACCESS HOSPITALS

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

SUBJECT: **CRITICAL ACCESS HOSPITAL (CAH) REGULATIONS**

We have sought and received clarification from the Centers for Medicare/Medicaid Services (CMS), Region X, Seattle, regarding which swing bed regulations apply to critical access hospitals. The Appendix T swing bed regulations mailed to you recently from this office, ***do not*** apply to critical access hospitals.

Enclosed is a new copy of the CAH federal regulations beginning with Swing Bed tag C386. Please note changes in the swing bed regulations beginning with tag C387, which was eliminated. Mainly the tags have been renumbered, however, please read from C386 to C406 to be certain you understand and are in compliance with those regulations.

Please accept our apology for the confusion and any inconvenience our error my have created at your facility. If you have questions regarding this letter or the enclosed regulations, please contact Sylvia Creswell, Supervisor, Non-Long Term Care.

Debby Ransom

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

DR/nah
Enclosure
cc: Idaho Hospital Association

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C350	**§485.645 Special requirements for CAH providers of long-term care services ("swing-bed").** A CAH must meet the following requirements in order to be granted an approval from HCFA to provide post-hospital SNF care as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.	
C351	(a) Eligibility. A CAH must meet the following eligibility requirements-- (1) The facility has been certified as a CAH by HCFA under §485.606(b) of this subpart; and (2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.	
C352	(b) Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997. These facilities must meet the following requirements-- (1) Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a (RPCH) on September 30, 1997, and on that date had in effect an approval from HCFA to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and	

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C352 Cont.	limitations that were applicable at the time these approvals were granted.. 2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and a swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section, and may not request reinstatement under paragraph (b)(1) of this section.	
C355	(c) Payment. Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in §413.114 of this chapter.	
C360	(d) SNF services. The CAH is substantially in compliance with the following SNF requirements contained in Subpart B of part 483 of this chapter:	

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C360 Cont.	(1) Resident rights (§483.10(b)(3) through (b)(6), (d), (e), (h),(i), (j)(1)(vii) and (viii), (1), and (m) of this chapter); (2) Admission, transfer, and discharge rights (§483.12(a) of this chapter); (3) Resident behavior and facility practices (§483.13 of this chapter); (4) Patient activities (§483.15(f) of this chapter), except that the services 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; (5) Social services (§483.15(g) of this chapter); (6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (d), and (e) of this chapter); (7) Specialized rehabilitative services (§483.45 of this chapter); (8) Dental services (§483.55 of this chapter); (9) Nutrition (§483.25(i) of this chapter).	

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C361	**§483.10 Residents rights.** The resident has the 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: (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 Guideline §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. This includes minimizing use of technical jargon in communicating with the resident, having the ability to communicate in a foreign language and the use of sign language or other aids, as necessary. (See §483.10(d)(3) Tag C366 for the right of the resident to plan care and treatment). Survey Procedures and Probes §483.10(b)(3) Look, particularly during observations and record reviews, 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 and communicated at times it could be most useful to residents, such as when they are expressing concerns, or raising questions, as well as on an on-going basis.
C362	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.	Interpretive Guideline §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. As provided under State law, 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. A facility may not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are met (See §483.12(a)(1) or (2) (C373 and 374)).

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C362 Cont.		If the resident is unable to make a health care decision, a decision by the resident's surrogate or representative to forego treatment may, subject to State law, be equally binding on the facility. The facility should determine exactly what the resident is refusing and why. To the extent the facility is able, it should address the resident's concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for this resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services. If a resident's refusal of treatment brings about a significant change, the facility should reassess the resident and institute care planning changes. A resident's refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well being in the context of making that refusal. 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 (e.g., medication, treatment) 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 residents' 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? In this regard, §483.75(c) Relationship to Other HHS Regulations applies (i.e, the facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research). See §483.10(b)(8) Tag C362 with respect to the advance directives requirement.
C363	(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--	Interpretive Guideline §483.10(b)(5) and (6) Residents should be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes. "Periodically" means that whenever changes are being introduced that will affect the resident's liability and whenever there are changes in services.

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C363 Cont.	(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.	A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided that notice provisions of §483.10(b)(6), if applicable, are met. Survey Procedures and Probes §483.10(b)(5) and (6) See §483.10(c)(8) for those items and services that must be included in payment under skilled nursing and nursing facility benefits.
C364	(d) Free Choice. The resident has the right to- (1) Choose a personal attending physician;	Interpretive Guideline §483.10(d)(1) The right to choose a personal physician does not mean that the physician must or will serve the resident, or that a resident must designate a personal physician. If a physician of the resident's choosing fails to fulfill a given requirement, such as §483.25(l)(1), Unnecessary drugs, §483.25(1)(2), Antipsychotic drugs, or §483.40 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 physicians. For example, 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 or her choice in finding another physician.

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C364 Cont.		Before consulting an alternate physician, one mechanism to alleviate a possible problem could involve the facility's utilization of a peer review process for cases which cannot be satisfactorily resolved by discussion between the medical director and the attending physician. Only after a failed attempt to work with the attending physician or mediate differences in delivery of care should the facility request an alternate physician when requested to do so by the resident or when the physician will not adhere to the regulations. If it is a condition for admission to a continuing care retirement center, the requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges at the retirement center. A resident in a distinct part of a general acute care hospital can choose his/her own physician, unless the hospital requires that physicians with residents in the distinct part have hospital admitting privileges. If this is so, the resident can choose his/her own physician, but cannot have a physician who does not have hospital admitting privileges. If residents appear to have problems in choosing physicians, determine how the facility makes physician services available to residents.
C365	(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 Guideline §483.10(d)(2) "Informed in advance" means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives.
C366	(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 Guideline §483.10(d)(3) "Participates in planning care and treatment" means that the resident is afforded the opportunity to select from alternative treatments. This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment. The resident's right to participate in care planning and to refuse treatment are covered in §§483.20(d)(2) and 483.10(b)(4). A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been formally declared incompetent by a court, should, to the extent practicable, be kept informed and be consulted on personal preferences.

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C366 Cont.		Whenever 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. 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 (e.g., ask residents or their representatives during interviews).
C367	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality for his or her personal and clinical records. (1) 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 Guideline §483.10(e) "Right to privacy" means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual, and, to the extent desired for visits or other activities, 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. Personal and clinical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated or other. Additional guidelines on mail and visitation are addressed in §483.10(I)(j)(1)(vii) and (viii), (Tag C369 and C370)

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C367 Cont.		Survey Procedures and Probes §483.10(e)(1)-(3) Document any instances where you observe a resident's privacy being violated. Completely document how the resident's privacy was violated (e.g., Resident #12 left without gown or bed covers and unattended), and where and when this occurred (e.g., 2B Corridor, 3:30 p.m. February 25). If possible, identify the responsible party.
C368	(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 Guideline §483.10(h)(1)-(2) "Prevailing rate" is the wage paid to workers in the community surrounding the facility for essentially the same type, quality, and quantity of work requiring comparable skills. 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 discussion of 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. Survey Procedures and Probes §483.10(h)(1)-(2) Are residents engaged in what may be paid or volunteer 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 you observe such a situation, determine if the resident is in fact performing work and, if so, is this work, whether voluntary or paid, described in the plan of care?
C369	(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 Guideline §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, except when there is no regularly scheduled postal delivery and pickup service.

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C370	(j) Access and Visitation Rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following-- (i) Any representative of the Secretary; (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 Guideline §483.10(j)(1)(I)(vii) and (viii) The facility must provide immediate access to any representative of the Secretary of the Department of Health and Human Services. The residents cannot refuse to see surveyors representing the Department of Health and Human Services. Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. However, the facility may try to change the location of visits to assist care giving or protect the privacy of other residents, if these visitation rights infringe upon the rights of other residents in the facility. For example, a resident's family visits in the late evening, which prevents the resident's roommate from sleeping. Non-family visitors must also be granted "immediate access" to the resident. The facility may place reasonable restrictions upon the exercise of this right such as reasonable visitation hours to facilitate care giving for the resident or to protect the privacy of other residents, such as requiring that visits not take place in the resident's room if the roommate is asleep or receiving care. An individual or representative of an agency that provides health, social, legal, or other services to the resident has the right of "reasonable access" to the resident, which means that the facility may establish guidelines regarding the timing or other circumstances of the visit, such as location. These guidelines must allow for ready access of residents to these services. Survey Procedures and Probes §483.10(j)(1)(i)(vii) and (viii) If you identify problems during interviews, determine how the facility ensures access to-- O Representative of the U.S. Department of Health and Human Services (DHHS); O Family or relatives; and O Other visitors.
C371	(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 Guideline §483.10(l) All residents' possessions, regardless of their apparent value to others, must be treated with respect, for what they are and for what they may represent to the resident. The right to retain and use personal possessions assures that the residents' environment be as homelike as possible and that residents retain as much control over their lives as possible. The facility has the right to limit the resident's exercise of this right on grounds of space and health or safety.

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C371 Cont.		The intent of this regulation is to encourage residents to bring perrsonal possessions into the facility, as space, safety considerations and fire code permits. Survey Procedures and Probes §483.10(1) If residents' rooms have few personal possessions, ask residents and families if-- O Residents are encouraged to have and to use them; O The facility informs residents not to bring in certain items and for what reason; and O Personal property is safe in the facility. Ask staff if the facility sets limits on the value of the property that residents may have in their possession or requires that residents put personal property in the facility's safe.
C372	(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 Guideline §483.10(m) The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. 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. If a married resident's spouse is admitted to the facility later and the couple want to share a room, the facility must provide a shared room as quickly as posssible. However, a couple is not able to share a room if one of the spouses has a different payment source for which the facility is not certified (if the room is in a distinct part, unless one of the spouses elects to pay for his or her care).
C373	**§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 Guideline §483.12(a)(1) This requirement applies to transfer or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility's decision, these requirements apply whenever a facility initiates the transfer or discharge. "Transfer" is moving the resident from the facility to another legally responsible institutional setting, while "discharge" is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care. Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility may not transfer or discharge the resident unless--

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C373 Cont.		1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility; 2. 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; 3. The safety of individuals in the facility is endangered; 4. The health of individuals in the facility would otherwise be endangered; 5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or 6. The facility ceases to operate. To demonstrate that any of the events specified in 1 - 5 have occurred, the law requires documentation in the resident's clinical record. To demonstrate situations 1 and 2, the resident's physician must provide the documentation. In situation 4, the documentation must be provided by any physician. Moreover, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative, of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility's notice must include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a developmentally disabled individual, the notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled, and in the case of a mentally ill individual, the name, address and phone number of the agency responsible for advocating for mentally ill individuals. See §483.12(a)(4). Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of-- O Endangerment to the health or safety of others in the facility; O When a resident's health has improved to allow a more immediate transfer or discharge; O When a resident's urgent medical needs require more immediate transfer; and O When a resident has not resided in the facility for 30 days. In these cases, the notice must be provided as soon as practicable before the discharge. See §483.12(a)(5).

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C373 Cont.		Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. See §483.12(a)(7) Under Medicaid, a participating facility is also required to provide notice to its residents of the facility's bed hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. A resident cannot be transferred for non- payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.
C374	(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;	Interpretive Guideline §483.12(a)(2) and (3) If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. (See §483.20(b)(4)(iv) Tag C389 for information concerning assessments upon significant change.) Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment. Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy. Survey Procedures and Probes §483.12(a)(2) and (3) During closed record review, determine the reasons for transfer/discharge.

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C375	(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.	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. N 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? If so, determine differences between these residents and those who were transferred or discharged. O Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a)(2). 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.
C376	(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.	

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C377	(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.	Survey Procedures and Probes §483.12(a)(4)-(6) If the team determines that there are concerns about the facility's transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including: O Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge; O Reason for transfer/discharge; O The effective date of the transfer or discharge; O The location to which the resident was transferred or discharged; and O Right of appeal. Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.
C378	(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;	

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C378 Cont.	(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.	
C379	(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	

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C379 Cont.	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.	
C380	(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 Guideline §483.12(a)(7) "Sufficient preparation" means the facility inform the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost; orienting staff in the receiving facility to resident's daily patterns; and reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan. Survey Procedures and Probes §483.12(a)(7) During Resident Review, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.
C381	**§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 Guideline §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 which restricts freedom of movement or normal access to ones body.

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C381 Cont.		"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. Restraint use may constitute an accident hazard and professional standards of practice have eliminated the need for physical restraints except under limited medical circumstances. Therefore, medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. It is further expected that for those residents whose care plans indicate the need for restraints that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). The resident's right to participate in care planning and the right to refuse treatment are addressed at §§483.20(d) and 483.10(b), respectively and include the right to accept or refuse restraints. For the resident to make an informed choice about the use of restraints, the facility should explain to the resident the negative outcomes of restraint use. Potential negative outcomes include incontinence, decreased range of motion, and decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. In the case of a resident who is incapable of making a decision, the surrogate or representative may exercise this right based on the same information that would have been provided to the resident. However, the surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely because a surrogate or representative has approved or requested them. "Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays that the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as--

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C381 Cont.		o Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; o Tucking in a sheet so tightly that a bed bound resident cannot move; o Using wheel chair safety bars to prevent a resident from rising out of a chair; o Placing a resident in a chair that prevents rising; and o Placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Orthotic body devices may be used solely for therapeutic purposes to improve overall functional capacity of the resident. Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Bed rails used as restraints add risk to the resident. They potentially increase the risk of more significant injury from a fall from a bed with raised bed rails than from a fall from a bed without bed rails. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Other interventions that the facility might incorporate in care planning include-- o Providing restorative care to enhance abilities to stand safely and to walk; o A trapeze to increase bed mobility; o Placing the bed lower to the floor and surrounding the bed with a soft mat; o Equipping the resident with a device that monitors attempts to arise; o Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or o Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information. When used for mobility or transfer, assessment should include a review of the residents-- o Bed mobility (e.g., would the use of the bed rail assist the resident to turn from side to side? Or, is the resident totally immobile and cannot shift without assistance?); and o Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised bed rail add risk to the resident's ability to transfer?). However, as with other restraints, for residents who have been restrained by bed rails, it is expected that the process facilities employ to reduce the use of bed rails as restraints is systematic and gradual (e.g., lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell).

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C381 Cont.		Before a resident is restrained, the facility must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his or her highest level of physical and psychosocial well-being. Appropriate exercise, therapeutic interventions such as orthotic devices, pillows, pads, or lap trays often assist in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use. Restraints may not be used to permit staff to administer treatment to which the resident has not consented. However, if the resident needs emergency care, restraints may be use for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. Survey Procedures an d Probes §483.13(a) Since continued restraint usage is associated with a potential for a decline in functioning if the risk is Not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint Use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributable to unavoidable disease progression, versus inappropriate use of restraints. Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. For sampled residents observed as physically restrained during the survey or whose clinical Records show the use of physical restraints within 30 days of the survey, determine the intended use of the restraint, convenience or discipline, or a therapeutic intervention for specified periods to attain and maintain the resident's highest practicable physical, mental or psychosocial well being. This systematic process should answer these questions-- 1. What are the symptoms that led to the consideration of the use of restraints? 2. Are these symptoms caused by failure to-- o Meet individual needs in accordance with section III of the M.D.S., Customary Daily Routines (M.D.S. version 2.0 section AC), in the context of relevant information in sections I and II of the M.D.S. (M.D.S. version 2.0 sections AA and AB)? o Use aggressive rehabilitative/restorative care? o Provide meaningful activities? o Manipulate the resident's environment, including seating?

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C381 Cont.		3. Can the cause(s) be removed? 4. If the cause(s) cannot be removed, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use? (See Physical Restraints Resident Assessment Protocol (RAP), paragraph 1). 5. If the alternatives have been tried and found wanting, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce negative outcomes while continually trying to find and use less restrictive alternatives? 6. Did the resident make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained? 7. Does the facility use the Physical Restraints RAP to evaluate the appropriateness of restraint use? 8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained resident's strength and mobility? If responses to these questions indicate that restraint use may not comply with these requirements, is there evidence of restraints used for staff convenience (i.e., restrained residents left alone for lone periods, not toileted and not provided with exercise. Refer to M.D.S. sections Customary Daily Routine, K, N, E, H, L, (M.D.S. version 2.0 sections AC, J, M, G, E and K respectively) and relevant RAPS, and to notes from other health professionals to determine if restrained residents have maintained their physical, mental, psychosocial and functional status; or if the use of restraints has been associated with an increase in falls, urinary or fecal incontinence, pressure sores, loss of muscle tone, loss of independent mobility, increased agitation, loss of balance, symptoms of withdrawal or depression, reduced social contact, or decreased appetite.
C382	(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	Interpretive Guideline §483.13(b)(c) These requirements specify the right of each resident to be free from abuse, corporal punishment, and involuntary seclusion, and the facility's responsibilities to prevent not only abuse, but also those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse.

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C382 Cont.		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. "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. "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. <u>Survey Procedures and Probes §483.13(b)</u> Offsite, presurvey 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.

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C382 Cont.		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 as described in §483.13(c). If a resident is being temporarily separated from other residents, i.e., 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 in accordance with section III (M.D.S. version 2.0 section AC), Customary Daily Routines, in the context of relevant information in sections I (M.D.S. and II of the M.D.S. (M.D.S. version 2.0 sections AA and AB)? o Provide meaningful activities? o Manipulate the resident's environment? 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. If these alternatives have been tried and found wanting, 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.

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C382 Cont.		10. If the purpose of the unit is to provide an emergency short term monitored separation for a resident who showed temporary behavior problems (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staff or others in the facility) then answer the questions with regard to temporary separation set out above.
C383	(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 Guideline §483.13(c) The intent of this regulation is to assure that the facility has in place an effective system that regardless of the source (staff, other residents, visitors, etc), prevents mistreatment, neglect and abuse of residents, and misappropriation of resident's property. However, such a system cannot guarantee that a resident will not be abused; it can only assure that the facility does whatever is within its control to prevent mistreatment, neglect, and abuse of residents or misappropriation of their property. Such steps include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents, an assessment of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abusive behavior, and reassessment of the strategies on a regular basis. For each sampled resident in a secured unit, determine the facility's stated purpose for the unit and the facility's intent in placing the individual in the unit. "Neglect", is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (See Older Americans Act, §302(a)(29)). Neglect occurs on an individual basis when a resident has a lack of care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces). "Misappropriation of resident 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.
C384	(ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or	Interpretive Guideline §483.13(c)(1)(ii) 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 (e.g., residents of a nursing facility or patients in a hospital). Facilities must be thorough in their investigations of the past

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C384 Cont.	(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. (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.	Histories of individuals they are considering hiring. In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility should check all 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. Interpretive Guidelines §483.13(c)(1)(iii) An aide or other 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, if applicable. Further, if a facility determines that actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), then the facility must report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authority (if a licensed staff member). Such a determination by the facility is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment. If, during a survey, the survey team is made aware of a previous incident of neglect or abuse, evaluate current residents for evidence of similar problems that might indicate that the facility has not addressed systemic problems to protect residents from neglect, abuse and misappropriation of property. Survey Procedures and Probes §483.13(c)(2)(3) and (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--

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C384 Cont.		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. 2. In addition, spot check employment-- o 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. o Records for contact with State Nurse Aide Registry. Determine if applicants with a finding concerning mistreatment, neglect, abuse of residents or misappropriation of their property have been rejected. o New employees for registry entries. 3. 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)?

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C385	**§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	Interpretive Guidelines §483.15(f)(1) Because the activities program should occur within the context of each resident's comprehensive assessment and care plan, it should be multi-faceted and reflect each individual resident's needs. Therefore, the activities program should provide stimulation or solace; promote physical, cognitive and/or emotional health; enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice. 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)(1) Observe individual, group and bedside activities. 1. Are residents who are confined or choose to remain in their rooms provided with in room activities in keeping with lifelong interests (e.g., music, reading, visits with individuals who share their interests or reasonable attempts to connect the resident with such individuals) and in room projects they can work on independently? Do any facility staff members assist the resident with activities he or she can pursue independently? 2. If residents sit for long periods of time with no apparently meaningful activities, is the cause-- o Resident 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? For residents selected for a comprehensive review, or a focused review, as appropriate, determine to what extent the activities reflect the individual resident's assessment. (See especially M.D.S. III.1 and Sections B, C, D, and I; M.D.S. version 2.0 sections AC, B, C, D, and N.)

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C385 Cont.	(iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.	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. Review clinical records and activity attendance records of residents receiving a comprehensive review, or a focused review, as appropriate, 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. <u>Interpretive Guideline §483.15(f)(2)</u> 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. <u>Survey Procedures and Probes §483.15(f)(2)</u> If there are problems with provision of activities, determine if these services are provided by qualified staff.

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C386	(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. NOTE: §483.15(g)(2) which requires a full time qualified social worker be employed is inapplicable to CAHs.	Interpretive Guideline §483.15(g)(1) Regardless of size, all facilities are required to 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. It is not required that a qualified social worker necessarily provide all of these services. Rather, 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. The intent is to assure that sufficient and appropriate social services are provided to meet the resident's needs. "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 might include, for example-- 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 and their ramifications; 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 Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices; o Building relationships between residents and staff and teaching staff how to understand and support residents individual needs; o Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality; 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 most meet the physical and emotional needs of each resident;

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C386 Cont.		o Providing alternatives to drug therapy or restraints by understanding and communicating to staff Why residents act as they do, what they are attempting to communicate, and what needs the staff must meet; o Meeting the needs of residents who are grieving; and o Finding options which most meet their physical and emotional needs. Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for: o Dental/denture care; o Podiatric care; o Eye care; o Hearing services; o Equipment for mobility or assistive eating devices; and o Need for home-like environment, control, dignity, privacy. Where needed services are not covered by the Medicaid State Plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid State Plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance. Types of conditions to which the facility should respond with social services by staff or referral include: o Lack of an effective family/social support system; o Behavioral symptoms; o If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his or her re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victim while it assesses the circumstances of the resident's behavior); o Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer's disease, schizophrenia); o Depression; o Chronic or acute pain; o Difficulty with personal interaction and socialization skills; o Presence of legal or financial problems; o Abuse of alcohol or other drugs;

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C386 Cont.		o Inability to cope with loss of function; o Need for emotional support; o Changes in family relationships, living arrangements, and/or resident's condition or functioning; and o A physical or chemical restraint. For residents with or who develop mental disorders as defined by The Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), see §483.45 Tag C401. Survey Procedures and Probes §483.15(g)(1) For residents selected for a comprehensive or focused review as appropriate-- o How do facility staff implement social services interventions to assist the resident in meeting treatment goals? o How do staff 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 Have 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 .
C388	**§483.20 Resident assessment.** The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.	Interpretive Guidelines §483.20(b)(1)(2) The guidelines for resident assessment are consistent with the requirements for each State's specified Resident Assessment Instrument (RAI). The assessments provide the facility with the information necessary to develop a care plan and to provide the appropriate care and services for each resident. Each State's RAI includes at least the Minimum Data Set (M.D.S.) and common definitions, triggers, and utilization guidelines developed by HCFA, which include the Resident Assessment Protocols (RAPS).

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C388 Cont.	(b) Comprehensive assessment. (1) The facility must make a comprehensive assessment of a resident's needs which-- (i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and (ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity. (2) The comprehensive assessment must include at least the following information-- (i) Medically defined conditions and prior medical history; (ii) Medical status measurement; (iii) Physical and mental functional status;	The information required in §483.20(b)(2)(I - xiii) is incorporated into the MDS, which forms the core of each States's approved RAI. Additional assessment information is also gathered using triggered RAPS. Each facility must use its State specified RAI (which includes both the MDS and utilization guidelines including the RAPs) to assess newly admitted residents, annual review and those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPS. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission. All reference to version 2.0 (v. 2.0) of the MDS are effective when the State respecifies its RAI. (This corresponds to MDS Identification Information I.11-12 and Section J; MDS v. 2.0 Section AB9-10 and Section I, Disease Diagnosis, respectively.) "Medically defined conditions and prior medical history" is defined as the resident's medical history before admission and a description of current medical diagnoses. It includes history of mental retardation and current mental illness, if applicable. (This corresponds to MDS section B1-6, J1-2, K1 and K3, and P1-2; MDS v. 2.0 sections B1-6, I1-2, J1-3, 5 and P1 and 9.) "Medical status measurement" is defined as objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic test. (This corresponds to MDS sections E1-8 and G1-3; MDS v. 2.0 sections G1-9 and F1-3.) "Physical and mental functional status" is defined as the resident's ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, or other communication systems. Includes determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day to day activities of the facility.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C388 Cont.	(iv) Sensory and physical impairments;	(This corresponds to MDS sections C1-6, D1-3, E4 and F1-4; MDS v. 2.0 sections C1-7, D1-3, G4, and H1-4.) "Sensory and physical impairments" are defined as neurological or muscular deficits. For example, a decrease in vision or hearing, paralysis, or bladder incontinence.
	(v) Nutritional status and requirements;	(This corresponds to MDS section L1-4; MDS v. 2.0 section K1-6.) "Nutritional status and requirements" are defined as weight, height, hematologic and biochemical assessments, clinical observations of nutrition, nutritional intake, resident's eating habits and preferences, and dietary restrictions.
	(vi) Special treatments or procedures;	(This corresponds to MDS sections L4, N1-4, P1; MDS v. 2.0 sections K5, M5, and P1.) "Special treatments or procedures" are defined as treatments and procedures that are <u>not</u> part of basic services provided. For example, treatment for pressure sores, nasogastric feedings, specialized rehabilitation services, or respiratory care.
	(vii) Mental and psychosocial status;	(This corresponds to MDS sections III (customary routine), G1-3 and H; MDS v. 2.0 sections AC, F1-3, and E.) "Mental and psychosocial status" is defined as the resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood.
	(viii)Discharge potential;	(This corresponds to MDS section A10; v. 2.0 section Q.) "Discharge potential" is defined as the facility's expectation of discharging the resident from the facility within the next three months.
	(ix) Dental condition;	(This corresponds to MDS section M; MDS v. 2.0 section L.) "Dental condition" is defined as the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communication abilities, or quality of life. The assessment should include the need for, and use of, dentures or other dental appliances.
	(x) Activities potential;	(This corresponds to M.D.S. section I (activities pursuit) and III (customary routine); M.D.S. v. 2.0 section N and AC.) "Activities potential" is defined as the resident's ability and desire to take part in activities which maintain or improve, physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of activities of daily living (ADLs) which a person pursues in order to obtain a sense of well-being. Also, includes activities which provide benefits in self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence. The assessment should consider the resident's normal everyday routines and lifetime preferences.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C388 Cont.	(xi) Rehabilitation potential; (xii) Cognitive status; and (xiii) Drug therapy.	(This corresponds to MDS section E7; MDS v. 2.0 section G8.) "Rehabilitation potential" is defined as the ability to improve independence in functional status through restorative care programs. (This corresponds to MDS section B1-6; MDS v. 2.0 section B1-6) OCognitive statuso is defined as the resident's ability to problem solve; decide, remember, and be aware of and respond to safety hazards. (This corresponds to MDS section O; v. 2.0 section O.) ODrug therapy" is defines as all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident. This information need not appear in the assessment. However, it must be in the resident's clinical record and included in the care plan. Survey Procedures and Probes: §483.20(b)(1)(2) O Has each resident in the sample been comprehensively assessed using the State specified RAI within the regulatory timeframes (i.e., within 14 days of admission, on significant change in status, and at least annually)? O Has the facility gathered supplemental assessment information based on triggered RAPs prior to establishing the care plan? O Does information in the RAI correspond with information obtained during observations of and interviews with the resident, facility staff and resident's family?
C389	(4) Frequency. Assessments must be conducted-- (i) No later than 14 days after the date of admission; (ii) For current NF residents not later than October 1, 1991; (iii) For current SNF residents, not later than January 1, 1991; Item (ii) does not apply to CAHs.	Interpretive Guidelines §483.20(b)(4) The intent of this regulation is to assess residents in a timely manner. "Admission to the facility is defined as an initial stay or a return stay (not a readmission) in the facility. A return stay applies to those residents who are discharged without expectation that they will return to the facility, but who do return to the facility. A "readmission is an expected return to the facility following a temporary absence for hospitalization, off-site visit or therapeutic leave. A resident who is readmitted and for whom there is a prior RAI on file does not require a new assessment unless a significant change in status has occurred (see below), and should remain on the same schedule as if there had been no temporary absence. An M.D.S./RAI need not be completed for residents discharged in less than 14 days, although the facility is to provide care appropriate to the resident's needs from admission to discharge.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C390	(iv) Promptly after a significant change in the resident's physical or mental condition; and	If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment. Facilities may correct errors on the M.D.S. per HCFA policy within 7 days of its completion. The following guidance concerning significant change is applicable until the State respecifies its RAI for version 2.0. A "significant change" may include, but is not limited to, any of the following, or may be determined by a physician's decision if uncertainty exists-- o Deterioration in two or more ADLs, or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent. For example, pronounced deterioration in function and communication following a stroke; o Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush or comb. Temporary loss of ability, such as during an acute illness, is not included; o Deterioration in behavior or mood, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention; o Deterioration in a resident's health status, where this change places the resident's life in danger, (e.g., stroke, heart disease, metastatic cancer); is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or is associated with an initial diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time, (e.g., Alzheimer's disease or diabetes) or the onset of significant (unplanned) weight loss (5% in last 30 days, 10% in last 180 days); or o Improvement in behavior, mood or functional status to the extent that the plan of care no longer addresses the needs of the resident. Comprehensive resident assessment is not required if declines in physical, mental or psychosocial well being are short-term or insignificant (i.e., do not require a change in the resident's care plan). This may include-- o Discrete and easily reversible symptoms documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level;

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C390 Cont.		" Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect a full recovery of the resident's pre-morbid functional abilities and health status; o Well established symptoms associated with previously diagnosed cyclical conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease; or o If the resident continues to make steady progress under the current course of care, reassessment is required only when the condition has stabilized. "Promptly" means that once it is determined that the resident's change in status is significant or likely to be permanent, a full assessment must be completed within 14 days of this determination. The following definition of a criteria for significant change are effective when the State respecifies its RAI-- A "significant change" is a major change in the resident's status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. According to this definition, a significant change reassessment would be indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement. Following are examples which could indicate a significant change. <u>Decline:</u> o Any decline in ADL physical functioning where a resident is newly coded as 3, 4 or 8 (Extensive assistance, Total dependency, Activity did not occur); o Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1's" for E4B); o Resident's decision making changes from 0 or 1, to 2 or 3; o Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter; o Emergence of sad or anxious mood as a problem that is not easily altered; o Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); o Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before; o Emergence of a condition/disease in which a resident is judged to be unstable; o Emergence of a pressure ulcer at stage II or higher, when no ulcers were previously present at Stage II or higher; or o Overall deterioration of resident's condition; resident received more support (e.g., in ADLs or decision making).

PART III-INTERPRETIVE GUIDELINES-CRITICAL ACCESS HOSPITALS

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C390 Cont.		Improvement: o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered"; o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports. If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment. Survey Procedures and Probes: §483.20(b)(4) o Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)? o Has the facility identified those residents who have experienced a significant change? o Has the facility reassessed residents using the State-specified RAI who had a change in status within 14 days after determining the change was significant or appears to be permanent?
C391	(v) In no case less often than once every 12 months.	
C392	(5) Review of Assessments. The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	Interpretive Guidelines: §483.20(b)(5) The intent of the regulation is to assure that the resident's assessment is accurate and reflects the resident's current status. At least each quarter, the facility shall review each resident with respect to those M.D.S. items specified under the State's quarterly review requirement. At a minimum, this would include all items contained in HCFA's quarterly review form. Until the State respecifies its RAI for version 2.0, facilities are not required to use HCFA's form unless specified by the State. However, when the State respecifies its RAI, the quarterly review form will be required. If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the significant change reassessment. Until the State respecifies its RAI, review at least quarterly;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C392 Cont.		o Cognitive patterns, especially memory and daily decision-making ability; o Communication/hearing ability, especially the ability to make ones self understood and to understand others; o Physical functioning and ADL abilities; o Continence; o Mood and behavior patterns; o New disease diagnoses that have a relationship to current ADL status, behavior status, medical treatments, or risk of death; o Weight loss; o Medication use, particularly psychotropic medications; and o Special treatments and procedures, including restraints. NOTE: These quarterly assessment domains will no longer apply when the State respecifies its RAI. Survey Procedures and Probes: §483.20(b)(5) o Is the facility assessing and acting, no less than once every 3 months, on the results of resident's functional and cognitive status examinations? o Is the quarterly review of the resident's condition consistent with information in the progress notes, the plan of care and your resident observations and interviews?
C393	(6) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.	Survey Procedures and Probes: §483.20(b)(6) See §483.20(d).
C394	(7) Coordination. The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.	Interpretive Guidelines: §483.20(b)(7) As the facility determines appropriate, if required portions of the comprehensive assessment have been performed as part of a pre-admission screening program, enter the results of the pre-admission screening into the appropriate portion of the comprehensive assessment instrument. Unless a significant change has occurred between pre-admission screening and admission, the facility may choose not to repeat those portions of the assessment. For example, medical records containing the resident's history and course of previous hospitalizations, pertinent laboratory results and social history data may be used where applicable to enter information on the assessment form. The intent of this regulation is to prevent duplicative data gathering by using M.D.S. assessment Information for more than one purpose.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
C395	(d) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following-- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	Interpretive Guidelines: §483.20(d) An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the RAP Summary or clinical record of the resident's status in triggered RAP areas and their rationale for deciding whether to proceed with care planning and that they considered the development of care planning interventions for all RAPs triggered by the MDS. The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care. The requirements reflect the facility's responsibility to provide necessary 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. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record. (See guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment.) Survey Procedures and Probes: §483.20(d)(1) o Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment? o Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths? o Do treatment objectives have measurable outcomes? o Does the care plan reflect standards of current professional practice? o Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment. o Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment. o If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? For implementation of care plan, see §483.20(d)(3).

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C396	(2) A comprehensive care plan must be-- (i) Developed within 7 days after the completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Interpretive Guidelines: §483.20(d)(2) As used in this requirement, Ointerdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. The physician must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-to-one discussions and conference calls. The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. See §§483.10(d)(2) and (3) and 483.10(b)(4). The facility should encourage residents, surrogates, and representatives to participate in care planning, including encouraging attendance at care planning conferences if they so desire. Survey Procedures and Probes: §483.20(d)(2) 1. Was interdisciplinary expertise utilized to develop a plan to improve the resident's functional abilities? o For example, did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability? o Do the dietitian and the speech therapist determine, for example, the optimum textures and consistency for the resident's food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident? o Is there evidence of physician involvement in development of the care plan (e.g., presence at care planning meetings, conversations with team members concerning the care plan, conference calls)? o In what ways do staff involve residents and families, surrogate, and/or representatives in care planning? o Do staff make an effort to schedule care plan meetings at the best time of the day for residents and their families? o Do facility staff attempt to make the process understandable to the resident/family? (Individual) Have you had concerns or questions about your care and brought them to the attention of facility staff? If yes, what happened as a result?

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C396 Cont.		Interpretive Guidelines: §483.20(d)(2)(iii) See §483.75(g)(2) for Qualified Person. Survey Procedures and Probes: §483.20(d)(2)(iii) Is the care plan evaluated and revised as the resident's status changes?
C397	(3) The services provided or arranged by the facility must-- (i) Meet professional standards of quality; and	Interpretive Guidelines: §483.20(d)(3)(i) The intent of this regulation is to assure that persons providing services are qualified to do so, that the resident's plan of care is implemented, and that those services provided meet professional standards of quality (in accordance with the following definition) and are provided by appropriate qualified persons (e.g., licensed, certified). "Professional standards of quality" means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include-- " Current manuals or textbooks on nursing, social work, physical therapy, etc. " Standards published by professional organizations such as the American Nurses' Association, the National Association of Social Work, the American Dietetic Association, the National Association of Activity Professionals, the American Medical Association, etc. " Clinical practice guidelines published by the Agency for Health Care Policy and Research. " Current professional journal articles. If a negative resident outcome is determined to be related to the facility's failure to meet professional standards, and the team determine a deficiency has occurred, it should be cited under the appropriate quality of care or other relevant requirement.
C398	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.	

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C398 Cont.		Survey Procedures and Probes: §483.20(d)(3) Question only those practices which have a negative outcome or have a potential negative outcome. Ask the facility to produce references upon which the practice is based. o Do nurses notify physicians, as appropriate, and show evidence of discussions of acute medical problems? o Are residents with acute conditions who require intensive monitoring and hospital level treatments that the facility is unable to provide, promptly hospitalized? o Are there errors in the techniques of medication administration? o Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan? o Are physicians' orders carried out, unless otherwise indicated by an advanced directive? o Can direct care giving staff describe the care, services and expected outcomes of the care they provide; have a general knowledge of the care and services being provided by other therapists; have an understanding of the expected outcomes of this care, and understand the relationship of these expected outcomes to the care they provide. Interpretive Guidelines: §483.(d)(3)(ii) If you find problems with quality of care, quality of life, or resident rights, are these problems attributable to the qualifications of the facility staff, or lack of, inadequate or incorrect implementation of the care plan?
C399	(e) 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	.Interpretive Guidelines: §483.20(e) The intent of this regulation is to ensure appropriate discharge planning and communication of necessary information to the continuing care provider. A post discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for mentally retarded individuals. A "post discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. "Anticipates" means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident's death.

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C399 Cont.	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.	"Adjust to his or her living environment" means that the post discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple care givers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/care giver education needs to ensure the resident/care giver is able to meet care needs after discharge. Survey Procedures and Probes: §483.20(e) o Does the discharge summary have information pertinent to continuing care for the resident? o Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)? o Do discharge plans address necessary post discharge care? o Has the facility aided the resident and his/her family in locating and coordinating post discharge services? o What types of predischarge preparation and education has the facility provided the resident and his/her family?
C400	**§483.25 Quality of Care.** Each resident must receive and the facility must provide the necessary 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. (i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident-- (1) Maintains acceptable parameters of nutritional status, such as body weight and	Interpretive Guidelines: §483.25(i) This corresponds to M.D.S., section L; M.D.S. 2.0 sections G, I, J, K and L when specified for use by the State. Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels).

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C400 Cont.	protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	Weight: Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should be examined in light of the individual's former life style as well as the current diagnosis.
C401	(2) Receives a therapeutic diet when there is a nutritional problem.	Suggested parameters for evaluating significance of unplanned and undesired weight loss are: Interval / Significant Loss / Severe Loss 1 month / 5% / Greater than 5% 3 months / 7.5% / Greater than 7.5% 6 months / 10% / Greater than 10% The following formula determines percentage of loss: % of body weight loss = (usual weight - actual weight) / usual weight x 100 In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food? Suggested laboratory values are: Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion) Plasma Transferrin >60 yr.:180 - 380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.) Hemoglobin Males: 14-17 g/dl Females: 12-15 g/dl Hematocrit Males: 41 - 53 Females: 36 - 46 Potassium 3.5 - 5.0 mEq/L Magnesium 1.3 - 2.0 mEq/L Some laboratories may have different "normals". Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values.

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C401 Cont.		NOTE: There is no requirement that facilities order the tests referenced above. Clinical Observations: Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting. Risk factors for malnutrition are-- 1. Drug therapy that may contribute to nutritional deficiencies such as-- o Cardiac glycosides; o Diuretics; o Anti-inflammatory drugs; o Antacids (antacid overuse); o Laxatives (laxative overuse); o Psychotropic drug overuse; o Anticonvulsants; o Antineoplastic drugs; o Phenothiazines; o Oral hypoglycemics; 2. Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations; 3. Depression or dementia; 4. Therapeutic or mechanically altered diet; 5. Lack of access to culturally acceptable foods; 6. Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and 7. Cancer. Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be possible include, but are not limited to-- o Refusal to eat and refusal of other methods of nourishment; o Advanced disease (i.e., cancer, malabsorption syndrome); o Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns); o Radiation or chemotherapy; o Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism;

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C401 Cont.		o Gastrointestinal surgery; and o Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice. "Therapeutic diet" means a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet, (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). Survey Procedures and Probes §483.25(i) Determine if residents selected for a comprehensive review, or focused review as appropriate, have maintained acceptable parameters of nutritional status. Where indicated by the resident's medical status, have clinically appropriate therapeutic diets been prescribed? For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable-- o Did the facility identify factors that put the resident at risk for malnutrition? o Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the casual factors for decline, potential for decline or lack of improvement. o What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)? o Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes? o Was this care provided consistently? o Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?
C402	**§483.45 Specialized rehabilitative services.**	

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C402 Cont.	(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.	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 differentiated from restorative services which are provided by nursing staff. Specialized rehabilitative services are provided by or coordinated by qualified personnel. Specialized rehabilitative services are considered a facility service and are, thus, 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 MI or 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. They are-- "Specialized services for MI or MR" refers to those services to be provided by the State which can only be delivered by personnel or programs other than those of the NF (e.g., outside the NF setting), because the overall level of NF services is not as intense as necessary to meet the individuals needs. The Preadmission Screening and Annual Resident Review (PASARR) report indicates specialized services required by the resident. The State is required to list those services in the report, as well as provide or arrange for the provision of the services. If the State determines that the resident does not require specialized services, the facility is responsible to provide all services necessary to meet the resident's mental health or mental retardation 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

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C402 Cont.		whether or not they are required to be subject to the PASARR process and whether or not they require additional services to be provided or arranged for by the State as specialized services. The facility should provide interventions which complement, reinforce and are consistent with any specialized services (as defined by the resident's PASARR) the individual is receiving or is required to receive by the State. The individual's plan of care should specify how the facility will integrate relevant activities throughout all hours of the individual's day at the NF to achieve this consistency and enhancement of PASARR goals. The surveyor should see competent interaction by staff at all times, in both formal and informal settings in accordance with the individual's needs. 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); 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)(1)(2)</u> For sampled residents, whose comprehensive assessment indicates physical, psychosocial, and/or communications rehabilitation potential (See M.D.S. Sections E, C, G, H, in version 2.0, sections G, C, F, E. References to version 2.0 of the M.D.S. are effective when the State respecifies its RAI), observe for unmet needs for rehabilitative services. Determine the extent of follow through with the comprehensive care plan using probes outlined below. Verify from the chart that the resident is receiving frequency and type of therapy as outlined in the care plan.

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C402 Cont.		1. PHYSICAL THERAPY 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? 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 such as understanding common, functional words, concepts of time and place, and conversation? o What did the facility do to improve speech production? o What did the facility do to improve expressive behavior such as the ability to name common, functional items? o What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audio logic evaluation? For example, did the facility instruct the resident how to effectively and independently use environmental controls to compensate for hearing loss such as eye contact, preferential seating, use of the better ear? o For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?

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C402 Cont.		4. REHABILITATIVE SERVICES FOR MI AND MR N 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? 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-- o Who do you talk to when you have a problem or need something? o What do you do when you feel happy? Sad? Can't sleep at night? o In what activities are you involved, and how often?
C403	(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) 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.

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C403 Cont.		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 residents rehabilitative care is identified that is related to the qualifications of the care providers, it may be necessary to validate the care providers qualification. 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?
C404	**§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 (i.e., employ a staff dentist or have 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. 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. The facility is responsible for selecting a dentist who provides dental services in accordance with professional standards of quality and timeliness under §483.75(h)(2).
C405	(a) Skilled nursing facilities. A facility-- (A) 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;	

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C406	(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. NOTE: §483.55(b) does not apply to CAHs.	"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. <u>Survey Procedures and Probes §483.55</u> 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?