Key Medicare SNF Regulatory and Survey Changes

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LTC Survey Pathways - Updated 12/13/2017 [ZIP, 2MB]

CMS-20052 Beneficiary Notice.pdf	Adobe Acrobat Document	363 KB
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CMS-20073 Hospice and End of Lif...	Adobe Acrobat Document	75 KB
CMS-20074 Death.pdf	Adobe Acrobat Document	45 KB
CMS-20075 Nutrition.pdf	Adobe Acrobat Document	49 KB
CMS-20076 Pain Mgt.pdf	Adobe Acrobat Document	36 KB
CMS-20077 Physical Restraints.pdf	Adobe Acrobat Document	71 KB
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CMS-20090 PASARR.pdf	Adobe Acrobat Document	66 KB
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CMS-20120 Positioning, Mobility, ...	Adobe Acrobat Document	101 KB
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CMS-20132 Discharge.pdf	Adobe Acrobat Document	76 KB
CMS-20133 Dementia Care.pdf	Adobe Acrobat Document	45 KB

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive MDS/CAAs for Sections B – Hearing, Speech, and Vision, C – Cognitive Patterns, E – Behavior, G – Functional Status, I – Active Diagnoses, J – Health Conditions-Pain, Falls, N – Medications, and O – Special Treatments, Procedures, and Programs.
- ☐ Physician's orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).
- ☐ Pertinent diagnoses.
- ☐ Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident's hospitalization.
- ☐ Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident's needs, goals, preferences, and assessment).

Observations:

- ☐ Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
  - Physical distress;
  - Mental status changes;
  - A change in condition; and/or
  - Pain?
- ☐ If symptoms are exhibited, what does staff do?
- ☐ Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

- ☐ Why were you sent to the hospital? Has your condition improved? If not, do you know why it's not getting better?
- ☐ When did you start to feel different, sick, or have a change in condition?
- ☐ Do you feel staff responded as quickly as they could have when you had a change in condition?
- ☐ Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?
- ☐ Do you have pain? If so, what does staff do for your pain?
- ☐ Has your health declined since you were in the hospital? If so, what has staff done?
- ☐ What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).

Downloaded from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

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- ☐ Were you notified immediately about your change in condition and need for potential hospitalization?
- ☐ Were you involved in the development of the care plan and goals regarding your care before and after you got back from the hospital?
- ☐ Do the interventions reflect your choices and preferences?
- ☐ Did you refuse care related to the symptoms which led to your hospitalization? If so, what was your reason for refusing care? Did the staff provide you with other options for treatment or provide you with education on what might happen if you did not follow the treatment plan?
- ☐ Has your hospitalization caused you to be less involved in activities you enjoy?
- ☐ Since your hospitalization, have you had a change in your mood or ability to function? If so, what has staff done?
- ☐ Did you receive a notice of transfer or discharge from the facility?
- ☐ Did the facility give you information about holding your bed for you while you were at the hospital?
- ☐ Were you allowed to return to the facility and to your previous room? If not, do you know why not?

Staff Interviews (Nursing Aides, Nurses, DON, Practitioner):

- ☐ Are you familiar with the resident's care?
- ☐ When did the hospitalization occur? What was the cause (e.g., pain, infection, mental status change, or fall)?
- ☐ Do you have a structured process for identifying and addressing a resident's change in condition (e.g., facility developed tool, Interventions to Reduce Acute Care Transfers [INTERACT])?
- ☐ Prior to the hospitalization, did the resident have a change or decline in condition? If so, when? How often did you assess the resident? Where is it documented?
- ☐ If the resident had a change in condition, who did you notify (e.g., practitioner or representative) and when?
- ☐ Prior to or after the hospitalization, did the resident refuse any treatment? What do you do if the resident refuses?
- ☐ Is the resident at risk for additional hospitalizations?
- ☐ Since the resident returned from the hospital, has the resident had a change or decline in condition? If so, what interventions are in place to address the problem(s)?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ How did you involve the resident/representative in decisions regarding treatments?
- ☐ If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current care plan.
- ☐ Ask about identified concerns.

Hospitalization Critical Element Pathway

Record Review:

- ☐ Was the cause of the hospitalization assessed, monitored, and documented timely (e.g., nursing notes, EMT records, hospital discharge summaries, H&P, progress notes/vital signs)?
- ☐ Did the facility adequately identify and address the resident's change in condition?
- ☐ Were changes in the resident's status or other risks associated with the hospitalization identified as soon as possible?
- ☐ Were changes in the resident's status related to the hospitalization communicated to staff, practitioner, resident and representative immediately after they were identified?
- ☐ Was the transfer to the hospital necessary (e.g., the resident's needs couldn't be met after facility attempts to address the needs, or the health or safety of individuals in the facility would be endangered if the resident stayed in the facility)?
- ☐ Did the facility send all necessary clinical information to the hospital (i.e., practitioner and representative's contact info, advance directive, special instructions or precautions for ongoing care, care plan goals, and all other information needed to care for the resident). Refer to 483.15(c)(2)(iii) for additional guidance on what must be conveyed.
- ☐ Did the appropriate practitioner document the basis for the transfer? [F622, 483.15(c)(2)(ii)]
- ☐ Was the resident/representative provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand?
- ☐ Did the notice meet all the notice requirements at 483.15(c)(3)?
- ☐ Did the resident/representative receive the notice of Bed Hold per 483.15(d)?
- ☐ Did the facility assess and monitor the resident's response to interventions?
- ☐ Did the facility identify necessary changes in interventions to prevent further hospitalizations?
- ☐ Does the resident have a medical condition or receive medications that require monitoring? If so, did the monitoring take place and was it documented (e.g., blood glucose monitored and treated appropriately)?
- ☐ Were there any medication changes that were pertinent to the hospitalization?
- ☐ Were any laboratory results pertinent to the hospitalization?
- ☐ Review facility policies and procedures relevant to the resident's hospitalization (e.g., policy on changes in condition).
- ☐ Review the facility's admission information provided during the Entrance Conference regarding bed holds and transfers.
- ☐ Ensure the resident was provided the policy on returning to the facility in the same room, if possible, and bed holds.
- ☐ Could the transfer to the hospital have been avoided (e.g., had the change in condition been identified and addressed earlier, the condition would not have declined to the point where the resident required a transfer)?
- ☐ **Residents not permitted to return to facility after hospitalization (Discharge):** When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is considered to be a facility-initiated discharge – ensure the facility is in compliance with all discharge requirements at 483.15.

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☐ For any resident whose **transfer to the hospital resulted in a discharge**, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave: [Refer to 483.15(c), (d), and (e) for additional guidance.]

- What was the basis for the resident's initial transfer to the acute care facility? [Refer to F622]
- Did the resident/representative receive all appropriate notification (Notice of Transfer, containing the basis for transfer; and Notice of Bed Hold); Was a copy of the notice sent to the ombudsman? [Refer to F623 and F625]
- Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F624]
- When the transfer became a discharge, did the facility issue another notice of Discharge? If so, what was the basis for the discharge? For residents discharged because the health or safety of individuals would be endangered, is there evidence that residents with similar health needs, conditions, or symptoms currently reside in the facility, or were admitted after the resident was discharged? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to F622]
- Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to F626]
- Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to F622]

Critical Element Decisions:

1) Did the facility ensure that the resident received treatment and care to prevent the hospitalization, that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice??
If No, cite the relevant outcome tag in Quality of Life, Quality of Care, or if no specific outcome tag, cite F684

2) Was the basis for the resident's transfer/discharge consistent with the requirements at 483.15(c)(1)? Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements at 483.15(c)(2)(i)-(ii)? Is there evidence that the information conveyed to the receiving provider met the requirements at 483.15(c)(2)(III)? Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
If No to any of these questions, cite F622

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3) Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?

AND/OR

For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?
If No, cite F623

4) Was the resident sufficiently prepared and oriented for their transfer to the hospital?
If No, cite F624

5) Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
If No, cite F625

6) Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
If No, cite F626

7) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident?Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

8) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

9) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637

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NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change status.

10) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status) ?
If No, cite F641

11) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

12) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAA/QAPI (Task).

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
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(Rev. 11-22-17)

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If a facility does not have a composite distinct part this provision does not apply. If there are concerns as to whether or not a facility meets the requirements for a distinct or composite distinct part of a larger institution or institutional complex, consult with the CMS Regional Office for clarification.

Room changes within either a composite distinct part SNF or a distinct part SNF are subject to the requirements at §483.10(e)(7) and F560, which address the resident's right to refuse transfer/room change. For concerns regarding the resident's right to refuse such a transfer or room change, refer to §483.10(e)(7) and F560.

PROBES

Determine if residents are grouped in separate wings or floors for reasons other than care needs, and if the quality of care is different between the different wings/floors.
Ask nursing home administrator, social worker, charge nurses, unit managers, and/or Director of Nursing:

- *What factors led to decisions to place residents in different wings or floors (or locations if a SNF composed of composite distinct parts)?*
- *Do factors other than medical and nursing needs affect where residents are placed?*

Ask representatives of the Office of the State Long-Term Care Ombudsman if they have information that could indicate the facility treats residents differently in transfer, discharge and covered services based on source of payment.
If concerns arise regarding equal access to care, ask the resident or representative:

- *Were there any changes to care or services when their payor source changed, for example did they notice fewer staff available to meet their needs when their payor source was due to change or had changed?*
- *Did the resident receive notice of changes in charges for services?*
- *Were they asked to move or were they moved to a different location in the building when their payor source changed?*

F622

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) 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;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) 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. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. 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

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals;

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

INTENT

To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation. Additionally, these

requirements specify the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting.

DEFINITIONS

"Facility-initiated transfer or discharge": *A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.*

"Resident-initiated transfer or discharge": *Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).*

"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. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

GUIDANCE

NOTE*: The provisions at §483.15(c) (1) and (2) (i)-(ii), only apply to transfers or discharges that are initiated by the facility, not by the resident. Section §483.15(c) (2) (iii) applies to both facility and resident initiated transfers (for information required at discharge, refer to F661, Discharge Summary).*

These regulations limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from involuntary discharge.

In the following limited circumstances, facilities may initiate transfers or discharges:

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.*
3. *The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.*
5. *The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.*
6. *The facility ceases to operate.*

Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility. See additional guidance at F626, §483.15(e) (1),

Permitting Residents to Return. Facility-initiated transfers and discharges must meet all transfer and discharge requirements at §483.15(c) (1) - (5).

Section §483.15(c) (1) (i) provides that "The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." This means that once admitted, for most residents (other than short-stay rehabilitation residents) the facility becomes the resident's home. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment. (See F838, Facility Assessment). There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Resident-initiated transfers or discharges occur when the resident or, if appropriate, his/her representative has given written or verbal notice of their intent to leave the facility. A resident's expression of a general desire or goal to return to home or to the community or the elopement of a resident who is cognitively-impaired should not be taken as a notice of intent to leave the facility.

Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

***NOTE**: In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors would review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return.*
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 and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs. (See §483.20(b) (2) (ii), F637 for information concerning assessment upon significant change.)

A resident's declination of treatment does not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. The facility must be able to demonstrate that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment, and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others.

Nonpayment as Basis for Discharge

Non-payment for a stay in the facility occurs when:

- *The resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or*
- *After the third party payor denied the claim and the resident refused to pay.*

It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third party paperwork. In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf, before discharging the resident. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Additionally, conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Emergent Transfers to Acute Care

Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected.

*Residents who are sent to the emergency room, **must** be permitted to return to the facility, unless the resident meets one of the criteria under which the facility can initiate discharge. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status is not based on his or her condition at the time of transfer) meets one of the criteria at §483.15(c)(i)(A) through (D).*

483.15(c)(1)(ii) Discharge pending appeal

When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending. Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. Appeal procedures vary by State.

If the resident, or if applicable, their representative, appeals his or her discharge while in a hospital, facilities must allow the resident to return pending their appeal, unless there is evidence that the facility cannot meet the resident's needs, or the resident's return would pose a danger to the health or safety of the resident or others in the facility. If there are concerns related to a facility's determination that it cannot meet a resident's needs, surveyors should assess whether the facility has admitted residents with similar needs. A facility's determination

to not permit a resident to return while an appeal of the resident's discharge is pending must not be based on the resident's condition when originally transferred to the hospital.

Required Documentation
To demonstrate that any of the cirmcumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge.

For circumstances 1 and 2 above for permissible facililty-initiated transfer or discharge, the ***resident's physician*** *must document information about the basis for the transfer or discharge. Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the* ***resident's physician must*** *include:*

- *The specific resident needs the facility could not meet;*
- *The facility efforts to meet those needs; and*
- *The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.*

In circumstances 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

NOTE*: Documentation of the transfer or discharge may be completed by a non-physician practitioner (NPP) in accordance with State law.*

Information Conveyed to Receiving Provider
The regulations at §483.15(c)(2)(iii) address information that must be conveyed to the receiving provider when a resident is transferred or discharged. The specific information which must be conveyed depends upon whether the resident is transferred (expected to return), or is discharged (not expected to return). If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider:

- *Contact information of the practitioner who was responsible for the care of the resident;*
- *Resident representative information, including contact information;*
- *Advance directive information;*
- *Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:*
  - *Treatments and devices (oxygen, implants, IVs, tubes/catheters);*
  - *Precautions such as isolation or contact;*
  - *Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;*
- *The resident's comprehensive care plan goals; and*
- *All information necessary to meet the resident's needs, which includes, but may not be limited to:*
  - *Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;*
  - *Diagnoses and allergies;*
  - *Medications (including when last received); and*

- *Most recent relevant labs, other diagnostic tests, and recent immunizations.*
- *Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information).*

***NOTE**: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer.*

For residents being discharged (return not expected), the facility must convey all of the information listed above, along with required information found at §483.21(c)(2) Discharge Summary, F661. Communicating this information to the receiving provider is one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting.

Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. The transferring or discharging facility may transmit the information electronically in a secure manner which protects the resident's privacy, as long as the receiving facility has the capacity to receive and use the information. Communication of this required information should occur as close as possible to the time of transfer or discharge.

INVESTIGATIVE PROTOCOL
Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility transfer or discharge requirements.

Summary of Investigative Procedure
*Briefly review the most recent comprehensive assessment, comprehensive care plan, progress notes, and orders to identify the basis for the transfer or discharge; during this review, identify the extent to which the facility has developed and implemented interventions to avoid transferring or discharging the resident, in accordance with the resident's needs, goals for care and professional standards of practice. This information will guide observations and interviews to be made in order to corroborate concerns identified. **NOTE**: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

F623

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

Assessment Factors Use to Determine the Seriousness of Deficiencies Matrix

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	**J** PoC Required	**K** PoC Required	**L** PoC Required
Actual harm that is not immediate	**G** PoC Required	**H** PoC Required	**I** PoC Required
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** PoC Required	**E** PoC Required	**F** PoC Required
No actual harm with potential for minimal harm	**A** **No** PoC Required No remedies Commitment to Correct Not on CMS-2567	**B** PoC Required	**C** PoC Required

Substandard quality of care means one or more deficiencies related to participation requirements under §483.10 "Resident rights", paragraphs (a)(1) through (a)(2), (b)(1) through (b)(2), (e) (except for (e)(2), (e)(7), and (e)(8)), (f)(1) through (f)(3), (f)(5) through (f)(8), and (i) of this chapter; §483.12 of this chapter "Freedom from abuse, neglect, and exploitation"; §483.24 of this chapter "Quality of life"; §483.25 of this chapter "Quality of care"; §483.40 "Behavioral health services", paragraphs (b) and (d) of this chapter; §483.45 "Pharmacy services", paragraphs (d), (e), and (f) of this chapter; §483.70 "Administration", paragraph (p) of this chapter, and §483.80 "Infection control", paragraph (d) of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Substantial compliance

Guidance on Severity Levels

There are four severity levels. Level 1, no actual harm with potential for minimal harm; Level 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy; Level 3, actual harm that is not immediate jeopardy; Level 4, immediate jeopardy to resident health or safety. These four levels are defined accordingly:

Level 1 - No actual harm with potential for minimal harm: A deficiency that has the potential for causing no more than a minor negative impact on the resident(s) or employees.

Level 2 - No actual harm with a potential for more than minimal harm that is not immediate jeopardy: Noncompliance with the requirements of the life safety code that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident or employee and/or that result in minimal discomfort to the residents or employees of the facility, but has the potential to result in more than minimal harm that is not immediate jeopardy.

Level 3 - Actual harm that is not immediate jeopardy: Noncompliance with the requirements of the life safety code that results in actual harm to residents or employees that is not immediate jeopardy.

Level 4 - Immediate jeopardy to resident health or safety: Noncompliance with the requirements of the life safety code that results in immediate jeopardy to resident or employee health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those life safety code requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident receiving care in a facility or an employee of the facility.

Guidance on Scope Levels

Scope has three levels: isolated; pattern; and widespread. The scope levels are defined accordingly:

Isolated - Scope is isolated when one or a very limited number of residents or employees is/are affected and/or a very limited area or number of locations within the facility are affected.

Pattern - Scope is a pattern when more than a very limited number of residents or employees are affected, and/or the situation has occurred in more than a limited number of locations but the locations are not dispersed throughout the facility.

Widespread - Scope is widespread when the problems causing the deficiency are pervasive (affect many locations) throughout the facility and/or represent a systemic failure that affected, or has the potential to affect, a large portion or all of the residents or employees.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 17-36-NH

DATE: **June 30, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

Memorandum Summary

- **Revised Interpretive Guidance:** In September 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Requirements for Participation under the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities rule. CMS is releasing revised Interpretive Guidance to be effective November 28, 2017.
- **Revised F Tags**: The revisions to the regulations caused many of the prior regulatory citations to be re-designated. As such, CMS was required to re-number the F-Tags used to identify each regulatory part. Those new F-Tags are described here.
- **Training Resources:** CMS is providing several training resources on our website and on an MLN Connect call on July 25, 2017 from 1:30 to 3:00pm EST.
- **Enforcement and Nursing Home Compare Considerations:** To address concerns related to the scope and timing of the changes, CMS will be providing limited enforcement remedies for certain Phase 2 provisions and will be holding constant the Nursing Home Compare health inspection rating for one year.

I. Background

Revised Medicare and Medicaid requirements for participation for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) were released on September 28, 2016 and became effective as of November 28, 2016, with a three-part phase-in of implementation dates over the next three years. These requirements include the minimum health and safety standards that long-term care facilities must meet to participate in Medicaid and Medicare. **The implementation date for Phase 2 of the revisions is November 28, 2017**. CMS is releasing this revised version of Appendix PP in advance of that implementation date so that State Survey Agencies (SAs), long term care facilities and the public have sufficient time to become aware of the sub-regulatory guidance for the regulations and how they will be surveyed.

We recognize that CMS has asked for comment on the underlying regulations to reduce burden and simplify rules and policies for Medicare beneficiaries, clinicians, providers and supplier through the proposed rule (CMS-1679-P) released in April 2017. We are reviewing these comments and sincerely appreciate all of the stakeholder input provided to date.

II. Appendix PP

CMS provides surveyor guidance through Interpretive Guidelines in the SOM. The Interpretive Guidelines for Long-Term Care include guidance primarily for the surveyors, however these guidelines are frequently used by facilities to ensure they understand the health and safety expectations that will be evaluated through the survey process. Many standards have remained unchanged since the early 1990's. For these areas, CMS reviewed the existing Interpretive Guidelines and updated where necessary to ensure that the standards and examples were clear. We also added a section in some areas to the Interpretive Guidance titled "Key Elements of Noncompliance." This is intended to guide surveyors and nursing facilities about the key behaviors and practices identified in the regulation.

This Interpretive Guidance is effective November 28, 2017. The Interpretive Guidance includes clarifications to existing requirements, guidance for new Phase 2 requirements, and references to the revised survey process and protocols.

III. F-Tags

As described above, CMS is revising the nursing facility F-Tags to correspond with the new regulatory sections. We are enclosing two documents for your use:

1) A revised list of the F-Tags under each regulatory group; and,
2) A crosswalk of old tags to new tags.

Given the re-structuring of the regulation, some tags were combined, and some tags were split into multiple subparts as described in these Attachments. These new F-Tags will be used after November 28, 2017.

IV. Survey Process

In addition, implementation of Phase 2 is scheduled to occur simultaneously with a new, computer-based Long Term Care survey system. CMS is incorporating the new regulatory requirements while combining the Traditional and Quality Indicator Survey processes. Within the Interpretive Guidance, there is information about the survey process. Information about the survey process is also available on our website described below, where CMS will be making additional materials available in the coming months

V. Training Resources

Between July and October 2017, CMS will provide a number of trainings for SAs, nursing facilities and the public to understand and meet the new requirements of the survey process and regulations. States may offer additional training. Publicly-available training will include:

- A Medicare Learning Network (MLN) Call on July 25th from 1:30 to 3:00pm to discuss the Interpretive Guidance and Survey Process. Questions can be submitted in advance to NHSurveyDevelopment@cms.hhs.gov.

- Information about the call can be found at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html when it is posted in the coming weeks. The call information will also be posted on our registration website at https://blh.ier.intercall.com/ when registration opens.

- CMS' website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html which includes a slide deck outlining the survey process. We will also be posting a Frequently Asked Questions document and links to other training resources in the future.
- The Integrated Surveyor Training Website (https://surveyortraining.cms.hhs.gov/index.aspx) will also host the following in the coming months:
  - Training videos by CMS staff that review highlights of 11 key topics for the Interpretive Guidance including for example, person-centered care, sufficient and competent staff, pharmacy services and infection control. These videos will review key components of the requirements;
  - Self-paced, online training describing the survey process changes to the Regional Office and State staff (which will also be made available publicly); and
  - Provider-specific training that will focus on those elements needed for the LTC survey process (e.g., materials to be requested during the entrance conference, etc.).

VI. Enforcement and Nursing Home Compare Considerations

Enforcement

CMS has heard concerns regarding the scope and timing of the new requirements for Phase 2. We believe that these standards (for example, development of an antibiotic stewardship program to combat multi-drug resistant organisms) represent important national health and safety standards. However, to address these concerns, CMS will provide a one- year restriction of enforcement remedies for specific Phase 2 requirements. Specifically, we will not utilize civil money penalties, denial of payment, and/or termination. Should a facility be found to be out of compliance with these new requirements beginning in November of 2017, CMS would use this year-long period to educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional directed in-service training. Enforcement for other existing standards (including Phase 1 requirements) would follow the standard process. Please note, this one-year period is not a change in the required implementation date for Phase 2 provisions.

The listing of specific Phase 2 requirements associated with enforcement delays will be shared at a later date. In general, CMS will identify those requirements that are associated with a unique and separate tag and where specialized efforts and technical assistance may be needed (e.g., antibiotic stewardship, facility assessment, Quality Assurance and Performance Improvement (QAPI) plan).

Nursing Home Compare
Currently, the *Nursing Home Five Star Quality Rating System* calculates a rating based on each facility's survey performance as compared to others' in the same State. Most facilities will be surveyed for compliance with Phase 2 requirements using the revised survey process within a year of the November 28, 2017 effective date. However, due to the differing standards being phased in over the year, CMS will be holding constant for one year the Nursing Home Compare health inspection rating for any surveys conducted after November 28, 2017. CMS has done this previously where the star ratings are maintained for a period of time as new requirements are phased-in. To address the concern that serious quality concerns will not be known, CMS will separately flag those nursing facilities to ensure public transparency. CMS will provide more detailed methodology information at a later date.

Contact: For any questions, please contact CMS at NHSurveyDevelopment@cms.hhs.gov.

Effective Date: November 28, 2017. This information should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

Attachments:
Attachment 1: F-Tag Crosswalk
Attachment 2: Advanced Copy-Revised Interpretive Guidance, Appendix PP SOM

cc: Survey and Certification Regional Office Management

The contents of this letter support activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-04-NH

DATE: **November 24, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to *Nursing Home Compare*

Memorandum Summary

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements:** CMS will provide an 18 month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18 month period will be used to educate facilities about specific new Phase 2 standards.
- **Freeze Health Inspection Star Ratings:** Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the *Nursing Home Compare* (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018.
- **Availability of Survey Findings:** The survey findings of facilities surveyed under the new LTC survey process will be published on NHC, but will not be incorporated into calculations for the *Five-Star Quality Rating System* for 12 months. CMS will add indicators to NHC that summarize survey findings.
- **Methodological Changes and Changes in Nursing Home Compare:** In early 2018, NHC health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspections.

Background

On September 28, 2016, CMS revised the SNF and NF Requirements for Participation, which became effective on November 28, 2016, and have a three-part phase-in of implementation dates over three years. Phase 1 became effective on November 28, 2016. Implementation of the new regulations for nursing homes under Phase 2 will become effective on November 28, 2017 (see S&C memo: 17-36-NH, dated June 30, 2017).

We also published revised interpretive guidance for Appendix PP of the SOM with the June 30, 2017 memo reflecting the new regulatory changes, which includes renumbering the nursing home F-Tags to correspond with the new regulatory sections. Implementation of Phase 2 reforms is scheduled to occur simultaneously with a new, computer-based LTC survey process in which we are incorporating the new regulatory requirements as well as combining the Traditional and Quality Indicator Survey processes.

To address concerns about the implementation of the new requirements and new LTC survey process, CMS will be making specific policy and process adjustments to the enforcement system and results posted on Nursing Home Compare. These changes are described in more detail below.

Temporary Moratorium on Imposition of Certain Enforcement Remedies

To address concerns regarding the scope and timing of the revised requirements (42 CFR part 483, subpart B), there will be a 18-month moratorium on the imposition of civil money penalties (CMPs), discretionary denials of payment for new admissions (DPNAs) and discretionary termination where the remedy is based on a deficiency finding of one of the specified Phase 2 F-tags noted below. CMS is not extending the moratorium to F608 which addresses reporting reasonable suspicion of a crime due to the concerns about significant resident abuse going unreported. CMS will use this 18-month moratorium period to educate surveyors and the providers to ensure they understand the health and safety expectations that will be evaluated through the survey process since these Phase 2 requirements are associated with unique and separate tags where specialized efforts and technical assistance may be needed. Previous communication indicated that the moratorium would be in effect for 12 months; that has been extended to 18 months to ensure provider understanding and readiness. Deficiency findings for all other F-tags will follow the standard enforcement process which includes all available enforcement remedies. Please note, facilities cited for any noncompliance with Phase 1 or Phase 2 requirements (beginning November 28, 2017), or both, will continue to be subject to statutorily-required provisions (mandatory DPNA and termination for failure to achieve substantial compliance within the required timeframes). Further note that this 18 month moratorium on the imposition of remedies does not change the implementation date for the Phase 2 provisions and state survey agencies should cite these tags as appropriate and continue to forward their findings to the RO as normal.

<u>The following F-Tags included in this moratorium are</u>:

- F655 (Baseline Care Plan); ***§483.21(a)(1)-(a)(3)***
- F740 (Behavioral Health Services); ***§483.40***
- F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); ***§483.40(a)(1)-(a)(2)***
- F758 (Psychotropic Medications) related to PRN Limitations ***§483.45(e)(3)-(e)(5)***
- F838 (Facility Assessment); ***§483.70(e)***
- F881 (Antibiotic Stewardship Program); ***§483.80(a)(3)***
- F865 (QAPI Program and Plan) related to the development of the QAPI Plan; ***§483.75(a)(2)*** and,
- F926 (Smoking Policies). ***§483.90(i)(5)***

For surveys identifying noncompliance of both Phase 1 and the Phase 2 tags specified above, the CMS Regional Office (RO) will follow standard enforcement procedures related to the Phase 1 tag if the Phase 1 tag(s) necessitates the imposition of remedies. For example, if a survey conducted during the moratorium period cites deficiencies both for infection control practices at tag F880 and antibiotic stewardship at tag F881 and the RO determines enforcement remedies are warranted, the RO may impose appropriate remedies as it relates to F880; however, only a Directed Plan of Correction (DPOC) and/or Directed In-Service training (DIST) remedy could be imposed for the findings related to tag F881. Once the temporary moratorium period is over, enforcement for all cited tags will return to the normal enforcement policies. The following chart explains how the enforcement remedies will be applied during the 18month moratorium time period.

Application of Discretionary Enforcement Remedies During 18 Month Moratorium

Discretionary Enforcement Remedies	Phase 1 Tags Only	Both Phase 1 and Phase 2 Tags	Phase 2 Tags Only
Normal Enforcement Policies Apply Or 18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)	Normal Enforcement Policies Apply	Normal Enforcement Policies Apply for the Phase 1 tag(s); and DPOC/DIST only may be imposed for Phase 2 tag(s)	18 Month Moratorium Enforcement Policies Apply (DPOC/DIST)

Directed Plan of Correction

A Directed Plan of Correction (as defined in 42 CFR §488.424) is an enforcement remedy developed by CMS, the State Survey Agency (or a temporary manager if applicable) requiring a facility to take action within specified timeframes to correct cited non-compliance. For these Phase 2 F-Tags identified above, we expect that the Directed Plan of Correction would address the structures, policies and processes needed by the facility to demonstrate and maintain substantial compliance.

A Directed Plan of Correction is completed when the facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that can be verified by CMS without an on-site visit. Surveyors are expected to go back on-site to review compliance when there is a credible allegation of compliance by the facility if any of the F-tags cited are Substandard Quality of Care (SQC), or when tags are at the actual harm or immediate jeopardy levels. See § 7317.2 of the CMS State Operations Manual (SOM) for information concerning on-site revisits and § 7500 for information concerning Directed Plans of Correction.

Directed In-Service Training

Directed In-Service Training is an enforcement remedy that may be used when CMS or the State, (or the temporary manager if applicable) believes that education is likely to correct the deficiencies and help the facility achieve and sustain substantial compliance. For this remedy to be used effectively and appropriately, the deficiency finding should demonstrate that a knowledge deficit significantly contributed to the deficiency. This remedy requires the relevant staff of the facility to attend an in-service training program that will address a demonstrated knowledge deficit. The purpose of directed in-service training is to provide the information necessary for the facility to achieve and maintain substantial compliance. Facilities should use programs developed by well-established centers of geriatric health services education such as schools of medicine or nursing, centers for
the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or CMS RO may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize their state's ombudsman program to provide training about residents' rights and quality of life issues.

After the directed in-service training has been completed, CMS RO or the State will assess whether substantial compliance has been achieved either through an on-site visit or by examining credible written evidence that it can be verified without an on-site visit. See § 7317.2 of the SOM for information concerning on-site revisits and § 7502 for information concerning Directed In-Service Training.

Statutorily Mandated Remedies not affected by Temporary Moratorium

The temporary moratorium described above does not include remedies that are required by federal law such as the Denial of Payment for New Admissions (DPNA) if the facility has not achieved compliance within 3 months of the finding under sections 1819(h)(2)(D) and 1919(h)(3)(C) of the Social Security Act (Act) and Termination after 23 days for immediate jeopardy under sections 1819(h)(4) and 1919(h)(5) of the Act or termination after 6 months for non-immediate jeopardy noncompliance under sections 1819(h)(2)(C) and 1919(h)(2)(D) of the Act.

CMS expects that the non-compliance for covered Phase 2 requirements would be corrected in advance of the statutorily-mandated timeframes as occurs with most cited deficiencies.

Temporary Freeze of Health Inspection Five-Star Ratings

Most facilities will be surveyed for compliance with Phase 2 requirements using the LTC revised survey process within one year after the November 28, 2017 Phase 2 implementation date. Due to the differing standards and process between those facilities surveyed under the new survey process compared to prior surveys, CMS will be holding constant, or "freezing," the health inspection star rating for health inspection surveys and complaint investigations conducted on or after November 28, 2017. We expect this freeze to begin in early 2018, and last approximately one year. Note that recent health surveys and complaint investigations conducted before November 28, 2017, will continue to be calculated in a facility's star rating, including any revisit

or changes based on informal dispute resolutions (IDR) or independent IDR. *Examples of when ratings can change include*:

1) A standard health inspection survey and revisit is conducted within the month of October 2017, and is closed after November 28, 2017. The survey results will be used in the nursing home's star rating as a survey conducted before the ratings freeze. Similar actions will take place for complaint investigations conducted prior to the ratings freeze.

2) A request for an IDR is received prior to the freeze and completed after November 28, 2017 with a change in scope/severity for at least one citation. The change will be reflected in the nursing home's star rating as a change prior to the ratings freeze.

Additionally, the health inspection star rating will no longer use information of the third (oldest) cycle of health inspection survey and complaint investigation data that is part of a nursing home's health inspection score. The weighted health inspection score and star rating for all nursing homes will then be based on the two most recent cycles of survey data. This change is to account for the fact that the data would have been dropped from the health inspection score because of its age, as part of the normal update process. This change will also occur in early 2018 for all facilities. At that time, the most recent cycle of data will be weighted at 60 percent and the prior cycle of data will receive a 40 percent weighting. We will be updating the *Five Star Quality Rating System* Technical User's Guide to reflect these changes.

CMS will continually monitor survey activity during the one year period to determine if any changes to the freezing methodology need to be made.

Other Changes to Nursing Home Compare

In addition to the items listed above, CMS is implementing other adjustments to ensure transparency. In addition to freezing the health inspection star rating on *Nursing Home Compare*, CMS plans to provide summaries of a facility's most recent survey findings, such as the total number of deficiencies cited, and the highest scope and severity level cited. This also includes identifying nursing homes with deficiency-free surveys. We also will post the full report of each survey (Form CMS-2567), which provides more details about the survey findings. We expect to implement these changes in early 2018, concurrent with the changes to the *Five Star Quality Rating System.*

CMS is aware that multiple programs (e.g., accountable care organizations (ACOs), bundled payment models, Medicare Advantage plans) use the *Five-Star Quality Rating System* as a component of their program. We have communicated information about changes to the rating system noted in this memorandum to these programs so they can evaluate any potential impact, and make any changes they feel warranted. The *Nursing Home Compare* website will also display information about the changes to the ratings system. For questions about how the *Five-Star Quality Rating System* is used or may impact one of these or other programs, we encourage individuals to communicate directly with the program's specific organizational or primary contact.

The changes explained in the memorandum serve a temporary need to accommodate the implementation of the first major regulatory change to the LTC requirements in over 25 years.

These types of changes are rare, and the *Five Star Quality Rating System* and *Nursing Home Compare* website remain an excellent source for information about nursing homes. In addition to survey findings, consumers can find information about quality measures and staffing to help support their decision making. We're also looking forward to future improvements, such as the inclusion of new staffing data from the Payroll-Based Journal program. That said, we believe the website and ratings system is one source of information about nursing homes, but consumers should seek other sources as well. For example, we encourage families to visit the facility and speak to the administrator, other staff, current residents, or the family or resident council. Also, speak with their physician or friends who have had similar situations.

Contact: For questions or concerns, please contact NHSurveyDevelopment@cms.hhs.gov

Effective Date: November 28, 2017. This policy should be immediately communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management

Final Rule – Three Phase Implementation

Phase 1	Phase 2	Phase 3
Effective 11/28/16	Effective 11/28/17 with an 18-month moratorium on the imposition of certain enforcement remedies (but not implementation) for Phase 2 F-tags noted below.	Effective 11/28/19
• Resident Rights and Facility Responsibilities* • Freedom from Abuse, Neglect and Exploitation* • Admission, Transfer and Discharge* • Resident Assessment • Comprehensive, Person-Centered Care Planning* • Quality of Life • Quality of Care* • Physician Services • Nursing Services* • Pharmacy Services* • Laboratory, radiology and other diagnostic services • Dental services* • Food and Nutrition* • Specialized Rehabilitation • Administration- Facility Assessment* • QAPI – QAA Committee • Infection Control Program* • Physical Environment	• Behavioral Health Services* • QAPI Plan* • Infection Control – Facility Assessment and Antibiotic Stewardship* • Compliance and Ethics* • Physical Environment - Smoking Policies* **<u>18-Month Moratorium Applicable to:</u>** • F-655 - Baseline Care Plan • F-740 - Behavioral Health Services • F-741 - Sufficient/Competent Direct Care/Access Staff-Behavioral Health • F-758 - Psychotropic Medications related to PRN Limitations • F-838 - Facility Assessment • F-881 - Antibiotic Stewardship Program • F-865 - QAPI Program and Plan related to the development of the QAPI Plan • F-926 - Smoking Policies	• QAPI- Implementation • Infection Control- Infection Control Preventionist* • Compliance and Ethics* • Physical Environment- Call Lights at Bedsides* • Training*

*Sections which are partially implemented in other phases.

An Example of Severity Level 1 Non-Compliance: No Actual Harm with Potential for Minimal Harm includes but is not limited to:

- *The facility failed to document that the resident was provided education on the influenza vaccine prior to administration. When interviewed, the resident stated he had received a copy of the information on influenza risks and benefits and provided the copy to the surveyor. However, the medical record did not reflect receipt of the information.*

F895

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.85 Compliance and ethics program.
[§483.85 and all subparts will be implemented beginning November 28, 2019 (Phase 3)]

§483.85(a) Definitions.
For purposes of this section, the following definitions apply:
Compliance and ethics program means, with respect to a facility, a program of the operating organization that—

§483.85(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and

§483.85(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.

High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.
Operating organization means the individual(s) or entity that operates a facility.

§483.85(b) General rule.
Beginning on November 28, 2019, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.

§483.85(c) Required components for all facilities.
The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:

§483.85(c)(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting

suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.

§483.85(c)(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.

§483.85(c)(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures.

§483.85(c)(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.

§483.85(c)(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program.

§483.85(c)(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.

§483.85(c)(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program.

§483.85(c)(8) After a violation is detected, the operating organization must ensure that all reasonable steps §483.85(identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the

operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.

§483.85(d) Additional required components for operating organizations with five or more facilities.
In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:

§483.85(d)(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f).

§483.85(d)(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.

§483.85(d)(3) Designated compliance liaisons located at each of the operating organization's facilities.

§483.85 (e) Annual review.
The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.
[§483.85 and all subparts will be implemented beginning November 28, 2019 (Phase 3)]

§483.90 Physical Environment.
The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

§483.90(a) Life safety from fire.

§483.90(a)(1) Except as otherwise provided in this section –

§483.90(a)(1)(i) The LTC facility must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

§483.90(a)(1)(ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

§483.90(a)(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate,

Why the Final CMS Rule Could Have Been Worse

October 4, 2016 | Diane E. Felix | Aarthi Krishnamurthy

Long-term care providers and organizations involved with post-acute care will find a lot to dislike in the 713-page final rule released by the Centers for Medicare & Medicaid Services (CMS) on September 28, 2016. The final rule, which applies to long-term care facilities that participate in Medicare and/or Medicaid, establishes many new requirements that will increase the cost and paperwork involved in providing care.

While it's small comfort, the final rule could have been worse. Based on issues raised in many of the almost 10,000 comments CMS received on the proposed rule, CMS dropped or modified a handful of problematic proposals. CMS also resisted calls from some commenters to impose even more burdensome requirements. Issues of note include:

- **Hospital transfers** – The proposed rule would have required an in-person screening by a physician, physician assistant or nurse practitioner prior to any unscheduled non-emergency transfers of residents to a hospital. Commenters had raised concerns about the existing problems with access to such practitioners and the impact the proposed rule would have on efforts to recruit qualified practitioners to serve residents in facilities. CMS discussed its ongoing efforts to reduce avoidable hospitalizations and determined that it would not "finalize this requirement at this time."
- **Physician credentialing** – CMS had proposed requiring facilities to have a "professional credentialing" process for physicians caring for residents. After hearing from multiple commenters who questioned how this would be interpreted and raised concerns about consequent delays in obtaining services from the resident-selected physician, CMS withdrew the proposed requirement.
- **Open visitation** – "Immediate access to a resident" would have been required under the proposed rule for anyone visiting with the resident's consent, "subject to reasonable clinical and safety restrictions." Numerous comments raised safety-related concerns and discussed visitor behaviors that pose a risk to the well-being of residents. CMS did not withdraw the proposal, but added a provision requiring facilities to have visitation policies and procedures setting out reasonable restrictions based on clinical or safety concerns (42 CFR §483.10(f)(v)). Acceptable safety restrictions mentioned by CMS include locking the facility at night, requiring visitors to make prior arrangements for late night access, and denying access to visitors who have been found to have abused, exploited or coerced a resident or who are inebriated and disruptive.
- **Staffing** – CMS reported that "many commenters" requested that it establish and require minimum staffing levels as well as require 24/7 registered nurse (RN) staffing. CMS declined to do so, saying it did not agree that a "'one size fits all' approach is best." CMS also expressed concern that RN supply might make such a mandate "particularly challenging" in some markets. CMS did say that it would consider one commenter's recommendation to examine whether the current "five-star" rating system methodology could potentially be adapted to establish presumptive levels.

Even with the changes outlined above, the final rule poses many challenges for long-term care providers and organizations involved with post-acute care. Armstrong Teasdale lawyers can assist clients with determining how they will be individually affected by the final rule and developing strategies to address the changes.

https://www.armstrongteasdale.com/Why-the-Final-CMS-Rule-Could-Have-Been-Worse-10-04-2016/

CMS.gov
Centers for Medicare & Medicaid Services

Nursing Homes

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

Nursing home surveys are conducted in accordance with survey protocols and Federal requirements to determine whether a citation of non-compliance appropriate. Consolidated Medicare and Medicaid requirements for participation (requirements) for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) were first published in the Federal Register on February 2, 1989 (54 FR 5316). The requirements for participation were recently revised to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. The revisions were published in a final rule that became **effective on November 28, 2016**.

The survey protocols and interpretive guidelines serve to clarify and/or explain the intent of the regulations. All surveyors are required to use them in assessing compliance with Federal requirements. Deficiencies are based on violations of the regulations, which are to be based on observations of the nursing home's performance or practices.

The sections below provide additional information about the background and overview of the final rule, frequently asked questions, and other related resources.

Downloads

LTC Survey FAQs - Updated 02/06/2018 [PDF, 701KB]
Appendix PP State Operations Manual (Revised 11/22/2017) [PDF, 3MB]
List of Revised FTags [Effective November 28, 2017] [PDF, 152KB]
S&C Memo: Revision to State Operations Manual Appendix PP for Phase 2 (Includes Training Information and Related Issues) [PDF, 121KB]
F-Tag Crosswalk [XLSX, 495KB]
Training for Phase 1 Implementation of New Nursing Home Regulations [PDF, 108KB]
New Long-term Care Survey Process – Slide Deck and Speaker Notes [PPTX, 8MB]
Entrance Conference Form Beneficiary Notice Worksheet (Updated 12/06/2017) [ZIP, 164KB]
LTC Survey Pathways - Updated 12/13/2017 [ZIP, 2MB]
LTCSP Procedure Guide [PDF, 1MB]
LTCSP Initial Pool Care Areas - Updated 11/17/2017 [ZIP, 1MB]
Survey Resources - Updated 01/18/2018 [ZIP, 10MB]
Matrix with Instructions - Content Unchanged [PDF, 299KB]
LTCSP Mapping Document [PDF, 740KB]
LTCSP Interim Revisit Instructions [PDF, 171KB]

Related Links

MLN – Long Term Care Facilities
Final Rule for Long Term Care
Electronic Code of Federal Regulations
Nursing Homes

Page last Modified: 02/06/2018 9:38 AM
Help with File Formats and Plug-Ins

CMS.gov A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244

Other Useful LTC Resources:

Proposed Rule	https://www.gpo.gov/fdsys/pkg/FR-2015-07-16/pdf/2015-17207.pdf
Final Rule	https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf
State Operations Manual: Appendix PP (Rev. 11/22/17)	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf
CMS Survey and Certification Letters	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html
CMS New LTC Survey Process Procedure Guide	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Procedure-Guide.pdf
CMS New LTC Survey Process	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/New-Long-term-Care-Survey-Process%E2%80%93Slide-Deck-and-Speaker-Notes.pptx
Memorandum on Revision of CMP Policies and CMP Analytic Tool (S&C 17-37-NH)	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html *(Omitted from handouts due to length)*
Other Useful Links	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html https://www.ahcancal.org/facility_operations/Pages/SNF-Requirements-of-Participation.aspx