***Regulations That Reference Facility Policies***

***Tag Number:***

***483.5 Definitions***

***F540 – Definitions***

***483.10 Resident Rights***

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***483.12 Freedom from Abuse, Neglect, and Exploitation***

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***F946 - (Phase 3) Compliance and Ethics Training***

***F947 – Required In-Service Training for Nurse Aides***

***Details of Policy Requirement***

***F540 – 483.5 – Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must met all of the following requirements: … (C)The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions. … (iii)The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.***

***F550 – 483.10 (a) Resident Rights; 483.10(a)(1); 483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.- 483.10(b); 483.10(b)(1); 483.10(b)(2)***

***The facility shall not establish policies or impose conditions on the justice involved resident that result in restrictions which violate the resident's rights.***

***The facility must not establish policies or practices that hamper, compel, treat differently, or retaliate against a resident for exercising his or her rights.***

***F563 – 483.10(f)(4)The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.***

***The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. (Review the facility's written visitation policy and procedures to determine whether they support the resident's right to visitors and whether they explain those situations where visitors may be restricted due to clinical or safety concerns.)***

***F572 – 483.10(g); 483.10(g)(1); 483.10(g)(16) –***

***Any time State or Federal laws or regulation relating to resident rights or facility policies change during the resident's stay in the facility, he/she must promptly be informed of these changes in a manner that is clear to the resident.***

***Whatever rules or policies the facility has formalized, and by which it expects residents to abide, should be included in the residents' statement of rights and responsibilities.***

***Determine when and how residents or their representatives are informed of their rights, services, facility policies and procedures, and resident responsibilities.***

***F578 – 483.10( c)(6), 483.10( c), 483.10(g)(12) – The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.***

***This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, refuse medical or surgical treatment. In addition, the facility management is responsible for ensuring that staff follow those policies and procedures.***

***The facility's policies and procedures delineate the various steps necessary to promote and implement these rights… This includes a written description of the facility's policies to implement advance directives and applicable State law regarding advance directives.***

***(Review the resident's medical record to determine if: the resident has an advance directive and a copy is located in the medical record; and, the facility has policies and procedures to implement advance directives.)***

***To cite deficient practice at F578, the surveyor's investigation will generally show that the facility failed to do one or more of the following: …Have policies and procedures for implementing advance directives…or follow policies to implement advance directives and applicable State laws regarding advance directives. If there is a deficiency specific to the requirement at 483.10(g)(15), do not cite here, but cite under 483.15( a)(1)-(7), F620, regarding admission policies.***

***F580 – 483.10(g)(14) Notification of Changes; 483.10(g)(15 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in 483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under 483.15( c)(9).***

***F583 – 483.10(h), 483.10(h)(l), 483.10(h)(2), (483.10(h)(3) – Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records; Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident…***

***If concerns are found, interview staff regarding facility policy or procedures regarding protecting resident privacy and confidentiality.***

***F585 – 483.10(J), 483.10(J)(1), 483.10(J)(2), 483.10(J)(3), 483.10(J)(4) Grievances – The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay…..***

***The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the resident's rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:***

***(i)Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii)Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary In light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with 483.12©(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of those residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.***

***Ensure a policy is in place to process grievances…. Review facility grievance policy to see if compliant with necessary requirements as listed above….***

***Noncompliance related to policy …… Establish a grievance policy that includes: Notifying the resident individually or with prominent postings throughout the facility about: The right to file a grievance in writing or orally, the right to file a grievance anonymously, the reasonable timeframe the resident can expect a completed review of the grievance, the right to obtain the review in writing, the required contact information of the grievance official, the contact information of independent entities with whom grievances may also be filed, or identify the grievance official, or prevent any further potential violation of any resident right during the grievance review, if necessary, or immediately report certain violations as required by State law to the Administrator, or ensure written grievance decisions meets documentation requirements, or take appropriate corrective action in accordance with State law if the grievance is confirmed by the facility or an outside entity having jurisdiction, or maintain evidence of the result of all grievances for no less than 3 years from the date the grievance decision was issued.***

***F600 – 483.12, 483.12(a), 483.12(a)(1) - Freedom from Abuse, Neglect, and Exploitation – Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion…***

***Survey team must review whether the facility has developed and implemented Policies and Procedures related to visitor access….. This would include safety restrictions, such as denying access or providing limited and supervised access to a visitor who has been found to be abusing, exploiting, or coercing a resident or who is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed….. In addition, the survey team must review whether the facility has developed and implemented policies and procedures related to visitor access…***

***Facility policies, procedures and protocols, should identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded.***

***Resident Care policies and procedures to ensure that the facility provides care and services in accordance with current standards of practice, that address resident's diagnosis, and that provide clinical and technical direction to meet the needs of each resident admitted. Individual failures include, but not limited to: failure to oversee the implementation of resident care policies…..Interview staff and review facility policies and procedures to determine how the facility monitors and provides oversight of the provision of care and services, and how the facility responds when there are concerns that a resident(s) is not receiving necessary goods and services…***

***Determine if the facility developed, implemented and educated staff on policies and procedures that prohibit misappropriation of resident property and exploitation (F607); If the facility developed and implemented pre-employment procedures (F606)…Obtain and review the facility's policies and procedures related to misappropriation of resident property and exploitation.***

***Investigatory activities related to allegations of drug diversion: …Whether pharmacy policies at a minimum, address safeguarding and access, monitoring, administration, documentation, reconciliation and destruction of controlled substances. (see tag F755 for concerns related to facility procedures for pharmacy services)***

***F602 – 483.12 - The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms…***

***Determine whether the facility developed, implemented and educated staff on policies and procedures that prohibit misappropriation of resident property and exploitation.***

***Onsite survey activities- …Obtain and review the facility's policies and procedures related to misappropriation of resident property and exploitation. It is not necessary for these items to be maintained in one document or manual.***

***F603 – 483.12 – The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. 483.12(a) The facility must….. 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Each resident has the right to be free from involuntary seclusion….***

***The facility's policies must identify the type and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved; and the precautions should be the least restrictive possible for the resident based on his/her clinical situation.***

***Obtain and review the facility's policies and procedures related to the allegation under investigation.***

***Survey team must determine whether the facility has developed and implemented policies and procedures related to secured/locked areas, including criteria for placement and ongoing assessment to assure that the resident meets the criteria.***

***F606 – 483.12(a), 483.12(a)(3) The facility must not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. 483.12(a)(4) Report to the State nurse aide registry or licensing authorities 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.***

***If a facility has not developed and/or implemented policies and procedures related to screening procedures prior to employment, a finding of noncompliance should be considered at F607, not F606. If it is determined that the facility employed or engaged an individual, either directly or under contract, who was found guilty by a court of law of abuse, neglect, misappropriation of property, exploitation or mistreatment, or had a finding entered into the State nurse aide registry or has a disciplinary action in effect against his/her professional license concerning abuse, neglect, mistreatment of residents or misappropriation of resident property, a finding of noncompliance must be cited at F606. In this situation, there may also be a citation at F607 if the facility failed to develop and/or implement policies and procedures related to staff screening.***

***F607 – 483.12(b), 483.12(b)(1), 483,12(b)(2), 483.12(b)(3), 483.12(b)(4), 483.12(b)(4) – The facility must develop and implement written policies and procedures that: prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, Establish policies and procedures to investigate any such allegations, and Include training as required at paragraph 483.95, Establish coordination with the QAPI program required under 483.75 will be implemented beginning November 28, 2019. (Phase 3)***

***The facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. These written policies must include, but are not limited to the following seven components:***

***Screening; Training; Prevention; Identification; Investigation; Protection; Reporting / Response.***

***The facility's policies must also address how pre-screening occurs for prospective consultants, contractors, volunteers, caregivers and students in its nurse aide training program and students from affiliated academic institutions, including therapy, social, and activity programs.***

***To cite deficient practice at F607, the surveyor's investigation will generally show that the facility has failed to do one or more of the following: Develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property and includes the screening of prospective employees and residents; or Develop and implement written policies and procedures for the investigation of allegations of abuse, neglect and exploitation of residents and misappropriation of resident property and includes the staff identification of abuse, neglect, exploitation and misappropriation of resident property, protection of residents during investigations, and the reporting of allegations and investigative findings and taking corrective actions; or Develop and implement written policies and procedures that include training as required at 483.95.***

***F608 – 483.12(b), 483.12(b)(5) – The facility must develop and implement written policies and procedures that: Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements: Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements/ Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the event that cause the suspicion do not result in serious bodily injury. Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.***

***A facility's policies and procedures for reporting under 42 CFR 483.12(b)(5) should specify the following components, which include, but are not limited to: Identification of who in the facility is considered a covered individual; Identification of crimes that must be reported; Identification of what constitutes "serious bodily injury;" The timeframe for which the reports must be made; and Which entities must be contacted, for example, the State Survey Agency and local law enforcement.***

***The facility must include in its policies and procedures examples of crimes that would be reported, notifying covered individuals annually of their obligation to report reasonable suspicion of crimes in the facility, who are the covered individuals in the facility, how covered individuals are notified of the reporting requirements, each covered individual's independent obligation to report the suspicion of a crime against a resident, the timeframe requirements for reporting reasonable suspicion of crimes, penalties associated with failure to report, the mechanism for documenting that all covered individuals have been notified annually of their reporting obligations.***

***Facilities should develop policies and procedures that promote a culture of safety and open communication in the work environment. (Prohibiting retaliation)***

***Facility must develop and implement policies and procedures for posting notice in a conspicuous location informing covered individuals of their right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint.***

***Required policies and procedures for reporting suspicions of a crime:***

***What- F608 -Any reasonable suspicion of a crime against a resident; F609 -all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property; the results of all investigations of alleged violations.***

***Who is required to report: F608 – Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility: F609 – The facility***

***And To Whom and When***

***Whether the facility has included in its policies and procedures examples of crimes that would be reported.***

***Key Elements of Noncompliance: To cite deficient practice at F608, the surveyor's investigation will generally show that the facility failed to develop and implement policies and procedures for any one or more of the following: Ensure the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases; Notify covered individuals annually of their reporting obligations; Post signage of employee rights related to retaliation against the employee for reporting a suspected crime; or Prohibit and prevent retaliation.***

***F620 – 483.15(a), 483.15(a)(1), 483.15(1)(3), 483.15(1)(4), 483.15(a)(5), 483.15(a)(6). 483.15(a)(7) – The facility must establish and implement an admissions policy; A nursing facility that is a composite distinct part as defined in 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.***

***All facilities must establish and implement a policy or policies addressing resident admission to the facility. First, the admissions policy must comply with the provisions at 483.15©(1) which stipulate the limited conditions for transfer or discharge. The provisions at 483.15(a)(2)-(5), further prohibit the waiver of certain rights and preconditions for admission to, and continued stay in the facility. Additionally, under 483.15(a)(6)-(7), the admissions policy must identify information that must be disclosed to residents and potential residents, such as notice of special facility characteristics, any service limitations of the facility, if applicable. Additionally, it requires that the facility's admission agreement disclose its physical composition, including any composite distinct part locations, and must specify the policies that apply to room changes in a composite distinct part. The facility must also have a process for how it will disclose required information to residents and potential residents.***

***Compliance requires facilities to develop policies and procedures to safeguard residents' personal possessions without effectively prohibiting a resident's use of personal possessions.***

***Examples of reasonable facility policies may include 1(establishing a process to document high value personal property (particularly cash, valuables, and medical/assistive devices) brought in by residents; and 2) establishing a process to work with residents and their representatives/family to ensure safety as well as availability to the resident of cash and/or items over a certain dollar value, including medical/assistive devices. ….For composite distinct part facilities, determine if the facility discloses and has disclosed its various locations that make up the composite distinct parts and its policies for room changes between its different locations.***

***F621 – 483.15(b); 483.15(b)(1); 483.15(b)(2); 483.15(b)(3); 483.15(c)(9) – A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, as defined in 483.5 and the provision of services for all individuals regardless of source of payment, consistent with 483.10(a)(2)….***

***Identical policies and practices concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.***

***F625 – 483.15(d); 483.15(d)(1); 483.15(d)(2) – Notice of bed-hold policy and return… The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph ( e)(1) of this sections, permitting a resident to return;***

***To ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility.***

***All facilities must have policies that address holding a resident's bed during periods of absence, such as during hospitalization or therapeutic leave. Additionally, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours.***

***Ask to review facility policies on bed-hold. Review the facility's admission packet to determine if notice of bed-hold is given at admission. If not, determine how the facility notifies residents prior to transfer. Ask the resident, or if applicable, the resident's representative(s), whether they received the bed-hold notice and understand the facility's bed-hold policy. If not, determine how the facility notifies residents of this information prior to transfer.***

***F626 – 483.15€(1) – Permitting residents to return to facility – A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following: A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident – (A) requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. 483.15€(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in 483.5) the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.***

***Intent: To ensure that facilities develop and implement policies that address bed-hold and return to the facility for all residents.***

***Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. These policies must address how the facility will allow residents to return when their hospitalization or therapeutic leave has exceeded the bed-hold period allowed by the State Medicaid plan. Duration of and payment for bed-hold for residents eligible for Medicaid vary by State. The policy must also address how residents who pay privately, or receive Medicare, may pay to reserve their bed.***

***Key Elements of Noncompliance – The facility failed to establish and/or implement a policy that is in accordance with the State Medicaid plan, and addresses returning to the facility following hospitalization or therapeutic leave….***

***F642 – 483.20(h); 483.20(i); 483.20(i)(1); 483.20(i)(2); 483.20(j); 483.20(j)(1); 483.20(j)(2) – Coordination – A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals; A registered nurse must sign and certify that the assessment is completed.***

***Facilities may use electronic signatures on the MDS when permitted to do so by state and local law and when this is authorized by the facility's policy. Additionally, the facility must have written policies in place to ensure proper security measures are in place to protect use of an electronic signature by anyone other than the person to which the electronic signature belongs.***

***F660 – 483.21(c)(1) Discharge Planning process- The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions…***

***As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).***

***F678 – 483.24(a)(3) Personnel provide basic lift support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.***

***To ensure that each facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders, such as DNRs, and the resident's advance directives.***

***Facilities must have systems in place supported by policies and procedures to ensure there are an adequate number of staff present at all times who are properly trained and/or certified in CPR for Healthcare Providers to be able to provide CPR until emergency medical services arrives.***

***Facilities should have procedures in place to document a resident's choices regarding issues like CPR. Physician orders to support these choices should be obtained as soon as possible after admission, or a change in resident preference or condition, to facilitate staff in honoring resident choices. Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises.***

***Facility policies should address the provision of basic life support and CPR, including: Directing staff to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and: Who have requested CPR in their advance directives, or Who have not formulated an advance directive or, Who do not have a valid DNR order; Ensuring staff receive certification in performance of CPR. Facility policies must not limit staff to only calling 911 when cardiac or respiratory arrest occurs. Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac or respiratory arrest in accordance with that resident's advance directives or in the absence of advance directives or a DNR order. CPR-certified staff must be available at all times to provide CPR when needed.***

***Staff must maintain current CPR-certification for Healthcare Providers through a CPR provider whose training includes hands-on practice and in-person skills assessment; online-only certification is not acceptable. CPR certification that includes an online knowledge component, yet still requires an in-person demonstration and skills assessment to obtain certification or recertification, is acceptable.***

***Ensure the facility has appropriate policies directing staff when to initiate basic life support. Ensure staff is familiar with facility policies related to CPR.***

***Surveyors should ask to review the facility policies for: CPR, Advance Directives and/or Code Status. Review facility policies to ensure: Staff are directed to initiated CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and, who have requested CPR in their Advance Directive; or Who have not formulated an Advance Directive; or Who do not have a valid DNR order; Staff are expected to be certified in CPR for Healthcare Providers; Review facility records verifying staff certification in CPR for Healthcare Providers; Review the resident's medical record to determine if the resident has an advance directive in place. If so, does the resident's code status reflect their wishes as recorded in their Advance Directive? Does the MDS indicate that the resident has an Advanced Directive? The Interdisciplinary team has reviewed the Advanced Directive on a regular basis with the resident, or representative to ensure that it is current?***

***To cite deficient practice at F678, the surveyor's investigation will generally show that the facility failed to do any one of the following: …have appropriate policies directing staff when to initiate basic life support…Ensure staff is familiar with facility policies related to CPR…***

***F684 – 483.25 Quality of Care – To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs.***

***Resident Care Policies: The facility in collaboration with the medical director must develop and implement resident care policies that are consistent with current professional standards of practice for not only pain management and symptom control, but for assessing residents' physical, intellectual, emotional, social, and spiritual needs as appropriate. In addition, if the facility has a written agreement with a Medicare-certified hospice, the policies must identify the ongoing collaboration and communication processes established by the nursing home and the hospice.***

***Any concerns identified by the survey team related to end of life and/or care provided by a hospice should trigger a review of the facility's policies and procedures on end of life and hospice care and/or related policies. (e.g. advance directives) in addition, the survey team should request a copy of the written agreement between the nursing home and the hospice. If there is a failure to develop and/or implement portions of the written agreement with a hospice, refer to f849 – Hospice Services.***

***F686 – 483.25(b) Skin Integrity – 483.25(b)(1) Pressure Ulcers***

***It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility.***

***A facility should be able to show that its treatment protocols are based upon current professional standards of practice and are in accord with the facility's policies and procedures as developed with the medical director's review and approval.***

***Administrative Review: The facility must develop resident care policies in collaboration with the Medical Director, Director of Nursing, and as appropriate, physical/occupational therapy consultant. This includes policies on restorative/rehabilitative treatments/services, based on professional standards of practice, including who may provide specific treatments and modalities according to applicable State law and/or practice acts. Refer to F841, Medical Director. These policies should also address equipment use, cleaning, and storage.***

***To cite F686, it is not necessary to prove that a PU/PI developed. F686 can be cited when it has been determined that the provider failed to implement interventions to prevent the development of a PU/PI for a resident identified at risk.***

***F688 – 483.25(c ), 483.25( c)(1), 483.25( c)(2), 483.25( c)(3) – Mobility The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.***

***The facility must develop resident care policies in collaboration with the medical director, director of nurses, and as appropriate, physical/occupational therapy consultant. This includes policies on restorative/rehabilitative treatments/services, based on professional standards of practice, including who may provide specific treatments and modalities according to applicable State law and/or practice acts. Refer to F841, Medical Director. These policies should also address equipment use, cleaning, and storage.***

***F689 – 483.25(d); 483.25(d)(1); 483.25(D)(2)- Accidents – The facility must ensure that the resident environment remains as free of accident hazards as is possible; and Each resident received adequate supervision and assistance devices to prevent accidents.***

***Additional measures may include informing all visitors of smoking policies and hazards.***

***A systematic approach enables leadership and direct care staff to work together to revise policies and procedures, based on feedback from workers who are most familiar with the residents and care processes. Effective facility systems address how to: communicate the observations of hazards, record resident specific information, and monitor data related to care processes that potentially lead to accidents.***

***Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. A facility's disaster and emergency preparedness plan should include a plan to locate a missing resident. Additional measures may include informing all visitors of smoking policies and hazards.***

***F690 – 483.25(e) Incontinence 483.25( e)(1); 483.24)e)(2); 483.25( e)(3)***

***The surveyor should determine if facility policy for obtaining urine for cultures is based upon current standards of practice, understanding that these standards may be revised and updated over time. The facility should be able to provide the most current standard that supports the policy that they have developed and implemented. (Also refer to F880 Infection Control and F881 for antibiotic stewardship program for infection assessment tools.)***

***Indwelling Urinary Catheter Use: If the facility provides care for a resident with an indwelling catheter, in collaboration with the medical director and director of nursing, and based upon current professional standards of practice, resident care policies and procedures must be developed and implemented that address catheter care and services, including but not limited to: Documentation, assessments, Identification and documentation of clinical indication for the use of a catheter, criteria for the discontinuance of the catheter, insertion, ongoing care and catheter removal protocols, ongoing monitoring for change in condition, clinical indications***

***F693 - 483.25(g); 483.25(g)(4)-(5); 483.25(g)(5) – Assisted Nutrition and Hydration; Enteral Nutrition***

***Technical and Nutritional Aspects of Feeding Tubes: It is important that staff providing care and services to the resident who has a feeding tube are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care. These protocols are required to be developed with the medical director in order to assure staff implement and provide care and services according to resident needs and professional standards of practice.***

***Facility policies and procedures regarding the technical aspects of feeding tubes must be developed and implemented, which address: Monitoring the feeding tube; How to verify that the tube is functioning before beginning a feeding and before administering medications; Care of the Feeding Tube; Feeding Tube Replacement; Nutritional Aspects of Feeding Tubes; Enteral Nutrition; Flow of Feeding; Complications Related to the Feeding Tube; Complications Related to the Administration of the Enteral Nutrition Product; Complications Management.***

***Flushing feeding tubes regularly and in association with medication administration, as indicated by current professional standards of practice and provided in the resident care policies…***

***If there are concerns regarding the facility's use and care of feeding tubes, review facility policies and practices with regard to the use and care of the feeding tubes.***

***F694 – 483.25(h) Parenteral Fluids***

***The facility must develop and implement resident care policies, based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuance of the IV as well as prevention of infection at the site to the extent possible. The procedures must include the care and use of all equipment, such as pumps, tubing, syringes, fluids, etc.***

***The facility minimizes risks to a resident receiving IV therapy by developing and implementing policies that adhere to professional standards of practice, which may include, but are not limited to: Use of appropriate hand hygiene during all aspects of IV services; Use of aseptic technique when placing a venous access device; Use of personal protective equipment (PPE) (based on potential for exposure to blood, bodily fluids, and infectious agents); Competency of staff to: Use infusion equipment; Accurately perform IV insertion, and maintain vascular access; and Assess for complications. Administration of solutions according to orders (correct solution, administration route, (central/peripheral line), duration, frequency, and infusion rate; and Labeling and dating, as appropriate, infusion fluids and lines.***

***Review facility policies and procedures related to parenteral therapy to determine if policies and/or procedures address: Aseptic technique for IV insertion; Maintenance of IV site; Frequency of IV site, tubing, and bag changes, and do they reflect current, professional standards of practice.***

***F695 – 483.25(i) Respiratory Care, including tracheostomy care and tracheal suctioning.***

***Based upon its facility assessment, the resident population, diagnosis, staffing, resources and staff skills/knowledge, the facility must determine whether it has the capability and capacity to provide the needed respiratory care/services for a resident with a respiratory diagnosis or syndrome that requires specialized respiratory care and/or services. This includes at a minimum, sufficient numbers of qualified professional staff, established resident care policies and staff trained and knowledgeable in respiratory care before admitting a resident that requires those services.***

***Resident Care Policies: The facility, in collaboration with the medical director, director of nurses, and respiratory therapist, as appropriate, must assure that resident care policies and procedures for respiratory care and services, are developed, according to professional standards of practice, prior to admission of a resident requiring specific types of respiratory care and services. (Also refer to F841, 483.70(h) Medical Director) The policies and procedures, based on the type of respiratory care and services provided, may include, but are not limited to: Oxygen services, including the safe handling, humidification, cleaning, storage, and dispensing of oxygen; Types of respiratory exercises provided such as coughing/deep breathing and if provided, therapeutic percussion/vibration and bronchopulmonary drainage; Aerosol drug delivery systems (nebulizers/metered-dose inhalers) and medications (preparation and/or administration) used for respiratory treatments; BIPAP/CPAP treatments; Delineation for all aspects of the provision of mechanical ventilation/tracheostomy care, including monitoring, oversight and supervision of mechanical ventilation, tracheostomy care and suctioning, and how to set, monitor and respond to ventilator alarms; Emergency care which includes staff training and competency for implementation of emergency interventions for, at a minimum, cardiac/respiratory complications, and include provision of appropriate equipment at the resident's bedside for immediate access, such as for unplanned extubation; Procedures to follow in the advent of adverse reactions to respiratory treatments or interventions, including mechanical ventilation, tracheostomy care and provision of oxygen; Respiratory assessment including who can conduct each aspect of the assessment, what is contained in an assessment, when and how it is conducted, the type of documentation required; Maintenance of equipment for respiratory care in accordance with the manufacturer specifications and consistent with federal, state, and local laws and regulations, such as oxygen equipment, or equipment for mechanical ventilation if provided, how and by whom the equipment is serviced and how it is maintained; Emergency power for essential equipment such as mechanical ventilation, if provided; Infection control measures during implementation of care, handling, cleaning, storage and disposal of equipment, supplies, biohazardous waste and including infection control practices for mechanical ventilation/tracheostomy care including the use of humidifiers; and Posting of cautionary and safety signs indicating the use of oxygen; and Staffing and Qualified Personnel – Refer to F483.65 specialized rehabilitative services, for review of provision of services by qualified personnel. When providing respiratory care, the facility must, based on professional standards of practice: Have sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws; and Identify who is authorized to perform each type of respiratory care service, such as responding to mechanical ventilator alarms, suctioning and tracheostomy care. NOTE: Surveyors are expected to determine the scope of practice and state laws regarding who may provide mechanical ventilation and/or tracheostomy care in their state.***

***F697 – 483.25(k) – Pain Management – The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.***

***The interdisciplinary team (nurses, practitioner, pharmacists, etc.) is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain, such as during a treatment. The regimen considers factors such as the causes, location, and severity of the pain, the potential benefits, risks and adverse consequences.***

***F698 – 483.25(l) – Dialysis – The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.***

***Resident Care Policies and Staffing Specific to Dialysis Care and Services: the nursing home must identify who is allowed to provide HHD/PD treatments to a resident, such as a licensed nurse or nurse aide. The dialysis facility is responsible for providing training and assuring the competency of staff or individuals that are allowed to initiate, access and discontinue dialysis treatments. The nursing home must maintain documentation of completion of training/competency for staff or other individuals providing dialysis treatments….A Nursing Home, that provides dialysis treatments, in collaboration with the nursing home medical director and the dialysis facility, must develop dialysis specific policies/procedures, based upon current standards of practice. This includes the care of a resident receiving dialysis services whether in the facility or at an offsite location. (Refer to F841 – Responsibilities of Medical Director). At a minimum, these policies must include, but are not limited to the following: The identification of all staff or contracted individuals who are allowed to provide HHD/PD and the training required. An RN, LPN/LVN, a nurse aide or a trained technician can provide dialysis treatments if not in conflict with the States Nurse Practice Act/Scope of Practice and only if the individual has received training from a qualified dialysis trainer from a certified dialysis facility for the individual resident receiving HHD/PD; The documentation of training and competency requirements for individuals providing dialysis treatments; If the facility allows a resident/family member or other individual to provide HHD/PD treatments, documentation that training and competency was provided by the certified dialysis facility; Procedures for the initiation, administration and discontinuation of HHD/PD treatments, type of monitoring required before, during and after the treatments, including documentation requirements; Procedures for methods of communication between the nursing home and the dialysis facility including how it will occur, with whom, and where the communication and responses will be documented; The development and implementation of a coordinated comprehensive care plan(s) that identifies nursing home and dialysis responsibilities and provides direction for nursing home staff; and The development and implementation of interventions, based upon current standards of practice including, but not limited to documentation and monitoring of complications, pre-and post-dialysis weights, access sites, nutrition and hydration, lab tests, vital signs including blood pressure and medications; Management of dialysis emergencies including procedures for medical complications, and for equipment and supplies necessary; The provision of medication on dialysis treatment days; Procedures for monitoring and documenting nutrition/hydration needs, including the provision of meals on days that dialysis treatments are provided; Assessing, observing and documenting care of access sites, as applicable, such as: auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow; significant changes in the extremity when compared to the opposite extremity (edema, pain, redness); Steal syndrome (pain, numbness, discoloration, or cold to touch in the fingers or hand indicating inadequate arterial flow); skin integrity (waxy skin, ulcerations, drainage from incisions); bruising/hematoma; collateral vein distension (veins in access arm close to AV fistula becoming larger); complaints of pain or numbness; or evidence of infection at the surgical site, such as drainage, redness, tenderness at incision site, fever; Safe and sanitary care and storage of dialysis equipment and supplies; Responsibility for reporting adverse events, including who to report to, investigating the event and correcting identified problems; Response and management of technical problems related to HHD and/or PD treatments such as power outages or: For PD, how to recognize impaired flow and drainage or failure of the PD cycler; For failure of HHD machines: clotting of the hemodialysis circuit, dialyzer blood leak, or line disconnection; and For HHD/PD: how and when to stop dialysis and/or seek help when there are significant issues.***

***Dialysis specific infection control policies, including but not limited to: Transmission based precautions including blood borne precautions, placement/location (cohorting), staff/visitor personal protection equipment (PPE) requirements, indications for the use of gloves, masks, and hand hygiene; Potential health care associated infections (HAI) including Hepatitis B and tuberculosis; Restrictions for visitors/roommate, if any, during provision of HHD/PD; Handling, using, and disposing of equipment/supplies, medications or other products in accordance with manufacturer's instructions, and in accordance with all applicable Federal, State and local laws and regulations;***

***NOTE: Nursing home staff who have been trained to provide dialysis treatments for a resident, must understand how to properly dispose of needles, effluents, disposable items, blood tubing and dialyzers to minimize risks of infection or injury to self and others and to prevent environmental contamination (e.g. using impervious puncture resistant containers for disposal of sharps, placing empty dialysate bags and dialysis tubing and other contaminated items in specific biohazard container(s) or bag(s) before discarding; Obtaining and reviewing dialysis facility monitoring for the dialysis water and dialysate quality, including total chlorine testing and at least quarterly testing of water and dialysate bacterial and endotoxin as applicable to the HHD equipment in use; Types of furnishings allowed (such as a recliner used during the dialysis treatment), based on infection control standards and the cleaning/sanitizing of these furnishings that have the potential to become contaminated with blood/blood products; Access to clean sink for hand washing, in addition, disposal needs to be addressed for dialysis by-products from the dialysis treatment;***

***Housekeeping/laundry policies for cleaning/sanitizing the location(s) where treatments are provided, including linen handling and waste disposal; Vascular access or peritoneal catheter care and dressing changes; and Cleaning and disinfecting dialysis equipment, including procedures for spills and splashes of blood or effluent on furnishings, equipment, floors and supplies.***

***Interim and Emergency Medications for Residents Receiving Dialysis: Nursing homes must have access to medications and treatment such as antibiotics and intravenous fluids to treat common complications of dialysis. The nursing home staff must collaborate with the medical director, consultant pharmacist and dialysis facility to develop policies and procedures to address common complications and to ensure access to needed medications.***

***F755 – 483.45 Pharmacy Services – 483.45 (a) Procedures – 483.45(b) Service Consultation – 483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility – 483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 483.45(b)(3) Determines that drug records are in order ant that an account of all controlled drugs is maintained and periodically reconciled.***

***The facility, in coordination with the licensed pharmacist, provided for: A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications; Prompt identification of loss or potential diversion of controlled medications; and Determination of the extent of loss or potential diversion of controlled medications.***

***NOTE: If permitted by, and in accordance with, state requirements, the facility may store some controlled medications in an emergency medication supply. The facility's policies and procedures must address the reconciliation and monitoring of this supply.***

***Facility procedures and applicable state laws may allow the facility to maintain a limited supply of medications in the facility for use during emergency or after-hours situations.***

***Procedures should identify how staff, who are responsible for medication administration: Ensure each resident has a sufficient supply of his or her prescribed medications. (Example, a resident who is on pain management has an adequate supply of medication available to meet his or her needs) At a minimum, the system is expected to include a process for the timely ordering and reordering of a medication.***

***Monitor the delivery and receipt of medications when they are ordered; and,***

***Determine the appropriate action, e.g., contact the prescriber or pharmacist, when a resident's medication(s) is not available for administration.***

***The pharmacist, in collaboration with the facility and medical director, helps develop and evaluate the implementation of pharmaceutical services procedures that address the needs of the residents, are consistent with state and federal requirements, and reflect current standards of practice. These procedures address, but are not limited to, acquiring; receiving; dispensing; administering; disposing (disposition of medications); labeling and storage of medications; and personnel authorized to access or administer medications.***

***The facility may store some controlled medications in an emergency medication supply. The facility policies and procedures must address the reconciliation and monitoring of this supply.***

***F756 – 483.45© Drug Regimen Review – 483.45( c)(1); 483.45( c)(2); 483.45( c)(4); 483.45( c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.***

***Facilities must develop policies and procedures to address the MRR (Medical Record Review). The policies and procedures must specifically address: The appropriate time frames for the different steps in the MRR process; and, The steps a pharmacist must follow when he or she identifies an irregularity that requires immediate action to protect the resident and prevent the occurrence of an adverse drug event. MRR policies and procedures should also address, but not limited to: MRRs for residents who are anticipated to stay less than 30 days; MRRs for residents who experience an acute change of condition and for whom an immediate MRR is requested after appropriate staff have notified the resident's physician, the medical director, and the director of nursing about the acute change.***

***The facility should have a procedure for how to resolve situations where: The attending physician does not concur with or take action on identified irregularities; and, The attending physician is also the medical director.***

***Key Elements of Noncompliance: (regarding policies and procedures) The facility failed to develop, maintain, and implement policies and procedures which address the time frames for the steps in the MRR process; or The facility failed to develop and implement policies and procedures which address steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.***

***F758 – 483.45( c)(3); 483.45( e); 483.45( e)(1); 483.45( e)(2); 483.45( e)(3); 483.45( e)(4); 483.45( e)(5); 483.45(d) – Psychotropic Drugs***

***Sources of information to facilitate defining the monitoring criteria or parameters may include cautions, warnings, and identified adverse consequences from: Manufacturer's package inserts and boxed warnings; facility policies and procedures; pharmacists; clinical practice guidelines or clinical standards of practice; medication references; and Clinical studies or evidence-based review articles that re published in medical and/or pharmacy journals.***

***The frequency and duration of monitoring needed to identify therapeutic effectiveness, achievement of resident goals, and adverse consequences will depend on factors such as clinical standards of practice, facility policies and procedures, manufacturer's specifications, and the resident's clinical condition and choices.***

***Excessive Duration: Continuation beyond the manufacturer's recommended time frames, the stop date or duration indicated on the medication order, facility-established stop order policies, or clinical practice guidelines, evidence-based studies from medical/pharmacy journals, or current standards of practice, without documented clinical justification….***

***Determine whether the medical director collaborated with the facility to help develop, implement, and evaluate policies and procedures for the safe and effective use of medications in the care of residents.***

***F759 – 483.45(f) Medication Errors – 483.45(f)(1) Medication error rates are not 5 percent or greater***

***F760 – 483.45 (f)(2) Residents are free of any significant medication errors***

***The facility's policy should dictate when it administers a.m. doses, or when it administers the first dose in a 4-times-a-day dosing schedule. The surveyor should ask appropriate staff to explain the facility policy or system for identification of residents.***

***F761 – 483.45(g) – Labeling of Drugs and Biologicals; 483.45(h) Storage of Drugs and Biologicals; 483.45(h)(1); 483.45(h)(2)***

***A facility is required to secure all medications in a locked storage area and to limit access to authorized personnel consistent with state or federal requirements and professional standards of practice.***

***The access system (e.g. key, security codes) used to lock Schedule II-V medications and other medications subject to abuse, cannot be the same access system used to obtain the non-scheduled medications. The facility must have a system to limit who has security access and when access is used.***

***The facility should have procedures for the control and safe storage of medications for those residents who can self-administer medications.***

***Because many medications can be altered by exposure to improper temperature, light, or humidity, it is important that the facility implement procedures that address and monitor the safe storage and handling of medications in accordance with manufacturers' specifications, State requirements and standards of practice.***

***483.50 – Laboratory, radiology, and other diagnostic services –***

***This regulation is intended to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource.***

***If a resident has been adversely affected, refer as appropriate, to Quality of Care, Quality of Life, Abuse, or Neglect. Also refer to Physician Services and Nursing Services if test results were not acted upon timely as per the facility's policies or the prescribing practitioner orders. There is not a tag for this section; refer to other tags for concerns related to noncompliance.***

***F771 – 483.50(a)(1) Laboratory Services;***

***If a nursing home provides blood transfusions (cross-matched at an outside laboratory), it must hold an appropriate CLIA certificate and must meet all of the requirements of 493.1103 for transfusion services and document all transfusion-related activities as required under 493.1103(d). The facility must have procedures for preventing transfusion reactions and promptly identify, investigate, and report blood and blood product transfusion reactions to the laboratory that provided the blood or blood products and as appropriate, to Federal and State authorities.***

***If the facility provides transfusion services, determine whether they have policies, procedures, and protocols for: Transfusion processes that include adverse reaction identification and corrective actions to be taken. Investigating all transfusion reactions; and, Reporting all transfusion reactions to the appropriate officials and agencies. Review the facility's procedures to ensure their process includes the positive identification of the blood or blood components to be transfused into the intended recipient.***

***If a facility has not established policies as referenced above do not cite here but cite under 483.70(d) Governing body, F837. Also consider requirements at 483.70(h) Medical director F841 for the responsibility to implement resident care policies.***

***F773 – 483.50(a)(2) Laboratory services***

***Provide or obtain laboratory services when***

***Promptly notify the ordering physician, physician assistant, nurse practitioner or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders…***

***For purposes of this requirement "promptly" means that results shall be relayed with little or no delay to the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist according to facility policies and procedures for notification and the medical orders.***

***Facility policies and procedures should be developed in consultation with the medical director and follow current standards of practice. Such policies may include defining categories that are considered outside clinical reference ranges for laboratory values, the urgency of reporting values, and a process for monitoring the effectiveness of communication to ensure that communication was received, and delegation by the ordering provider to a qualified on-call individual as appropriate.***

***F776 – 483.50(b); 483.50(b)(1) Radiology and other diagnostic services***

***If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.***

***F777 – 483.50(b)(2) - (i)The facility must provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.***

***Guidance: For purposes of this requirement "promptly" means that results shall be relayed with little or no delay to the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist according to facility policies and procedures for notification and the medical orders.***

***Facility policies and procedures should be developed in consultation with the medical director and follow current standards of practice. Such policies may include defining categories where follow-up is required, the urgency of reporting specific concerns, and a process for monitoring the effectiveness of communication to ensure that communication was received, and delegation by the ordering provider to a qualified on-call individual as appropriate.***

***F790 – 483.55 Dental Services; 483.55(a) Skilled Nursing Facilities 483.55(a)(1); (483.55(a)(2); 483.55(a)(3); Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility. 483.55(a)(4); 483.55(a)(5)***

***F791 – 483.55 Dental Services – The facility must assist resident in obtaining routine and 24-hour emergency dental care – 483.55(b); 483.55(b)(1); 483.55(b)(2); 483.55(b)(3); 483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; 483.55(b)(5)***

***The facility must have a policy identifying those instances when the loss or damage of partial or full dentures is the facility's responsibility, such as when facility staff discards dentures placed on a meal tray. A blanket policy of facility non-responsibility for the loss or damage of dentures or a policy stating the facility is only responsible when the dentures are in actual physical possession of facility staff would not meet the requirement. In addition, the facility is prohibited from requesting or requiring residents or potential residents to waive any potential facility liability for losses of personal property. (See 483.15(a)(2)(iii), F620, Admission Policy)***

***F812 – 483.60(i) Food Safety Requirements; 483.60(i)(1); 483.60(i)(2)***

***Employees who handle food must be***

***Nursing Home Gardens: Nursing homes that have their own gardens such as, vegetable, fruit, or herbs may be compliant with the food procurement requirements as long as the facility has and follows policies and procedures for maintaining and harvesting the gardens, including ensuring manufacturer's instructions are followed if any pesticide(s), fertilizer, or other topical or root-based plant preparations are applied.***

***Dishwashing machines manufacturer's instructions must always be followed.***

***Determine …if the facility has systems (e.g., policies, procedures, training, and monitoring) in place to prevent the spread of foodborne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food safety…***

***In order to investigate identified food safety concerns, review supporting data, as necessary, including but not limited to: Any facility documentation, such as dietary policies and procedures, related to compliance with food sanitation and safety, including but not limited to policies addressing facility food service, potluck events, food from visitors, facility gardens…***

***Employee Health – Employees who handle food must be free of communicable diseases and infected skin lesions. (See the requirement at 42 CFR 483.80(a)(2)(v), F880, Infection Control, requiring a facility to have an infection prevention and control program that specifies policies for, among other things, the circumstances under which a facility must prohibit an employee from direct contact with residents or their food.)***

***Review of Facility Practices – Review of facility practices may include, but is not limited to, review of policies and procedures for sufficient staffing, staff training, and following manufacturer's recommendations as indicated. In order to establish if the facility has a process in place to prevent the spread of foodborne illness, interview the staff to determine how they: Monitor whether the facility appropriately procures, stores, prepares, distributes, and serves food; Identify and analyze pertinent issues and underlying causes of a food safety concern; Implement interventions that are pertinent and timely in relation to the urgency and severity of a concern; and Monitor the implementation of interventions and determine if additional modification is needed.***

***F813 – 483.60(i) Food Safety Requirements – The facility must - 483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.***

***The facility must have a policy regarding food brought to residents by family and other visitors. The policy must also include ensuring facility staff assists the resident in accessing and consuming the food, if the resident is not able to do so on his or her own. The facility is also responsible for storing food brought in by family or visitors in a way that is either separate or easily distinguishable from facility food.***

***Interview family and/or visitors who bring food in to a resident to determine: If he or she was provided the policy about the use and storage of foods brought in by family or visitors; If the policy was provided in a language he or she could understand; If safe food handling practices were explained to him or her.***

***Interview facility staff to determine: If they are aware of the facility policy addressing food brought in by residents, family, or visitors and how to apply it; Who is responsible for sharing the facility policy with residents, families and visitors; How the facility ensures the resident, family, and/or visitors understand the policy; If they are assisting with reheating, preparation, or storage of the food, if they understand safe food handling practices.***

***Determine if the policy is not provided orally and in writing and in a manner the resident can understand. (F581)***

***F837 – 483.70(d) – Governing body… 483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility – 483.70(d)(2); 483.70(d)(3)***

***F838 – 483.70 e); 483.70(e)(1); 483.70(e)(2); 483.70(e)(3); Facility Assessment –***

***The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. (Any concerns regarding training refer to 483.95 Training)***

***F840 – 483.70(g); 483.70(g)(2) Use of outside resources; Arrangement as described in section 1861 (w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. "Timeliness" means that services are completed and results are provided within the timeframe(s) specified in accordance with facility policies and procedures, the medical orders, or professional standards of practice; and that facility staff notifies the resident's physician, dentist, physician assistant, nurse practitioner or clinical nurse specialist as directed in the medical order.***

***F841 – 483.70(h); 483.70(h)(1); 483.70(h)(2) – Medical Director- The medical director is responsible for – Implementation of resident care policies and, The coordination of medical care in the facility.***

***Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.***

***"Resident Care Policies" – refers to the facility's overall goals, directives, and governing statements that direct the delivery of care and services to residents consistent with current professional standards of practice.***

***Guidance: The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility.***

***While medical directors who work for multi-facility organizations, such as corporate or regional offices, may be involved in policy development, the facility's individual policies must be based on the facility's unique environment and its resident's needs, and not based on a broad, multi-facility structure.***

***Although the medical director is not required to sign policies, the facility must be able to show that the development, review, and approval of resident care policies included his/her input.***

***In addition, the medical director responsibilities should include, but are not limited to:***

***Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents. (Refer to Infection Control requirement at 483.80)***

***Cooperating with facility staff to establish policies for assuring that the rights of individuals (residents, staff member, and community members) are respected;***

***If a deficiency has been identified regarding a resident's care, also determine if the medical director had knowledge or should have had knowledge of a problem with care, or physician services, or lack of resident care policies and practices that meet current professional standards of practice and failed:***

***To get involved or to intercede with other physicians or practitioners in order to facilitate and/or coordinate medical care; and/or***

***To provide guidance for resident care policies.***

***Interview the medical director about his/her:***

***Involvement in assisting facility staff with resident care policies, medical care, and physician issues;***

***Noncompliance: facility failed to: ensure the medical director fulfilled his/her responsibility for the implementation of resident care policies or the coordination of medical care in the facility.***

***F842 – 482.20(f)(5); Resident-identifiable information- 483.70(i) – Medical Records – 483.70(i)(1) Medical records – 483.70(i)(2) confidential information – 483.70(i)(3) Safeguard medical record information against loss, destruction or unauthorized use – 483.70(i)(4) Medical records must be retained for….. – (483.70(i)(5) – Medical record must contain…***

***Use of Electronic Signatures – Electronic signatures are acceptable whether or not the record is entirely electronic. If a facility uses these signatures, they must have policies that identify those individuals who are authorized to sign electronically and describe the security safeguards to prevent unauthorized use of these signatures. Such security safeguards include, but are not limited to, the following: Built-in safeguards to minimize the possibility of fraud; That each staff responsible for an attestation has an individualized identifier; The date and time is recorded from the computer's internal clock at the time of entry; An entry is not to be changed after it has been recorded, and; The computer program controls what sections/areas any individual can access or enter data, based on the individual's personal identifier (and, therefore his/her level of professional qualifications).***

***Investigative Procedures: ….Interview facility staff to determine the facility's policies and practice for maintaining confidentiality of resident's records. Concerns regarding medical record confidentiality, storage (including archiving) should be reviewed under this tag.***

***F843 – 483.70(j) Transfer Agreement***

***Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law;***

***F845 –483.70(l); 483.70(l)(1); 483.70)l)(2); 483.70(l)(3) - Facility closure – Administrator –***

***The closure plan is developed when a facility knows it is closing or upon involuntary termination of the Medicare/Medicaid provider agreement. The closure plan should be based on policies and procedures as required by 483.70(m).***

***F846 – 483.70(m) Facility Closure –***

***The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (1) of this section.***

***Policies and procedures must be in place at all times in order to be used in the care of a facility closure or in care of termination of a facility's Medicare and/or Medicaid Provider Agreement, in order to meet the requirements of 483.70(l). The policies and procedures must address:***

***The administrator's duties and responsibilities as required per 483.70(l) for submitting a closure plan and providing timely written notice to the State Survey Agency, the State LTC Ombudsman, residents of the facility, and the legal representatives of residents or other responsible parties, including the CMS Regional Office (RO), the State Medicaid Agency, and staff responsible for providing care and services to residents.***

***How facility staff will identify available settings in terms of quality, services, and location, by taking into consideration each resident's individual needs, choices, and best interests. The facility many not close until all residents are transferred, relocated, or discharged in a safe and orderly manner to the most appropriate setting; and***

***Assurance that no new residents will be admitted to the facility on or after the date that the written notice of impending closure was provided to the State Survey Agency;***

***To ensure resident safety during a facility closure or termination of a facility's Medicare and/or Medicaid Provider Agreement, the policies and procedures should also address:***

***How the facility staff will ensure that all pertinent information about each resident is communicated to the receiving provider in accordance with 483.15( c)(2)(iii), and each resident's complete medical record information including archived files, Minimum Data Set (MDS) assessments, and all orders, recommendations or guidelines from the resident's attending physician;***

***In addition to the administrator, the primary contact(s) responsible for the daily operation and management of the facility during the facility's closure process;***

***The roles and responsibilities of the facility's owners, administrator, or their replacement(s) or temporary managers/monitors during the closure process, and their contact information'***

***Provisions for ongoing operations and management of the facility and its residents and staff during the closure process that include;***

***Payment of salaries and expenses to staff, vendors, contractors, etc.; Continuation of appropriate staffing and resources to meet the needs of each resident, including the provision of medications, services, supplies, and treatments as ordered by the resident's physician/practitioner;***

***Ongoing accounting, maintenance, and reporting of resident personal funds; and Labeling, safekeeping and appropriate transfer of resident's personal belongings, such as clothing, medications, furnishings, etc. at the time of transfer or relocation, including contact information for missing items after the facility has closed.***

***The facility's policies and procedures should also consider certain provisions to prepare residents to ensure a safe and orderly transfer from the facility. These provisions include, but are not limited to: Interviewing residents and their legal or other responsible parties, to determine each resident's goals, preferences, and needs in planning for the services, location, and setting to which they will be moved; Offering each resident (in a manner and language understood by the resident) the opportunity to obtain information regarding their community options, including setting and location; Providing residents with information or access to information pertaining to the quality of the providers and/or services they are considering; psychological preparation or counseling of each resident as necessary; and making every reasonable effort to accommodate each resident's goals/preferences and needs regarding receipt of services, location, and setting.***

***NOTE: The review of certain components such as an evaluation of the facility's closure plan, policies and procedures may be conducted off-site by the State Survey Agency and may include assistance from the State LTC Ombudsman as the State Survey Agency deems suitable and necessary.***

***F849 – 483.70(o) – Hospice Services…483.70(o)(1); 483.70(o)(2 – If Hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: ….Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident…); 483.70(o)(3); 483.70(o)(4)***

***The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident.***

***Designated employee is responsible for assuring that orientation is provided to hospice staff. This orientation is meant to address the overall facility environment including policies, rights, record keeping, and forms requirements. It is important for the nursing home to document and have available information regarding hospice staff orientation.***

***NOTE: In addition to the orientation that nursing homes must provide to hospice staff, hospices must provide orientation to nursing home staff providing care for hospice patients. The orientation requirements while separate regulations for both the nursing home and hospice, should be a collaborative effort to assure that the hospice employees provide services and care effectively in the nursing home and that the hospice ensures that the nursing home staff understands the basic philosophy and principles of hospice care. If a nursing home has written agreements with multiple hospice providers, the nursing home should collaborate with each hospice to assure that the nursing home staff are familiar with specific policies and procedures for each individual hospice. It may not be necessary for each hospice to provide information to nursing home staff regarding the hospice philosophy and principles of care if the nursing home staff has received this information and are aware of the philosophy and principles of care.***

***F866 – 483.75(c); 483.75(c)(1) Program feedback, data systems and monitoring***

***A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:***

***Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.***

***Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at 483.70( e) and including how such information will be used to develop and monitor performance indicators.***

***Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.***

***Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.***

***F867 – 483.75(d); 483.75(d)(1); 483.75(d)(2); 483.75( e); 483.75( e) (1); 483.75( e)(2); 483.75( e)(3; 483.75(g); 483.75(g(2); 483.75(g)(2)(ii)***

***Program systematic analysis and systemic action (Phase 3)***

***The facility will develop and implement policies addressing: How they will use a systematic approach to determine underlying causes of problems impacting larger systems; How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of lift, or safety problems; and How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.***

***F880 – 483.80; Infection Control; 483.80(a); 483.80(a)(1); 483.80(a)(2);***

***The facility must establish and maintain: …written standards, policies, and procedures for the program, which must include, but are not limited to:***

***A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;***

***When and to whom possible incidents of communicable disease or infections should be reported; Standard and transmission-based precautions to be followed to prevent spread of infections;***

***When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.***

***The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and***

***The hand hygiene procedure to be followed by staff involved in direct resident contact.***

***A system for recording incidents identified under the facility IPCP and the corrective actions taken by the facility.***

***Develops and implements written policies and procedures for infection control that, at a minimum:***

***Explain how standard precautions and when transmission-based precautions should be utilized…***

***Prohibit staff with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease,***

***Require staff follow hand hygiene practices consistent with accepted standards of practice***

***Requires staff handle, store, process, and transport all linens and laundry in accordance with accepted national standards***

***The results of the facility assessment must be used, in part, to establish and update the IPCP, its policies and/or protocols to include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, and visitors.***

***Infection Control Policies and Procedures***

***The facility must develop and implement written policies and procedures for the provision of infection prevention and control. The facility administration and medical director should ensure that current standards of practice based on recognized guidelines are incorporated in the resident care policies and procedures. These IPCP policies and procedures must include, at a minimum:***

 ***As necessary, and at least annually, review and revision of the IPCP based upon the facility assessment (according to §483.70(e)) which includes any facility and community risk;***

 ***An ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;***

 ***When and to whom possible incidents of communicable disease or infections should be reported within the facility;***

 ***Which communicable diseases are reportable to local/state public health authorities;***

***How to use standard precautions and how and when to use transmission-based precautions (i.e., contact precautions, droplet precautions, airborne isolation precautions). The areas described below are part of standard and transmission-based precautions40 which are further described under their respective sections. For example: o Hand hygiene (HH) (e.g., hand washing and/or ABHR): consistent with accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected Clostridium (C.) difficile or norovirus infection during an outbreak, or if infection rates of C. difficile infection (CDI) are high; in these circumstances, soap and water should be used; http://www.cdc.gov/handhygiene/providers/index.html NOTE: According to the CDC, strict adherence to glove use is the most effective means of preventing hand contamination with C. difficile spores as spores are not killed by ABHR and may be difficult to remove even with thorough hand washing. For further information on appropriate hand hygiene practices see the following CDC website:***

 ***The selection and use of PPE (e.g., indications, donning/doffing procedures) and the clinical conditions for which specific PPE should be used (e.g., CDI, influenza);***

 ***Addressing the provision of facemasks for residents with new respiratory symptoms;***

 ***Addressing resident room assignment (e.g. single/private room/cohorted) as appropriate and/or available, based on a case by case analysis of the presence of risk factors for increased likelihood of transmission (e.g., uncontained drainage, stool incontinence);40***

 ***The process to manage a resident on transmission-based precautions when a single/private room is not available;***

***Limiting the movement of a resident with a highly infectious disease (e.g., norovirus, CDI) who is on transmission-based precautions with active symptoms (e.g., resident has diarrhea, vomiting, draining wounds, or other uncontained excretions or secretions) while outside of his/her room for medically necessary purposes only; and,***

***Respiratory Hygiene/Cough Etiquette: Implementing policies and procedures would include providing resources and instructions for performing HH in or near lobby areas or entrances; provide conveniently-located dispensers of ABHR and supplies for hand washing where sinks are available.***

***Wound care, fecal/urinary incontinence care, and skin care. Since the IPCP must be based on the facility assessment, the presence of certain resident conditions would require that the facility have policies and procedures related to other specific services such as mechanical ventilation, infusion therapy, and/or dialysis either onsite or at an offsite dialysis facility;***

***Performing finger sticks and point-of-care testing (e.g., assisted blood glucose monitoring) to the extent identified as a resident need based on the facility assessment;***

***Preparation, administration, and care for medications administered by injection or peripheral and central venous catheters, if performed by the facility; and,***

***Use and care of peripheral and central venous catheters, if performed by the facility.***

***Environmental cleaning/disinfection:***

***Routine cleaning and disinfection of high-touch surfaces in common areas, resident rooms, and at the time of discharge; and***

***Cleaning/disinfection of resident care equipment including equipment shared among residents (e.g., blood pressure cuffs, rehabilitation therapy equipment, blood glucose meters, etc.).***

***Written occupational health policies that address:***

***Reporting of staff illnesses and following work restrictions per nationally recognized standards and guidelines;***

***Prohibiting contact with residents or their food when staff have potentially communicable diseases or infected skin lesions;***

***Assessing risks for tuberculosis (TB) based on regional/community data and screening staff to the extent permitted under applicable federal guidelines and state law;***

***Monitoring and evaluating for clusters or outbreaks of illness among staff;***

***Implementing an exposure control plan in order to address potential hazards posed by blood and body fluids, from dialysis, glucose monitoring or any other point of care testing; and***

***Education and competency assessment; Facilities must ensure staff follow the IPCP's standards, policies and procedures. Therefore, staff must be informed and competent. Knowledge and skills pertaining to the IPCP's standards, policies and procedures are needed by all staff in order to follow proper infection control practices (e.g., hand hygiene and appropriate use of personal protective equipment) while other needs are specific to particular roles, responsibilities, and situations (e.g., injection safety and point of care testing). Furthermore, residents and their representatives should receive education of the facility's IPCP as it relates to them (e.g., hand hygiene, cough etiquette) and to the degree possible/consistent with the resident's capacity. For example, residents should be advised of the IPCP's standards, policies and procedures regarding hand hygiene before eating and after using the restroom.***

***Surveillance:***

***The facility must establish a system for surveillance based upon national standards of practice and the facility assessment, including the resident population and the services and care provided. The facility must establish routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., HAI and community-acquired), infection risks, communicable disease outbreaks, and to maintain or improve resident health stats. As part of the system of surveillance, identification and prevention, the facility should determine how it will track the extent to which staff are following the facility's IPCP policies and procedures, and facilities would want to particularly address any areas that are related to a corrective action.***

***Process Surveillance:***

***Process surveillance is the review of practices by staff directly related to resident care. The purpose is to identify whether staff implement and comply with the facility's IPCP policies and procedures.***

***The facility's policies and procedures for a system of surveillance must include data to properly identify communicable diseases or infections before they spread. Therefore, the policies and procedures would include identifying:***

***Data to be collected, including how often and the type of data to be documented, including:***

***The infection site (i.e., type of infection), pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of resident (and staff, if applicable) who developed infections;***

***Observations of staff including the identification of ineffective practices (e.g., not practicing hand hygiene and/or using PPE when indicated as well as practices that do not follow the facility's IPCP policies and procedures) , if any; and***

***The identification of unusual or unexpected outcomes (e.g., foodborne outbreak), infection trends and patterns.***

***How the data will be used and shared with appropriate individuals (e.g., staff, medical direction, director of nursing, quality assessment and assurance committee – QAA), when applicable, to ensure that staff minimize spread of the infection or disease (e.g., require revision of staff education and competency assessment).***

***The facility must identify how reports will be provided to staff and/or prescribing practitioners in order to revise interventions/approaches and/or re-evaluate medical interventions related to the infection rates and outcomes.***

***Facility policies must identify the type (i.e., contact, droplet, airborne) and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved.***

***Facilities should review their policies and procedures and educate their staff regarding safe use of insulin pens.***

***A facility must develop and implement a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility based on the investigation of the incidents. The facility's system should include defining, identifying, analyzing, and reporting incidents related to failures in infection control practices to the director of nursing, medical director, and the QAA committee.***

***The facility must develop and follow practices on handling, storing, processing, and transporting laundry. The facility must monitor to ensure that the laundry practices are implemented, any deviations from practices must be identified, and corrective actions are put in place.***

***The facility must have a process to clean laundry.***

***If linen is sent off-site to a professional laundry, the facility has practices that address how the service will be provided, including how linen is processed and handled to prevent contamination from dust and dirt during loading and transport. The facility should assure that this laundry service meets healthcare industry laundry standards.***

***The facility must have practices that address the methods for cleaning and disinfecting items that are to be used for another resident after an individual resident's use such as but not limited to the following: mattress covers with tears or holes are replaced; moisture resistant mattress covers are cleaned and disinfected between use for different residents with an EPA-approved germicidal detergent to help prevent the spread of infections; fabric mattress covers are laundered between use for different residents; Pillow covers and washable pillows are laundered in a hot water laundry cycle between use for different residents or when they become contaminated with body substances; and mattresses are discarded if bodily fluids have penetrated into the mattress fabric.***

***The facility's IPCP and its standards, policies and procedures must be reviewed at least annually to ensure effectiveness and that they are in accordance with current standards of practice for preventing and controlling infections; the IPCP must be updated as necessary.***

***Key elements of noncompliance: To cite deficient practice at F880, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:***

***…Develop and implement written IPCP standards, policies, and procedures that are current and based on national standards. These must include: when and to whom possible incidents of communicable diseases should be reported; developing and implementing a system of surveillance to identify infections or communicable diseases; how to use standard precautions (to include appropriate hand hygiene) and how and when to use transmission-based precautions (i.e., "isolation precautions"); and/or prohibiting staff with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease….***

***F881 – 483.80(a); Infection Prevention and control program - 483.80(a)(3) – An antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use.***

***The intent of this regulation is to ensure that the facility: Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic; Reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use; and Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics.***

***NOTE: For examples of antibiotic use protocols, policies, and practices developed by the Agency for Healthcare Research and Quality, see: http://www.ahrq.gov/nhguide/index.html***

***….Core elements for antibiotic stewardship in nursing homes include:……Implement policy(ies) or practice to improve antibiotic use….***

***The facility must develop an antibiotic stewardship program which includes the development of protocols and a system to monitor antibiotic use. This development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program if different.***

***The antibiotic stewardship program protocols shall describe how the program will be implemented and antibiotic use will be monitored, consequently protocols must: Be incorporated in the overall infection prevention and control program; Be reviewed on an annual basis and as needed; Contain a system of reports related to monitoring antibiotic usage and resistance data. Examples may include the following: Summarizing antibiotic use from pharmacy data, such as the rate of new starts, types of antibiotics prescribed, or days of antibiotic treatment per 1,000 resident days; Summarizing antibiotic resistance (e.g., antibiogram) based on laboratory data from, for example, the last 18 months; and/or Tracking measures of outcome surveillance related to antibiotic use (e.g., C. difficile, MRSA, and/or CRE); Incorporate monitoring of antibiotic use, including the frequency of monitoring / review. Monitor/review when the resident is new to the facility; when a prior resident returns or is transferred from a hospital or other facility; during each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic regimen review as requested by the QAA committee. In addition, establish the frequency and mode or mechanism of feedback (e.g., verbal, written note in record) to prescribing practitioners regarding antibiotic resistance data, their antibiotic use, and their compliance with facility antibiotic use protocols. Feedback on prescribing practices and compliance with facility antibiotic use protocols may include information from medical reviews for new antibiotic starts to determine whether the resident had signs or symptoms of an infection; laboratory tests ordered and the results; prescription documentation including the indication for use (i.e., whether or not an infection or communicable disease has been documented), dosage and duration; and clinical justification for use of an antibiotic beyond the initial duration ordered such as a review of laboratory reports/cultures in order to determine if the antibiotic remains indicated or if adjustments to therapy should be made (e.g., more narrow spectrum antibiotic). Assess residents for any infection using standardized tools and criteria (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics; and Include the mode (e.g., verbal, written, online) and frequency (as determined by the facility) of education for prescribing practitioners and nursing staff on antibiotic use (stewardship) and the facility's antibiotic use protocols. NOTE: Prescribing practitioners can include attending physicians and non-physician practitioners (NPP) (i.e., nurse practitioners, clinical nurse specialists, and physician assistants).***

***Antibiotic Stewardship Review:***

***Determine whether the facility's antibiotic stewardship program includes antibiotic use protocol(s) addressing antibiotic prescribing practices (i.e., documentation of the indication, dose, and duration of the antibiotic; review of laboratory reports to determine if the antibiotic is indicated or needs to be adjusted; an infection assessment tool or management algorithm is used when prescribing) and a system to monitor antibiotic use (i.e., antibiotic use reports, antibiotic resistance reports).***

***Key Elements of Noncompliance:***

***To cite deficient practice at F881, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:***

***Develop and implement antibiotic use protocols to address the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotics; Develop and implement antibiotic use protocols that address unnecessary or inappropriate antibiotic use thereby reducing the risk of adverse events, including the development of antibiotic-resistant organisms; and/or Develop, promote and implement a facility-wide system to monitor the use of antibiotics.***

***F883 – 483.80(d) – Influenza and pneumococcal immunizations; 483.80(d)(1) – Influenza.***

***The facility must develop policies and procedures to ensure that – (i) before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through May 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.***

***483.80(d)(2) Pneumococcal disease The facility must develop policies and procedures to ensure that – (i) Before offering the pneumococcal immunization , each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.***

***An effective immunization program involves collaborating with the medical director to develop resident care policies for immunization(s) that reflect current standards of practice and that include:***

***Physician approved policies for orders of influenza and pneumococcal vaccines (administration must be based on an assessment of each resident for possible medical contraindications);***

***Review of the resident's record of vaccination and immunization status, including assessment for potential medical contraindications;***

***How pertinent information and education will be provided to residents or their representatives. The facility may wish to use educational resources such as those provided by the U.S. Centers for Disease Control and Prevention (CDC); and,***

***The vaccination schedule including mechanisms for recording and monitoring for administration of both influenza and pneumococcal vaccines in accordance with national recommendations.***

***NOTE: Review facility policies regarding the provision of vaccines in order to determine if the policies reflect current standards of practice. Refer to 483.21(b)(3)(i) – the services provided or arranged by the facility must meet professional standards of quality (F658). Also, refer to F880 for concerns with infection prevention and control.***

***As necessary, determine if the facility developed influenza and pneumococcal vaccine policies and procedures.***

***Key elements of Noncompliance:***

***To cite deficient practice at F883, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:***

***Develop, maintain, or follow policies and procedures for immunization of residents against influenza and pneumococcal disease in accordance with national standards of practice;***

***F895 – 483.85 Compliance and ethic program; 483.85(a) Definitions; 483.85(1); 483.85(2); 483.85(b) General Rule; 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 violation 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; 483.85( c)(3); 483.85( c)(4); 483.85( c)(6); 483.85( c)(7); 483.85( c)(8); 483.85(d); 483.85(d)(1); 483.85(d)(2); 483.85(d)(3); 483.85(e);***

***F922 – 483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply***

***The facility should have a written procedure which defines the source of water when there is a loss of normal water supply, including provisions for storing the water, both potable and non-potable, a method for distributing the water and a method for estimating the volume of water required.***

***During the entrance conference, ask the administrator the facility's procedure to ensure water availability.***

***F926 – 483.90(i)(5) Establish policies, accordance with applicable Federal, State and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents.***

***Review F689 guidance concerning smoking in the facility.***

***Review policies to determine if they have been developed and are being implemented in accordance with Federal, State and local laws and regulations in regards to smoking, smoking areas, and smoking safety for both smoking and non-smoking residents.***

***F940 – 483.95 Training Requirements***

***A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at 483.70(e). Training topics must include but are not limited to ---- [483.95 will be implemented beginning November 28, 2019 (Phase 3)]***

***F941 – 483.95 Communication***

***A facility must include effective communications as mandatory training for direct care staff [483.95 (a) will be implemented beginning November 28, 2019 (Phase 3)]***

***F943 – 483.95 ( c) Abuse, neglect, and exploitation; 483.95( c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at 483.12; 483.95( c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; 483.95( c)(3) Dementia management and resident abuse prevention.***

***All facilities must develop, implement and permanently maintain an effective training program for all staff, which includes, at a minimum, training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management, that is appropriate and effective, as determined by staff need and the facility assessment (as specified at 483.70( e)).***

***Facility procedures and Federal and State requirements for reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, timeframes for reporting, and to whom staff and others must report their knowledge related to any alleged violation without fear of retaliation.***

***Probes: How does the facility's policies reflect staff training is in compliance with 483.12 and 483.12( a)(1) Freedom from abuse, neglect, and exploitation, tag F600.***

***For concerns related to the development and implementation of written policies and procedures that includes training related to abuse, neglect, exploitation, and misappropriation of resident property, see 42 CFR 483.12(b)(3) Develop / Implement Abuse / Neglect, etc. Policies, tag F607.***

***F944 – 483.95(d) Quality Assurance and Performance Improvement – A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at 483.75. [483.95(d) will be implemented beginning November 28, 2019 (phase 2)]***

***F945 – 483.95( e) – Infection Control – A facility must include as part of its Infection Prevention and Control Program mandatory training that includes the written standards, policies, and procedures for the program as described at 483.80(a)(2) – [483.95( e) will be implemented beginning November 28, 2019 (Phase 3)]***

***F946 – 483.95(f) Compliance and ethics; 483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program; 483.95(f)(2) – Annual training if the operating organization operates five or more facilities [483.95(f)(1) and (f)(2) will be implemented beginning November 28, 2019 (Phase 3)]***

***F947 – 483.95(g) - Required in-service training for nurse aides. In-service training must—483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; 483.95(g)(2) – Include dementia management training and resident abuse prevention training. – 483.95(g)(3) – Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at 483.70( e) and may address the special needs of residents as determined by the facility staff; [483.95(g)(3) will be implemented on November 28, 2019 (Phase 3) with the exception of facility assessment which was implemented on November 28, 2017 (Phase 2).]; 483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.***

***All facilities must develop, implement and permanently maintain an in-service training program for nurse aides that is appropriate and effective, as determined by nurse aide evaluation or the facility assessment as specified at 483.70(e). Changes to the facility's population, the facility's physical environment, staff turnover, and modifications to the facility assessment may necessitate ongoing revisions to the facility's training program.***