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**INSTRUCTIONS FOR USING THIS DOCUMENT**:

LeadingAge Wisconsin provides this template as a tool that may assist members in organizing and tracking work relating to implementation of the revised CMS Requirements of Participation (ROPs) that took effect in Phase 1 (November 28, 2016). The Association wishes to thank its sister association, LeadingAge Minnesota, for producing this document allowing us to share it with the members.

It is especially important to note that the first column provides summary information only. It is not an exhaustive or fully-detailed list of every provision taking effect in Phase 1. Given the sheer volume of regulatory sections that are new or modified compared to current regulation, such a summary would be very difficult to create, and facilities should not use this document as a substitute for reading the new requirements themselves and adding items to the table as needed.

We offer this as a sample only, and each facility who uses it is responsible to customize or modify the table as necessary to meet its specific needs. This is the reason we have provided this document in a Microsoft Word format. A facility using this table should modify the first column to include the items and details need to address for Phase 1 – adding or delete rows as you see fit – then fill in the remaining columns.

Please visit our website for links to the Final Rule itself and other sources of information about the new requirements, and feel free to contact John Sauer at [jsauer@leadingagewi.org](mailto:jsauer@leadingagewi.org) or Brian Schoeneck at [bschoeneck@leadingagewi.org](mailto:bschoeneck@leadingagewi.org).

| Requirement | Action Steps | Responsible | Questions | Deadline and Status |
| --- | --- | --- | --- | --- |
| Definitions (§483.5)  * CMS has added the new definitions of   + “Abuse”   + “Adverse event”   + “Exploitation”,   + “Licensed health professional”   + “Misappropriation of resident property”   + “Mistreatment”   + “Neglect”   + “Nurse aide”   + “Person-centered care”   + “Resident representative”   + “Sexual abuse”, and   + “Transfer and discharge” * CMS also modified certain existing definitions. | * *[Example: Revise policies and procedures to reflect and apply the new and revised language.]* |  | * *[Example: Develop illustrations of what constitutes exploitation.]* |  |
| **§483.10(a) Residents Rights**   * Amends current language re equal access to care: “The facility must provide equal access to quality care regardless of diagnosis, severity, condition or payment source.” * Resident has a right not only to refuse treatment and refuse experimental research, but also the right to request treatment and/or discontinue treatment. * Interdisciplinary team must determine that self-administration of medications is “clinically appropriate,” rather than “safe” as stated in the current regulation. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Obtain updated Bill of Rights pamphlets, posters.* * *Identify process changes necessary to comply with new, person-centered care planning requirements (see also 483.21)* * *Develop procedures relating to confirmation of licensure for a resident’s attending physician.]* |  |  |  |
| **§483.10(b) Exercise of Rights**   * A resident not adjudicated incompetent may designate a representative, the rep may exercise the resident’s rights, and the facility’s must treat the representative’s decisions as those of the resident. * Resident representatives have certain responsibilities, whether appointed by a court of by the resident himself or herself. * Facility must report concerns if resident representative is not acting in the resident’s best interests. * Same sex spouse must be afforded treatment equal treatment. * Adds provisions specifying the right of residents to receive advance information about his/her care, type of professional delivering care, and risks and benefits of treatments and options. |  |  |  |  |
| **§483.10(c) Planning and Implementing Care**   * Adds detailed statements of a resident’s right to participate in the development and implementation of his or her person-centered plan of care, including steps the facility must take and information the resident is entitled to receive. |  |  |  |  |
| **§483.10(d) Choice of Attending Physician**   * Resident has a right to choose his or her attending physician: the physician must be licensed to practice and must meet applicable regulatory requirements; if alternative physician needed, the facility must discuss this with the resident and honor the resident’s preference among options/selection of a new physician. * Broadens current §483.10(b)(9) (contact information for resident’s physician) so that it applies both to the physician and other primary care professionals responsible for the resident’s care; also revises the language from “the facility must inform” to “the facility must ensure that each resident remains informed” …. |  |  |  |  |
| **§483.10(e) Respect and Dignity**   * Resident has right to room with roommate of choice when practicable and both consent. * Written notice before a change of room or roommate must include the reason for the change. * Resident may refuse transfer to another room if the transfer is purely for the convenience of staff. |  |  |  |  |
| **§483.10(f) Self-Determination**   * The resident has the right to (1) choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part. Resident has a right to participate in community activities. * Visitation:   + Adds resident representative to list of visitors entitled to immediate access to resident, w/o condition.   + Facilities must have written policies/procedures re visitation, including any clinical or safety restriction or limitation on such rights.   + Facilities must notify residents of their visitation rights.   + Facilities must not discriminate, and must ensure full and equal rights of all visitors. * Resident and family groups:   + Facility must take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.   + Staff designated to assist and respond must be approved by resident or family group and the facility.   + Facility must consider (currently “listen to”) the views of a resident or family group; it must act upon grievances and recommendations promptly; and be able to demonstrate its response and rationale.   + Regarding family groups: (i) Adds language that a **resident** has a right to participate in family groups; (ii) reframes the language to say the resident has a right to have family groups (including, under the new language, other resident representatives besides family) meet in the facility. * Financial affairs/resident funds   + Facility must convey resident funds and a final accounting within 30 days of a discharge or eviction.   + Re items and services for which a facility may not charge during a Medicare- or Medicaid-covered stay: (i) amends “dietary services” to “food and nutrition services”; amends “bathing” to “bathing assistance”; and adds Medicare or Medicaid covered hospice services.   + Re items and services a facility may charge to resident funds: (i) facility may not charge if the item/service is “required to achieve the goals stated in the resident’s care plan”; (ii) adds references to modern electronic devices; (iii) adds “cost to participate in” with reference to social events; and (iv) states facility may not charge for special food and meals ordered by a practitioner (see §483.60).   + If a resident requests a non-covered item or service, the new regulation adds a requirement that a facility must inform the resident about applicable charges both orally and in writing. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Prepare or revise written policies and procedures relating to visitation.* * *Document agreement with resident/family groups about staff liaison.]* |  |  |  |
| **§483.10(g) Information and Communication**   * Resident Access to Records   + Resident has right to access personal records in addition to medical records.   + Facility must provide records in the form and format requested by the resident, if readily producible, or if not in hard copy or other agreed upon form.   + A facility may impose only a reasonable cost-based fee in relation to records requests. * Facility must provide information in a form and manner the resident can access and understand. * Re posting of contact information for all pertinent state client advocacy groups: email addresses must be included; facilities must post a written statement that a resident may file complaints with the state survey agency, in addition to a written notice of that right. * Must post results of the most recent survey in a readily accessible place, without the requirement for a request by a resident (or family, etc.) to examine them; must have three years of “reports with respect to any surveys, certifications, and complaint investigations” available for review upon request; facilities must post a notice about their availability in areas that are prominent and accessible to the public. * Communications   + Resident has right to TTY/TDD services, as well as use of a cell phone at the resident’s own expense.   + Resident has right to reasonable access to the internet, to the extent available to the facility.   + Resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research – provided the access is available to the facility, at the resident’s expense if the facility incurs costs, and the use complies with state and federal law (e.g. does not involve access to illegal on-line content, etc.) * Notification of Changes:   + Notification of “need to alter treatment significantly,” includes a need to change a current treatment, in addition to discontinuing a current treatment or commencing a new treatment.   + When providing information to a physician under this section, the new rule requires that facilities ensure that all pertinent information specified in new §483.15(c)(2) (which requires that certain information be provided to a receiving provider for a transfer including all special instructions or precautions for ongoing care and the contact information of the practitioner responsible for the care of the resident) is available and provided upon request to the physician. * The current rule requires facilities to provide information about Medicaid-covered and non-Medicaid covered services (i) to residents “entitled to Medicaid” and (ii) at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid. New §483.10(g)(17) makes two changes here where clarification will be needed from CMS: (i) changes “entitled to Medicaid” to “eligible for Medicaid” and (ii) changes at the time of admission or when eligible to at the time of admission and when eligible. * Current §483.10(b)(6) requires that the facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate. The new rule adds five sub-requirements:   + Notice as soon as reasonably possible of changes to Medicare and/or Medicaid coverage   + 60 day advance written notice of changes in charges for non-Medicare/non-Medicaid-covered services   + If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility’s per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements   + Payment of any and all refunds due within 30 days of discharge.   + The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. | * *[Example: Assess readiness to provide info in form/manner residents can access/understand.]* |  |  |  |
| **§483.10(h) Privacy and Confidentiality**   * Expands current language granting ombudsman representatives the right to examine a resident’s clinical records; the new rule states “medical, social and administrative records”; CMS explains this is a necessary change to conform to the separate, recently-finalized federal rule governing the ombudsman program. [Note: New rule drops current language stating “with resident permission”.] |  |  |  |  |
| **§483.10(i) Safe Environment**   * The rule adds new language that a resident “has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatments and supports for daily living safely.” * It expands current §483.15(h)(1) by stating that the facility’s obligation to provide a safe, clean and homelike environment includes:   + ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk; and * The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | * *[Example: Evaluate policies/procedures for protecting resident property from loss and theft; focus must be on prevention.]* |  |  |  |
| **§483.10(j) Grievances**   * New requirements include:   + Establishment of a facility grievance policy (see the next row)   + Resident notification requirements regarding grievances   + Identifying a Grievance Official responsible for overseeing policies (doesn’t have to be person’s only job)   + Specifications for written grievance decisions, and   + Maintaining 3 years of evidence demonstrating the results of all grievances. | * *[Example: Prepare a written policy and procedure relating to grievances, being sure to include all of the required elements specified in 483.10(j).]* |  |  |  |
| **§483.10(j)(4)**: The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' 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 conclusion; 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(c)(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 of any of these residents' rights within its area of responsibility; and  (vii) Maintaining evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision. |  |  |  |  |
| **§483.10(k) Contact with External Entities**  States that a facility may not prohibit or in any way discourage a resident from communicating with federal, state or local officials regarding any matter. |  |  |  |  |
| Freedom from Abuse, Neglect and Exploitation (§ 483.12)  * Adds “exploitation” to list of actions/occurrences from which a facility must protect its residents and adds the concept into employment prohibitions, prevention, training, reporting, investigating, etc. * The current rule prohibits facilities from employing certain individuals. The new rule expands this by stating that facilities may not employ or “otherwise engage” such individuals – i.e. volunteer or a contractor. * Facility may not employ or otherwise engage a person who has 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. * Facilities must develop/ implement written policies & procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, and establish policies and procedures to investigate any allegations. Policies/procedures must include new training requirements for abuse, neglect and exploitation in §483.95. * Re reporting timelines, facilities must “ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. * The new rule adds adult protective services to the list of officials who must be notified in accordance with state law, where state law provides for jurisdiction in long-term care facilities. * Under current rules, a facility must prevent further potential abuse from occurring while it investigates. The new rule is broader and makes clear that a facility must prevent any further violation from occurring during its investigation – whether it be abuse, neglect, exploitation, or mistreatment. | *[Examples:*   * *Revise policy and procedures to reflect the new requirements, including all new and revised definitions and the new concept of exploitation.* * *Revise employment policies and procedures to reflect the revised employment prohibitions; extend the same to individuals whom a facility does not employ but otherwise engages – such as a volunteer or contractor* * *Compare existing staff training to the requirements in new §483.95, and align as needed.]* |  | * *[Example: Will updated guidance be provided by WI. DQA?* |  |
| Admission, Transfer and Discharge Rights (§483.15)  * Facility must establish and implement an admissions policy (which is not the same as an admissions agreement). The new requirements include several items that would be part of that policy. Examples include but are not limited to:   + E.g. Facility may not request/require waiver of potential liability for losses of personal property.   + E.g. must disclose and provide to a resident or potential resident notice of special characteristics or service limitations.   + E.g. if a composite distinct part, disclose physical configuration in admissions agreement and specify policies relating to room changes. * Clarifies facility requirements when transferring or discharging a resident, including the circumstances when it may do so, and updates physician documentation related to basis for transfer, the residents’ needs that cannot be met at the facility, the facility attempts to meet the residents’ needs and the services available at the receiving facility to meet the resident’s needs. * Updates language regarding the required notice to be given prior to transfer or discharge, including recipients, content of notice, and obligation to update the notice if information changes prior to effecting the transfer or discharge. * Revises requirements relating to notice of bed-hold policies, including need to provide the State’s reserve bed payment policy. * States that 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, | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language affecting pre-admission, admission and transfer/discharge.* * *Review any applicable partner agreements* * *Review care transition and discharge protocols, communication standardization (acute care, physician, other), sending and receiving facility expectations, monitoring of resident transfer and potential readmission, key data points for monitoring to ensure effective care transitions.]* |  |  |  |
| Resident Assessment (§483.20)  * Clarifies that the assessment is not just for understanding the resident’s needs but also to understand their strengths, goals, life history and preferences. * Clarifies that NFs need to incorporate the recommendations from the PASARR level II determination and evaluation report into the resident’s assessment, care planning, and transitions of care. * Clarifies that PASARR coordination must include referral of all residents with newly evident or possible serious mental disorder, intellectual disability or related condition for a level II review upon significant change in assessment status. The status change could be either a decline or improvement in the resident’s condition. * The rule also makes a few technical corrections regarding the PASARR and delineates exceptions to preadmission screening. * Requires a NF to notify the appropriate state agency promptly after a significant change in condition of a resident who has a mental disorder or intellectual disability for review. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Develop a policy and educate staff of the requirement to notify the State of significant change in condition of residents who are subject to PASARR level II review.]* |  |  |  |
| Comprehensive Resident-Centered Care Plans (§ 483.21)   * Adds a requirement to include as part of a resident’s care plan any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. * In consultation with resident and resident’s rep, care plan must address:   + resident’s goals for admission and desired outcomes,   + preference and potential for future discharge (including whether return to community was assessed),   + discharge plans as appropriate. * Adds a nurse aide and a member of the food and nutrition services staff to the required members of the interdisciplinary team that develops the comprehensive care plan (and other appropriate personnel) * Requires facilities to provide a written explanation in a resident’s medical record if the participation of the resident and their resident representative is determined to not be practicable for the development of the resident’s care plan. * Services must be culturally competent. * Discharge planning process must: (i) Result in the development of a discharge plan for each resident. (ii) Be updated to reflect changing needs. (iii) Involve the IDT. (iv) Consider caregiver/support person availability and capacity to perform post-discharge care. (v) Involve and inform the resident and resident representative. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community; if discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) Assist residents and their resident representatives in selecting a post-acute care provider by using post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. * Specifies additional elements of a discharge summary, including reconciliation of all pre-discharge and post-discharge medications. | * *[Example: Revise policies and procedures to reflect and apply the new and revised language.]* |  |  |  |
| **Resident Quality of Care and Quality of Life** (§§ 483.24-483.25)   * Activities program to include consideration of care plan and resident preferences, as well as potential for independence and ability to interact with the community. * Facility must ensure appropriate personnel to provide basic life support/CPR. * Includes new language addressing:   + Skin care/pressure ulcers and foot care to be consistent with professional standards of practice etc.   + Continence of both bladder and bowel   + Services and equipment to maintain or improve mobility   + Modification of existing requirements for nasogastric tubes to reflect current clinical practice, and to include enteral fluids in the requirements for assisted nutrition and hydration. * 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 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. * Bed rails have expanded language related to use, alternatives, safety requirements, and resident/representative informed consent. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Implement staff training as needed.]* |  | * *[Example: Do we have all manufacturers’ use specifications etc for beds and mattresses?]* |  |
| **Physician Services (§483.30)**   * Retains the requirement that a physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. Then adds: **A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.**   + Current 483.20(a) will also be retained without change, which reads: “At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.” * New: A resident's attending physician may delegate the task of writing dietary orders, consistent with § 483.60, to a qualified dietitian or other clinically qualified nutrition professional who— (i) Is acting within the scope of practice as defined by State law; and (ii) Is under the supervision of the physician. * New: A resident's attending physician may delegate the task of writing therapy orders, consistent with § 483.65, to a qualified therapist who— (i) Is acting within the scope of practice as defined by State law; and (ii) Is under the supervision of the physician |  |  | * *[Example: Confirm the scope of practice under WI law, including any specific requirements relating to documenting physician supervision / collaborative practice.]* |  |
| **Nursing Services (§483.35)**   * Creates a competency-based staffing approach:   + In addition to sufficient numbers, a facility’s nursing staff must have appropriate competencies and skill sets to provide services, as identified through resident assessments and care plans.     - Ties into facility-wide assessment in Phase 2.   + Facility must ensure licensed nurses have the specific competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments and care plans. * Caring for a resident's needs includes assessing, evaluating, planning and implementing resident care plans and responding to each resident's needs. * Non-permanent caregivers must meet the same competency, knowledge and skill requirements as permanent personnel. (See revised definition of nurse aide.) | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language* * *Confirm/establish policies and procedures for documentation of training.]* |  |  |  |
| **Behavioral Health Services (§483.40)**  (b) Based on the comprehensive assessment of a resident, the facility must ensure that—  (1) A resident who displays **or is diagnosed with** mental disorder or psychosocial adjustment difficulty, **or who has a history of trauma and/or post-traumatic stress disorder,** receives appropriate treatment and services to correct the assessed problem **or to attain the highest practicable mental and psychosocial well-being;**  (2) A resident whose assessment did not reveal **or who does not have a diagnosis of** a mental or psychosocial adjustment difficulty **or a documented history of trauma and/or post-traumatic stress disorder** does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable.  (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. (Consistent with current regulation.) |  |  |  |  |
| **Pharmacy Services (§483.45)**  Drug Regimen Review:   * The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.   (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.  (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.  (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.   * 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. | *[Examples:*   * Clinical team should meet with consulting pharmacist to review the new requirements. * Revise policies and procedures to reflect and apply the new and revised language.] |  |  |  |
| **Laboratory, Radiology, and Other Diagnostic Services (§483.50)**  483.50(a)(2) Facility must: (i) Provide or obtain laboratory 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 **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.**  **NOTE: Identical language is also established at 483.50(b)(2) with respect to radiology and other diagnostic services:**  (2) The facility must:  (i) 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.** | * *[Example: Clinical leadership team to create policies that direct staff when and how to report specific test results by type and by range of abnormality. Often times the contracted laboratory will also have guidance for how staff should handle results notifications. It is important that any such guidelines be reviewed for appropriateness and for compliance with state law.]* |  | * *[What guidelines are to be used regarding “clinical reference ranges”?]* |  |
| **Dental Services (§483.55)**   * The facility must, if necessary **or if requested**, assist the resident—   (i) In making appointments; and  (ii) By arranging for transportation to and from the **dental services locations** (technical change to reflect that a dentist office is not the only location where a dental service may be provided).   * Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. |  |  |  |  |
| Food and Nutrition (§483.60)   * The facility must take into consideration the preferences of each resident. * The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care**.** [Will also tie to the facility-wide assessment in Phase 2.] * The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. * A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). * New language states that menus must**:**   + meet the nutritional needs of residents in accordance with established national guidelines**.**   + Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups;   + Be updated periodically;   + Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and   + Nothing should be construed to limit the resident's right to make personal dietary choices. * The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. * Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. * Food sources: (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. * A facility must 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. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Confirm/establish policies and procedures for documentation of training.]* |  |  |  |
| Specialized Rehabilitative Services (§483.65)  * Adds respiratory therapy to the list of specialized rehabilitative services that a facility must provide or obtain if it is required in the resident’s plan of care. * When it is necessary for a facility to obtain respiratory therapy from an outside resource, the services obtained must come from a provider of specialized rehabilitative services that is not excluded from participating in any federal or state health care programs.   NOTE: In response to comments pertaining to the availability of respiratory therapists to meet this need and related to the request for clear discussion of the qualifications necessary for individuals to furnish these services to help providers better understand how to meet these requirements, CMS stated:   * All specialized rehabilitative services are considered facility services and are included within the scope of facility services. Therefore, the facility must provide the necessary respiratory therapy services for all residents who need them, so that the needs of the resident are met and support the resident in attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Regulations at §483.70(f) discuss staff qualifications and specify that the facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of the requirements for LTC facilities. This would include those services related to specialized rehabilitative services, including respiratory therapy. In addition, the regulations at §483.70(f) require that professional staff must be licensed, certified, or registered in accordance with applicable state laws. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Assess internal and external capabilities of providing respiratory therapy services and take necessary steps to secure such services as needed (full-time, part-time or contracted).]* |  |  |  |
| Administration (**§**483.70)  * The governing body appoints the administrator who is— (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. * Transfer agreement. (1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that … (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community, will be exchanged between the providers, including but not limited to the information required under § 483.15(c)(2)(iii). * Binding arbitration agreements.   + (1) A facility must not enter into a pre-dispute agreement for binding arbitration with any resident or resident's representative nor require that a resident sign an arbitration agreement as a condition of admission to the LTC facility.   + (2) If, after a dispute between the facility and a resident arises, and a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.   **NOTE: On November 8, 2016, a federal judge enjoined CMS from enforcing the arbitration provisions above, so it will not take effect Nov. 28, 2016. This may be temporary, however, as CMS will likely pursue additional legal action to restore this provision.** | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *If organizational structure includes a CEO between the administrator and the Board, evaluate whether a change is needed to Board policies to reflect awareness of this rule and the Board’s appointment of the CEO as an intermediary.]* |  |  |  |
| Quality Assurance and Performance Improvement (§483.75) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:  (i) The director of nursing services;  (ii) The Medical Director or his or her designee;  (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role.  (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (Consistent with current regulation.)  (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. (Consistent with current regulation.) | * *[Example: Revise policies and procedures to reflect and apply the new language regarding composition of the QAA.]* |  |  |  |
| Infection Control (§483.80)  * Infection prevention and control program. The facility must establish an infection **prevention and** control program (IPCP) that must include, at a minimum, the following elements:   (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement …. and following accepted national standards (Phase 2: will also tie into facility-wide assessment)  (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv) 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. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Implement staff training as needed.]* |  |  |  |
| (v) 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  (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.  (3) [Antibiotic stewardship program. Phase 2 requirement.]  (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  - Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.  Also see 483.80(d)(1)-(2) re immunizations: “Resident representative” is referred to in several places; deletes current language that “a second pneumococcal immunization may be given after 5 years following the first …” |  |  |  |  |
| **Physical Environment (§ 483.90)**   * The facility must provide each resident with—(i) A separate bed of proper size and height for the **safety and** convenience of the resident; * Resident call system. The facility must be adequately equipped to allow residents to call for staff assistance through a communication system from which **relays the call directly to a staff member or to a centralized staff work area** from ….(bedside, bathroom). * For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. * For facilities that receive approval of construction from State and local authorities or are newly certified after November 28, 2016, each resident room must have its own bathroom equipped with at least a commode and sink. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Develop systems and standards for inspections of mattresses, bedframes, rails* * *If seeking approval of construction projects, be sure to assess the implication of the resident room provisions; seek additional guidance about what scope of project would trigger these requirements.* * *Notify corporate counsel of the “newly certified” language if organization is considering acquisition of another existing facility.* |  |  |  |
| Training Requirements (§483.95) 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. Training topics must include but are not limited to—  Phase 1 requirements are:  (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on— (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. (3) Dementia management and resident abuse prevention.  (g) Required in-service training for nurse aides. In-service training must— (1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (2) Include dementia management training and resident abuse prevention training. (3) Address areas of weakness as determined in nurse aides' performance reviews **[phase 2: and facility assessment at § 483.70(e)]** and may address the special needs of residents as determined by the facility staff. (4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  (h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160. | *[Examples:*   * *Revise policies and procedures to reflect and apply the new and revised language.* * *Update current training to reflect the new requirements.]* |  |  |  |