Indiana Department of Health

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) STATE OPERATIONS MANUAL (SOM) REVISIONS

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02/13/25

OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.

Revisions to LTCSP and SOM

CMS QSO-25-07-NH: original date Nov. 18, 2024, now:

QSO-25-12-NH: Guidance and training revised; updates to Appendix PP and the Long-Term Care Survey Process

Revised Guidance: Admission, Transfer & Discharge, Chemical Restraints/Unnecessary Psychotropic Medication, Resident Assessment, Nursing Services, Payroll Based Journal, Quality of Life and Quality of Care, Administration, Quality Assurance Performance Improvement (QAPI), Infection Prevention and Control, and other areas

Purpose of Revisions

- Health and safety updates are made regularly to address emerging trends in deficiency citations nationwide
- This ensures guidance remains aligned with current standards of practice and reflects the evolving needs of residents
- These updates are essential to maintaining the integrity of nursing home care

F 605 Right To Be Free From Chemical Restraints

F 605

- F 757 has been revised and reorganized to exclude unnecessary psychotropic medications
- F 758 deleted and incorporated into F605
- **Purpose:** Streamline the survey process, increase consistency and strengthen the prevention of unnecessary use of psychotropic medication

F 605 Change in Definition

Chemical Restraints: Convenience and Discipline

Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Facilities are responsible for knowing the effects medications have on their residents. If a medication has a sedating or subduing effect on a resident and is not being administered to treat a medical symptom, the medication is acting as a chemical restraint. These effects could indicate an intentional action to discipline or make care more convenient for staff, or the facility did not intend to sedate or subdue a resident, but an unnecessary medication is being administered that has that effect.

Convenience/Discipline

Convenience refers to the unnecessary administration of a medication that causes (intentionally or unintentionally) a change in a resident's behavior (e.g., sedation) such that the resident is subdued and/or requires less effort from staff. Therefore, if a medication causes symptoms consistent with sedation (e.g., excessive sleeping, drowsiness, withdrawal, decreased activity), it may take less effort to meet a resident's behavioral needs, which meets the definition of convenience.

Discipline refers to any action, such as the administration of a medication, taken by facility staff for the purpose of punishing or penalizing residents.

Examples of Convenience and Discipline

A resident has been wandering into other residents' rooms and staff administers a medication to restrict the resident to their room.

Staff becomes upset with a resident who resists receiving a bath and pinches staff. The staff did not assess the resident's needs or implement non-pharmacological interventions to address their resistance to bathing. Instead, staff administer medication to subdue the resident prior to providing the next bath.

Examples

A medication used for staff convenience or discipline that is not required to treat medical symptoms may cause:

- Sedation, such as sleeping during hours that he/she would not ordinarily sleep
- Withdrawal from activities and socializing
- Loss of autonomy and dignity
- Confusion, cognitive decline and depression
- Weight loss, decline in skin integrity or continence level
- Decline in physical functioning including an increased dependence in activities of daily living

F 605 Right to be Informed of Psychotropic Medication Use

Added guidance:

Resident's Right to be Informed

Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.

The resident has the right to accept or decline the initiation or increase of a psychotropic medication. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred.

F 605 Right to be Informed of Psychotropic Medication Use

- A written consent form may serve as evidence of a resident's consent to psychotropic medication, but other types of documentation are also acceptable
- If a psychotropic medication has been initiated or increased, and there is no documentation demonstrating compliance with the resident's right to be informed and participate in their treatment, noncompliance with §483.10(c) exists and F 552 must be cited
- A finding of deficient practice at F 605 will initiate the abuse icon on the nursing home compare report

Definitions

Psychotropic drugs are any drug that affects brain activities associated with mental processes and behavior including, but not limited to, anti-psychotic, anti-depressant, anti-anxiety and hypnotic medications.

Unnecessary drugs are any drug when used in excessive dose (including duplicate drug therapy), for excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of these reasons.

Based on comprehensive assessment, the facility must ensure:

- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record
- Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs
- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record
- PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
- PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication

F 627 and F 628 Admission, Transfer, Discharge

Admission, Transfer, Discharges

CMS is deleting the following F tags:

- F 622-626
- F 660 Discharge Planning Process
- F 661 Discharge Summary

These tags will be incorporated into new F 627 and F 628

New F 627: Transfer and Discharges

Incorporates F 622, F 624 and F 626

Language changes:

- The language for, “facility-initiated” and, “resident-initiated” is not included in F 627 or F 628
- When a resident is sent to an acute care setting emergently, this is considered a transfer since the resident’s return is generally expected

Intent:

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

F 627 Intent

- Ensure policies are developed and implemented which allow residents to return to the facility following hospitalization or therapeutic leave
- Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred
- Ensure that the discharge planning process addresses each resident's discharge goals and needs, including caregiver support and referrals to local agencies, as appropriate. It should also involve the resident, and, if applicable, the resident's representative and the interdisciplinary team, in developing the discharge plan.

F 627 Transfer Discharge Requirements

§483.15(c)(1)(i)-(ii) Transfer and Discharge Requirements - Use guidance at this F tag to determine if noncompliance exists when evidence suggests a facility should not have transferred or discharged a resident at the time of discharge, or at all. These circumstances may include, but are not limited to, the following.

When evidence in the medical record does not support the basis for discharge, such as:

- Discharge based on an inability to meet the resident's needs, but there is no evidence of facility attempts to meet the resident's needs, or no evidence of an assessment at the time of discharge indicating what needs cannot be met
- Discharge based on improvement of resident's health such that the services provided by the facility are no longer needed, but documentation shows the resident's health did not improve or declined

F 627 Transfer Discharge Requirements Cont.

- Discharge based on the endangerment of the safety or health of individuals in the facility, but there is no documentation in the resident's medical record that supports this discharge
- Discharge based on failure to pay, however there is no evidence that the facility offered the resident to pay privately or apply for Medical Assistance or that the resident refused to pay or have paid under Medicare or Medicaid
- Discharge occurring even though the resident appealed the discharge, the appeal is pending, and there is no documentation to support the failure to discharge would endanger the health and safety of individuals in the facility
- When evidence in the medical record shows that a resident was not permitted to return following hospitalization or therapeutic leave, and there is no valid basis for discharge
- There is no evidence that the facility considered the caregiver's availability, capacity, and/or capability to perform needed care to the resident following discharge
- The post-discharge plan of care did not address resident limitations in ability to care for themself

F 627 Discharge when Needs Cannot be Met or Safety or Health of Individuals is Endangered

§483.15(c)(1)(i)(A), (C) or (D)

Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs cannot be met based on the Facility Assessment requirements at §483.70(e) (see also F 838, Facility Assessment).

The facility must fully evaluate the resident and not base the discharge on the resident's status at the time of transfer to an acute care facility. Without an assessment of the resident's status and needs at the time of proposed return to the facility, there can be no determination of (A), the resident's needs cannot be met, or (C) and (D), that the safety or health of individuals would be endangered.

F 627 Needs

- In situations where a resident's choice to refuse care or treatment poses a risk to the resident's or others' health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate
- (F 656, Comprehensive Care Plans) The facility must be able to demonstrate the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment (F 552 and F 578) and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others; and see (§483.20 Resident Assessment and 483.35 Nursing Services)
- If the facility is unable to resolve situations where a resident's refusal of care poses a risk to the resident's or others' health or safety, the facility administration, nursing and medical directors may wish to convene an ethics meeting, including legal consultation, to determine whether the facility can meet the resident's needs or if the resident should be transferred or discharged

F 627 Nonpayment as Basis for Discharge

§483.15(c)(1)(i)(E) Nonpayment as Basis for Discharge

Non-payment for a stay in the facility occurs when the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and may apply:

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

F 627 Nonpayment

The facility must notify the resident or representative of a change in payment status and ensure the resident has necessary assistance to submit third-party paperwork. If exploitation or misappropriation from a representative is suspected, the facility should take steps to notify the appropriate authorities before discharging the resident.

In situations where a resident's Medicare coverage may be ending, the facility must comply with the requirements at §483.10(g)(17) and (18), F 582. If the resident continues to need long-term care services, the facility, under the requirements above, should offer the resident the ability to remain, which may include:

- Offering the resident the option to remain in the facility by paying privately for a bed;

F 627 Nonpayment

Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F 579, with an explanation that:

- If denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and
- If found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid

The resident cannot be discharged for nonpayment while a determination on the resident's Medicaid eligibility is pending.

F 627 Discharge Pending Appeal

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

When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending.

If the resident, or if applicable, their representative, appeals his or her discharge while in a hospital, facilities must allow the resident to return pending their appeal, unless there is evidence that the facility cannot meet the resident's needs, or the resident's return would pose a danger to the health or safety of the resident or others in the facility. A facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending must not be based on the resident's condition when originally transferred to the hospital.

F 627 Appeal (new information)

Successful Appeals on Discharges

For residents who have appealed their discharge and obtained a favorable ruling from the hearing, the resident or their representative may choose to report the discharge as a complaint to the State Survey Agency based on the favorable appeal ruling. However, the State Survey Agency cannot take a survey action, such as citing noncompliance exclusively based on the ruling of the hearing. Rather, the State Survey Agency must triage the complaint and conduct a survey. During the survey, surveyors must investigate compliance with the applicable regulations, such as the discharge requirements in this F-tag. Surveyors should also consider compliance with §483.70(b), Compliance with Federal, State, and local laws and professional standards at F 836. If noncompliance is found, cite the appropriate tag and level of scope and severity. **Also, if the resident's discharge location is to a setting that does not meet their health or safety needs, the facility's plan of correction should state that the facility will either, 1) Re-admit the resident until a safe and compliant discharge can be done, or 2) Coordinate a transfer of the resident to another setting where they will be safe.**

F 627 Required Documentation in the Medical Record

For circumstances where the discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs or the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the **resident's physician** must document information about the basis for the transfer or discharge. Additionally, if the facility determines it cannot meet the resident's needs, the documentation made by the **resident's physician must** include:

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

In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician (can be a non-physician practitioner.)

F 627 Bed Hold and Permitting Residents to return

§483.15(d)(1) – (e)(1)-(2) Bed Hold and Permitting Residents to Return

Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. **These policies apply to all residents, regardless of their payment source.** The facility policies must provide that residents who seek to return to the facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period or **when state law does not provide for bed-holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident**:

- Still requires the services provided by the facility; and
- Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services

The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements at 42 CFR 483.15(c).

Medicaid-eligible residents must be permitted to return to the first available bed even if the residents have outstanding Medicaid balances.

F 627 Not Permitting Residents to Return

***§483.15(e)(1)(ii)* Not Permitting Residents to Return**

Not permitting a resident to return following hospitalization or therapeutic leave constitutes a discharge and requires a facility to meet the requirements as outlined in §483.15(c)(1)(ii).

Because the facility was able to care for the resident prior to the **hospitalization** or therapeutic leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

If the facility does not permit a resident's return to the facility (i.e., discharges the resident) based on inability to meet the resident's needs, documentation must be in accordance with requirements. The facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

F 627 Preparation for Transfer or Discharge

§483.15(c)(7) Preparation for Transfer or Discharge

Sufficient preparation and orientation means the facility informs the resident where he or she is going and takes steps under its control to minimize anxiety. Examples of preparation and orientation may include explaining to a resident why they are going to the emergency room or other location or leaving the facility; working with family or resident's representative to assure the resident's possessions (as needed or requested by the resident) are not left behind or lost.

The facility must orient and prepare the resident regarding his or her transfer or discharge in a form and manner the resident can understand and must take into consideration factors that may affect the resident's ability to understand, such as educational level, language and/or communication barriers, and physical and mental impairments.

The facility must also document this orientation in the medical record, including the resident's understanding of the transfer or discharge.

F627 Discharge Planning

§483.21(c)(1) Discharge Planning

The discharge care plan is part of the comprehensive care plan and must:

- Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;
- Address the resident's goals for care and treatment preferences;
- Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;
- Be re-evaluated regularly and updated when the resident's needs or goals change;
- Document the resident's interest in, and any referrals made to the local contact agency; *and*
- Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance

F 627 Discharge Planning

To community: the nursing home must determine if appropriate and adequate supports are in place, including capacity and capability of the resident's caregivers at home. Family members, significant others or the resident's representative should be involved in this determination, with the resident's permission, unless the resident is unable to participate in the discharge planning process. The nursing home staff is responsible for making referrals to the local agency if appropriate, under the process that the State has established.

Nursing home staff should also make the resident and if applicable, the resident representative aware that the local ombudsman is available to provide information and assist with any transitions from the nursing home. New or improved community resources and supports may have become available since the resident was first admitted which may now enable the resident to return to a community setting.

To SNF, IRF, LTCH, or HHA: the facility must assist the resident in choosing an appropriate post-acute care provider that will meet the resident's needs, goals, and preferences. Information the facility must gather about potential receiving providers includes, but is not limited to:

Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and

Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.

F 627 Discharge Planning

The post-discharge plan of care must be developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the resident's representative. At the resident's request, a representative of the local contact agency may also be included in the development of the post-discharge plan of care. The post-discharge plan of care should show what arrangements have been made regarding:

- Where the resident will live after leaving the facility;
- Follow-up care the resident will receive from other providers, and that provider's contact information;
- Needed medical and non-medical services (including medical equipment);
- Community care and support services, if needed; and
- When and how to contact the continuing care provider

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

Note: These situations only apply when a resident expresses their wishes to be discharged earlier than outlined in the care plan. These situations do not apply if a facility offers to discharge a resident to a location which does not meet their health and/or safety needs, and the resident agrees (this would constitute noncompliance).

F 627 Deficiency Categorization

Violations of the requirements at F627, Inappropriate Discharges, would generally be cited at the severity level of Harm (Level 3) or Immediate Jeopardy (Level 4) when using the reasonable person approach in considering psychosocial outcomes as well as the likelihood for serious physical harm resulting from an unsafe discharge.

Level 4:

Did not allow a resident to remain in facility during an appeal and dropped resident at daughter's home, even though daughter indicated she could not care for the resident.

Resident discharged due not being able to meet needs. Found that that needs could be met as facility was caring for other residents with similar behaviors. Resident discharged with medical needs.

Resident could not return after leave and facility took no steps to comply with discharge requirements. Resident found living on the street without needed care, food, and shelter.

Resident with the G-tube discharged to a residential setting and within 24 hours of discharge the resident was transferred to the hospital for aspiration which resulted in brain death.

Please read the level 2 and 3, level 1 does not apply.

F 627 new POC requirement

For citations at **any** level of scope and severity, if the discharged resident's health and/or safety is threatened in the setting they are currently located, the facility's plan of correction should state that the facility will either,

1) Re-admit the resident until a safe and compliant discharge can be done, or
2) Coordinate a transfer of the resident to another setting where they will be safe. The facility should not be determined in substantial compliance until one of these two items is complete (and all other noncompliance has been corrected).

If the resident's needs are being met in their current location, the plan of correction should include specifics on how the facility will prevent inappropriate noncompliant discharges in the future.

F 627 New Enforcement

For situations in which residents' discharge locations did not meet their health and/or safety needs, enforcement should be implemented immediately. For example, a discretionary denial of payment for new admissions should be imposed to go into effect within 2 or 15 days (as appropriate) and remain in effect until a return to substantial compliance as evidenced by either,

1) the resident is readmitted and not discharged unless a safe and compliant discharge is done, or
2) the facility coordinates a discharge to another setting where their needs will be met.

F 628 Documentation

Incorporation of F 623 and F 625

Intent

- Documentation of specific information communicated with the receiving provider to ensure safe and effective transition of care
- Providing notice of transfer, discharge, and bed holds to ensure the facility adheres to all the applicable components of the transfer/discharge process
- Completing the discharge summary to be furnished at time resident leaves facility, to the receiving responsible party (hard copy or electronic)

F 628 Information Conveyed to Receiving Provider

§483.15(c)(2) If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider:

- Contact information of the practitioner who was responsible for the care of the resident;
- Resident representative information, including contact information;
- Advance directive information;
- All special instructions and/or precautions for ongoing care, as appropriate such as:
  - Treatments and devices (oxygen, implants, IVs, tubes/catheters);
  - Transmission-based precautions such as contact, droplet, or airborne;
  - Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;

F 628 Continued

The resident's comprehensive care plan goals; and all other information necessary to meet the resident's needs, which includes, but may not be limited to:

- Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;
- Diagnoses and allergies;
- Medications (including when last received); and
- Most recent relevant labs, other diagnostic tests, and recent immunizations

Additional information, if any, outlined in the transfer agreement with the acute care

F 628 Discharge Return Not Anticipated

For residents being discharged (return not expected), the facility must convey all the information listed above, along with a copy of the required information found at §483.21(c)(2) Discharge Summary, as applicable.

- §483.21(c)(2)(i) Recapitulation of Resident's Stay
- §483.21(c)(2)(ii) Final Summary of Resident Status

Items required to be in the final summary of the resident's status are:

- Identification and demographic information;
- Customary routine, cognitive patterns, communication, Vision, mood and behavior patterns, psychosocial well-being

Physical functioning and structural problems, continence, disease diagnoses and health conditions, dental and nutritional status, skin condition, activity pursuit, medications, special treatments and procedures. discharge planning (as evidenced by most recent discharge care plan).

Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and

Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.

F 628 Reconciliation of Medications

§483.21(c)(2)(iii) Reconciliation of Medications Prior to Discharge

Facility staff must compare the medications listed in the discharge summary to medications the resident was taking while residing in the nursing home. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes.

Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative, must accurately reflect the reconciled medication list in the discharge summary.

F 628 Notice of Transfer or Discharge and Ombudsman Notification

§483.15(c)(3) Notice of Transfer or Discharge and Ombudsman Notification

When a facility transfers or discharges a resident, prior to the transfer or discharge, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A 30-day notice is still required unless an emergency, then soon as possible.

Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman.

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative before the discharge and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman.

F 628 Notice of Transfer or Discharge and Ombudsman Notification

The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for ombudsman notification in their state.

Indiana:

- Acute discharge monthly
- Other discharges 30 days, if emergency discharge as soon as possible

Timely notification to the SLTCO and local Ombudsman Representative:

Notices must be sent to the SLTCO through the LTCOP's secure, encrypted web-based portal at https://in-ombudsman-pff.peerplace.com/.

F628 Content of Discharge Notice

§483.15(c)(5) Contents of the Notice

The facility's notice must include all the following at the time notice is provided:

- The specific reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F);
- The effective date of the transfer or discharge;
- The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged;
- An explanation of the right to appeal the transfer or discharge to the State;
- The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
- Information on how to obtain an appeal form;
- Information on obtaining assistance in completing and submitting the appeal hearing request; and
- The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman.

F628 Timing of Notice

§483.15(c)(4) Timing of the Notice

Generally, this notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:

The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;

The resident's health improves sufficiently to allow a more immediate transfer or discharge;

An immediate transfer or discharge is required by the resident's urgent medical needs; or

A resident has not resided in the facility for 30 days.

In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.

F 628 Changes to the Notice

§483.15(c)(6) Changes to the Notice

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. For significant changes, such as a change in the transfer or discharge destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date to provide 30-day advance notification and permit adequate time for discharge planning.

§483.15(c)(8) Notice in Advance of Facility Closure:

Refer to §483.70(l), F845 for guidance related to evaluating Notice in Advance of Facility Closure.

§483.15(d) Notice of Bed-Hold Policy (Indiana does not pay for bed-holds)

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. Notice should be given at time of transfer or within 24 hours. Should make multiple attempts. Must explain duration of bed hold, if any, payment policy, and permitting to return.

MDS changes

F637 Significant Change Assessments

Comprehensive assessment after a significant change:

Revisions were made to update the language regarding levels of assistance a resident receives for self-care and mobility activities to be consistent with Section GG.

F641 Before Changes

F641

(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

§483.20(g) Accuracy of Assessments.

The assessment must accurately reflect the resident's status.

F642 Before Changes

F642

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

§483.20(h) Coordination.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

§483.20(i) Certification.

§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.

§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment...

F642 Before Changes Continued

§483.20(j) Penalty for Falsification.

§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly—

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.

F641 After Changes

F641
(Rev.)
§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
§483.20(i) Certification.
§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.
§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
§483.20(j) Penalty for Falsification.
§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-
(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.

F641-Diagnosis Coding Updates

Inaccurate MDS Diagnosis Coding

CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia.

Surveyors should investigate this concern through record review and interviews with staff who completed the assessment. Surveyors are not questioning the physician's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.

Schizophrenia Diagnosis Documentation

Supporting documentation should include, but is not limited to

- Evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions,
- Ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions,
- Indications of distress,
- Changes in functional status,
- Resident complaints, behaviors, symptoms, and/or
- Preadmission Screening and Resident Review (PASARR) evaluation

Inaccurate MDS Diagnosis Coding

- One or two assessments with inaccurate MDS diagnosis coding should be cited, at F641, as isolated
- If the surveyor identifies a pattern (i.e., three or more) of inaccurate coding for a new diagnosis (such as schizophrenia) with no supporting documentation by a physician, the surveyor should cite the scope of the non-compliance at a minimum of pattern or widespread as appropriate
- Make appropriate referrals to the State Board of Nursing and the Office of the Inspector General as needed

Other Areas To Investigate

When concerns related to a diagnosis that lacks sufficient supporting documentation are identified, surveyors should review:

- F658: to determine if the documentation supports a diagnosis in accordance with standards of practice
- F644: to determine if the facility made a referral to the state designated authority (Family and Social Services Administration [FSSA] in Indiana) when a newly evident or possible serious mental disorder was identified
- F758: to evaluate psychotropic medication use based on a comprehensive assessment
- F841: to evaluate the medical director's oversight of medical care

Certification of Accuracy And Completion

Whether MDS assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of their responses. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the assessment.

Electronic Signatures

- When MDS forms are completed directly on the facility's computer, each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s) they completed
- Electronic signatures on the MDS are acceptable. The facility must have a written policy in place to safe-guard electronic signatures from being used by anyone other than the person to which they belong.

Backdating Completion Dates

- Backdating completion dates is not acceptable
- Recording the actual date of completion is not considered backdating
- For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating

Uses of MDS Data

- Clinical basis for care planning and care delivery
- Provides information for Medicare and Medicaid payment systems
- Quality monitoring
- Public reporting
- Payment rate implications

A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures.

Inaccuracies And Potential Fraud

- The MDS Assessment should reflect the resident's status at the time of the assessment reference date (ARD)

- Patterns of inaccurate MDS Assessments or reporting practices could result in
  - Higher reimbursement (payment fraud)
  - Care area assessments (CAAs) that are not triggered for care planning
  - Quality measures that are not flagged (an attempt to avoid negative quality measures)

Examples Of Potential Patterns

- Submitting MDS Assessments where the information does not accurately reflect the resident's status as of the ARD
- Submitting corrections to assessments in IQIES when the information in the correction does not accurately reflect the resident's status as of the original ARD or submitting a correction when there does not appear to have been an error
- Submitting a significant change in status assessment when the criteria for a significant change in the resident's status do not appear to have been met
- Delaying or withholding MDS Assessments

Investigative Procedures

- Use the Resident Assessment Critical Element Pathway when MDS concerns are noted, but the surveyor is not using a care area pathway
- Surveyors should focus on MDS coding accuracy but are not expected to investigate possible falsification of the MDS
- If the surveyor identifies a pattern (three or more residents) of inaccurate MDS coding by staff who completed, signed, and certified the accuracy of the portion of the MDS they completed, and there are indications the individual who completed the section knew the coding was inaccurate, a referral to the Office of Inspector General for the investigation of falsification is required. The SOM has more information on how to make a report if needed.

F 658 Comprehensive Care Plans

F 658 Comprehensive Care Plans Changes related to Nursing Services and the use of Psychotropic Medication

§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality.

INTENT

To assure that ALL services, as outlined by the comprehensive care plan, being provided meet professional standards of quality.

Mental Disorders are diagnosed by a practitioner, using evidence-based criteria and professional standards, such as the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and are supported by documentation in the resident's medical record. Supporting documentation should include, but is not limited to, evaluation of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation. These type of evaluation should be done on admission also.

F 658 Documentation

Insufficient documentation for a new mental health diagnosis means that the resident's medical record **does not** contain the following:

Documentation (e.g., nurses' notes) indicating the resident has had symptoms, disturbances, or behaviors consistent with those listed in the DSM criteria, **and** for the period in accordance with the DSM criteria.

Documentation from the diagnosing practitioner indicating that the diagnosis was given based on a comprehensive assessment, such as notes from a practitioner's visit.

Documentation from the diagnosing practitioner indicating that the symptoms, disturbances, or behaviors are not attributable to (i.e., ruled out) the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., UTI or high ammonia levels).

Documentation regarding the effect the disturbance is having on the resident's function, such as interpersonal relationships, or self-care, in comparison to their level of function prior to the onset of disturbance.

The medical record must include documentation of **ALL** of these items, if not, this would constitute insufficient documentation.

F 658 Deficiency Categorization

If the surveyor identifies a pattern (e.g., three or more) of residents who have a new diagnosis which lacks sufficient supporting documentation, the surveyor should cite the scope of the non-compliance at a minimum scope of pattern (e.g., level 2 = "E," Level 3 = "H," or Level 4 = "K").

Additionally, the surveyor should discuss the findings with their state agency to consider referring a physician, nurse practitioner, clinical nurse specialist, or physician assistant to their respective state board (e.g., state medical board, state nursing board, etc.).

F 678
Cardiopulmonary Resuscitation (CPR)

F 678 Cardiopulmonary Resuscitation (CPR)

CPR certification guidance revised to align with current nationally accepted standards and references the American Heart Association (AHA) guidelines.

The new guidance indicates staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards.

The facility must ensure the training includes hands-on practice and in-person skills assessment.

F 697 Pain Management

F 697 Pain Management

Added CDC definitions for acute, chronic, and subacute pain

- **Acute Pain** refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery
- **Chronic Pain** refers to pain that typically lasts greater than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause
- **Subacute Pain** refers to pain that has been present for 1–3 months

Use of Opioids for Pain Management

Opioid treatment for pain needs to be appropriately assessed and individualized for each resident.

When starting opioid therapy for acute, subacute, or chronic pain, clinicians may consider prescribing immediate-release opioids instead of extended-release and long-acting.

Resource links

- Exposure-Response Association Between Concurrent Opioid and Benzodiazepine Use and Risk of Opioid-Related Overdose in Medicare Part D Beneficiaries, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685628
- National Institute on Drug Abuse Benzodiazepines and Opioids, https://nida.nih.gov/researchtopics/opioids/benzodiazepines-opioids
- Geriatricpain.org, Resources and Tools for Quality Pain Care, https://geriatricpain.org/
- The Society for Post-Acute and Long-Term Care Medicine (AMDA) Opioids in Nursing Homes, https://paltc.org/opioids%20in%20nursing%20homes
- Centers for Disease Control Clinical Practice Guidelines for Prescribing Opioids for Pain, https://www.cdc.gov/opioids/patients/guideline.html

F 725 Sufficient Staffing

F 725 Sufficient Nursing Staff

- The PBJ staffing data report will be used as a source of information.
- Defines licensed nurse, charge nurse, and scope of practice.
- The facility is required to provide licensed nursing staff 24-hours a day unless waived, along with other nursing personnel, including but not limited to, nurse aides.
- The facility must also designate a licensed nurse to serve as a charge nurse on each tour of duty.

Sufficient Nursing Staff, RN 8 Hrs./7days/Wk., Full Time DON, & Payroll Based Journal

Guidance for investigations using the Payroll Based Journal Staffing Data Report has been added and this report will be used by surveyors as one of the sources of information indicative of potential noncompliance.

Instructions specific to staff interviews, observations, key elements of noncompliance, and deficiency categorization were added to the guidance.

Instructions to surveyors based on whether or not the report identified concerns were added to the guidance.

Investigative probes were added to the guidance for

- The Director of Nursing requirements,
- Deficiency categorization examples,
- Investigative procedures for evaluating compliance with the submission of direct care staffing information and payroll using the Payroll Based Journal Staffing Data Report

New Definitions

"Licensed Nurse" refers to any nurse that successfully completed the required National Council Licensure Examination (NCLEX-PN or NCLEX-RN).

- At a minimum this includes a Licensed Practical Nurse (LPN) or a Registered Nurse (RN)
- Licenses and titles are defined and protected by the Nurse Practice Act (NPA) for use in the public. The licenses and titles are privileged and granted by the Board of Nursing (BON) after the nurse meets the requirements for graduation from an accredited nursing educational program, passing professional board examinations, background checks, and paying applicable fees.

"Charge Nurse" refers to a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care.

"Scope of Practice" describes the services that a qualified health professional is deemed competent to perform and permitted to undertake – in keeping with the terms of their professional license.

F 725 Key points

- The facility assessment of the resident population contributes to the identification of staffing decisions and informs the facility about what skills and competencies staff must possess to deliver the necessary care required by the residents being served on any given day
- The facility is required to provide licensed nursing staff 24-hours a day, along with other nursing personnel, including but not limited to nurse aides
- The facility must also designate a licensed nurse to serve as a charge nurse on each tour of duty
- Concerns such as falls, weight loss, dehydration, pressure ulcers, elopement and resident altercations can also offer insight into potential insufficient numbers of staff available in the facility. Surveyors must discuss these concerns during team meetings and investigate how or if these adverse outcomes are related to sufficient staffing

F 725 Key points

Compliance with State staffing standards does not necessarily determine compliance with Federal staffing standards that require a sufficient number of staff to meet all of the residents' basic and individualized care needs.

- If a facility does not meet the state regulations requirements for staffing, the deficient practice will NOT be cited at F 725. The deficient practice will be investigated using F 836 Administration.
- F 725 should be cited if non-compliance related to a facility not providing services by a sufficient number of nursing personnel (licensed and non-licensed), not providing licensed nursing staff 24-hours a day, and/or does not have a licensed charge nurse on each tour of duty

NOTE: The actual or potential physical, mental, or psychosocial resident outcomes related to noncompliance cited at F725 should be investigated at the relevant tags, such as Abuse at §483.12, Quality of Life at §483.24, and/or Quality of Care at §483.25.

Investigative Procedures

- Surveyors will use the Sufficient and Competent Nurse Staffing Critical Element Pathway, the interpretive guidance, and procedures, to determine if the facility meets the requirements for, or investigating concerns related to sufficient staffing
- The facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system in accordance with F 851
- When completing the offsite preparation for a recertification survey, the team coordinator must obtain the PBJ Staffing Data Report and evaluate PBJ data submitted by the facility. This data is available through PBJ reports that can be obtained through CMS' survey system.

To cite deficient practice at F725

The surveyor's investigation will generally show that the facility failed to do any one of the following:

- Ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care; **or**
- Ensure licensed nurse coverage 24 hours a day, except when waived; this must be done by utilizing the PBJ Staffing Data Report. If the facility triggers on the report under the category of "No Licensed Staff," a citation at F725 should be issued at a minimum severity and scope of "F;"

or

- Ensure a licensed nurse is designated to serve as a charge nurse on each tour of duty, except when waived.

F 851 PBJ Data

F 851 PBJ Staffing Data Report

Many factors need to be considered when determining if a facility has sufficient nursing staff to care for residents' needs including, but not limited to, the facility assessment, the resident assessments, their plans of care, and the PBJ Staffing Data Report.

The PBJ Staffing Data Report

- Provides very clear and distinct areas that could identify deficient practices,
- Must be utilized by surveyors on at least every recertification survey, and
- Contains information about overall direct care staffing levels and licensed nurse staffing.

The surveyors will use the PBJ Staffing Data Report as a starting point to determine the facility's compliance with F725.

Purpose of the PBJ Staffing Data Report

The report identifies if the facility:

- Reported no RN hours (F 727),
- Failed to have Licensed Nursing Coverage 24-hours/day (F 725),
- Reported excessively low weekend staffing (F 725),
- Has a one-star Staffing Rating (F 725),
- Failed to submit PBJ data for the quarter (F 851), and
- Identifies the specific infraction dates when a facility reported they had no RN hours and failed to have a licensed nurse on duty for 24 hours in a day

The staffing domain of the Five Star Quality Rating system is based on six specific measurements that are derived from the PBJ data submitted by the facility.

Investigative procedures

The PBJ Staffing Data Report will be reviewed during offsite preparations for recertification survey and as applicable for abbreviated surveys, such as,

- Focused Concern Surveys (FCS)
- Resource and Support Surveys (RSS)
- Complaints

The LTC survey Team Coordinator (TC) must document any discrepancies identified in the PBJ Staffing Data Report offsite preparation review in the Long-Term Care Survey Process (LTCSP) software offsite preparation screen to inform all team members of staffing concerns prior to the team entering the facility.

Note: CMS expects every team member to be aware of the offsite preparation information prior to entering the facility.

NO licensed nursing coverage 24-hours/day

If this metric is triggered on the PBJ Staffing Data Report:

- During the entrance conference, the TC must inform the facility of these infraction dates and that a citation at F725 will be issued unless evidence is provided that shows the facility had licensed nursing coverage 24hours/day on those infraction dates
- Acceptable evidence is timecards, timesheets, or payroll information that clearly shows licensed nurse coverage on the dates in question
- A schedule of who was supposed to work is **NOT** acceptable

If the facility does not provide acceptable evidence, a citation at **F725** must be cited at a **minimum of scope and severity of "F".** The scope and severity may be increased based on further investigation throughout the survey.

If the facility does provide the evidence there was 24-hour licensed nursing coverage, surveyors must continue to conduct investigations to assess compliance with the requirements for facilities to have sufficient nurse staffing.

Note: If the facility failed to have licensed nursing coverage 24-hours/day, (e.g., four or more days as indicated by the PBJ Staffing Data Report or for even just one day as indicated through general investigations), **F725 must be cited**.

Interviews

If licensed nurse (LN) coverage is absent on one or more days the surveyor will conduct additional interviews with the Administrator, Director of Nursing (DON), and front-line staff (CNAs, Licensed nurses) to provide insight into the severity of deficient practice that may have already been identified, such as incidents that caused harm or placed residents in immediate jeopardy (IJ) for serious harm when a licensed nurse was not available.

Examples:

Director of Nursing or Administrator- What types of services or care are not provided when there is no Licensed Nurse staff on duty in a 24-hour period?

Front line staff-Who do you notify in the event of an emergency when there is no licensed nurse available?

> If the staff member is not aware of who to notify, ask if they've ever experienced this situation and what actions did they take? Was any resident harmed?
>
> If the staff member is aware of who to notify, what direction were they given? Was any resident harmed?

When the PBJ does not trigger:

The surveyor will ask generalized questions about the facility's ability to provide sufficient staffing using the probes provided in the LTCSP software application if the PBJ Staffing Data Report pertaining to F725, did not trigger for

- Failed to have Licensed Nurse Coverage 24-hours/day,
- Reported Excessively Low Weekend Staffing, or
- Has a One-star Rating Ratio

Additional investigations

PBJ Staffing Data Report areas:

- One Star Staffing Rating
- Excessively low Weekend Staffing

One Star Staffing Rating

If the facility triggered for **One Star Staffing Rating,** surveyors must interview at least two additional front-line staff (e.g., housekeeping, dietary, and/or maintenance) with focused questions such as:

- Have you noticed the facility not having enough staff, especially during the last six months?
- Have you observed the facility not having enough staff to meet residents' needs, such as residents waiting a long time for someone to help them? How often does this happen?
- Do you ever smell bad odors when you are walking through the facility, for example, when a resident did not receive toileting or incontinence assistance in a timely manner?
- Do you ever hear residents or their friends and family complain about not enough staff to provide the care needed?

Excessively Low Weekend Staffing

If the facility triggered for **Excessively Low Weekend Staffing,** surveyors must interview at least two additional front-line staff (housekeeping, dietary, and/or maintenance) with focused questions such as:

- Are there ever times when there are not enough staff to take care of the residents on the weekends? For example, are any residents calling for assistance for extended periods of time? If so, can you describe what happened to any residents affected?
- If there have not been enough staff during those times, do you know who you can alert to ensure that the residents needs are met?
- If you have ever notified that person, what was their response?
- Have weekend activities ever been canceled due to lack of staffing to get residents up and dressed to attend (e.g., church services or day trips)?
- Are beds left unmade and rooms messy on the weekend?

If **Excessively Low Weekend Staffing is triggered, the surveyor will** review the Facility Assessment to evaluate if the facility assessed resident needs and acuity to determine the number of qualified staff needed to meet each resident's needs.

Resident and Resident Representative Interview Examples

Facility Residents and/or Resident Representatives (including resident council)

- Has the facility informed you that care could not be provided because there wasn't a LN available?
- Do you receive the help and care you need without waiting a long time?

Staff Interview Examples

Nursing Staff

During interactions with staff, ask if they feel they have enough staff to meet resident needs and the training/skills needed to provide the care required. If no, additionally interview staff using the probes below to further evaluate staff sufficiency.

- Do you have enough time to complete your required assignments each day? If not, why, and what assignments are you not able to complete? Who do you report this to?
- Are you able to participate in care planning, attend team meetings and trainings, take meal breaks and provide the care residents need?
- How often are you asked to stay late, come in early, or work overtime? Tip: this assists in determining the frequency of open shifts, which provides insight into the extent of any staffing issues in the facility.
- Are you aware of who is the designated charge nurse on each shift?

Director of Nursing and Health Facilities Administrator

- What are the facility process to ensure resident needs are met during difficult staffing occurrences?

Staff Interviews

Dietary/Kitchen/Dining Staff

Interview staff if concerns related to resident food, weight loss, or nutrition are identified and are potentially related to nurse staffing.

- Do you hear residents complain about their food getting cold while they wait to be assisted by nursing staff?
- Do you see food trays come back untouched that might indicate insufficient nursing staff?
- Are you aware of any residents that might be absent because nursing staff was not available to assist them to the dining room?

Observation Examples

- Are there offensive odors? If so, what is the source?
- Do residents receive timely assistance with care needs, such as toileting and eating?
- Are residents still in bed and not dressed mid-morning or remain unkempt or unclean for extended periods of time?
- Are residents' care activities consistent with the time of day/night and their individual personal preferences, rather than at a time that is convenient for staff (e.g., bathing residents during normal hours of sleep)?
- Do staff rush when providing resident care (e.g., neglecting to explain what they are doing when assisting residents)?

Observation Examples

- Are call devices and alarms responded to timely? If concerns about staff responsiveness exist, monitor when the resident's call device is activated and record the response time of the staff.
- Are residents yelling out, crying, sitting around the nurse's station or in hallways without staff intervention, or wandering unsupervised and at risk?
- Are residents showing signs of sedation making it easier (i.e., convenient) for staff to care for or monitor residents, indicating the potential use of unnecessary psychotropic medications/chemical restraints?
- Are devices or practices in use that restrict freedom of movement (e.g., position change alarms or reclining chairs) making it easier for staff to care for or monitor residents, indicating the potential use of physical restraints?
- Are there delays in residents receiving their medications timely?
- When observing care or services provided by nursing staff, do they demonstrate competency according to professional standards?

F851 Mandatory submission of staffing information based on payroll data in a uniform format.

The most recent quarterly PBJ Staffing Data Report will be reviewed prior to recertification and complaint surveys.

If the report identifies the facility triggered for, “Failed to Submit Data for the Quarter.” and noncompliance is identified, F851 will be cited at a scope and severity of “F”, No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy.

F 841 Medical Director

F841 Responsibilities of the Medical Director

Medical Director responsibilities must include:

- Implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care
- Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her (Refer to F868)
- Addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities
- Active involvement in the process of conducting the facility assessment (Refer to F838)

Medical Director Responsibilities Should Include:

New: Administrative decisions including recommending, developing and approving facility policies related to resident care. Resident care includes the resident's physical, mental and psychosocial well-being.

Revised: Discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care, for example, physicians assigning new psychiatric diagnoses and/or prescribing psychotropic medications without following professional standards of practice.

F 841 Added Deficiency Categorization Example

Level 2

- The medical director, who is responsible for overseeing the medical care in the facility, was made aware of residents newly diagnosed with schizophrenia by their physician and/or other practitioner and their medical records did not contain documentation to support the new diagnoses.
- The medical director did not review the medical records for these residents, nor did he/she discuss the new diagnoses with the residents' physician and/or diagnosing practitioner.
- This practice resulted in residents being potentially misdiagnosed with schizophrenia and receiving antipsychotic medications. None of the residents experienced harm, but they were at risk for harm by receiving treatment, including antipsychotic medications, when they may not have been clinically indicated.
- Note: If this occurred on three or more residents, at minimum, this would be cited at a scope of pattern

F 867 Quality Assessment and Assurance

F 867 Quality Assessment and Assurance

The facility should ensure the activities process incorporates health equity concerns when obtaining feedback, collecting and monitoring data related to outcomes of sub-populations, and analyzing factors known to affect health equity, such as race, socioeconomic status, or language when investigating medical errors and adverse events.

Health equity refers to the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

F 867

Facilities should also consider factors that affect health equity and outcomes of their resident population when establishing priorities in their QAPI program.

Example, does the facility address the needs of individuals with disabilities, limited English proficiency, with different cultural or ethnic preferences, or other health equity concerns?

Resources

Additional information can be found on the CMS website: https://www.cms.gov/about-cms/agency-information/omh/health-equityprograms/cms-framework-for-health-equity

F 918 Bathroom Facilities

F918 Bathroom Facilities

Revisions were made to allow facilities that receive approval of construction from state or local authorities or are newly certified after Nov. 28, 2016 with two single occupancy rooms with one bathroom to meet the bedroom and bathroom facility requirements without undergoing major rehabilitation.

F 880 Infection Control

F880 Enhanced Barrier Precautions (EBP) to Prevent Multidrug-Resistant Organisms (MDRO)s

- Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities.
- Infection control guidance released in CMS Memo QSO-24-08-NH on March 20, 2024, was incorporated into the guidance along with new deficiency examples.

Resources

Information regarding CDC-targeted MDROs and current recommendations on EBP are available on the CDC webpage for, “Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug Resistant Organisms (MDROs)” at

https://www.cdc.gov/hai/containment/PPENursing-Homes.html

Review of EBP

EBP are indicated for residents with any of the following:

- Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or
- Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO
- Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.
- Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP.
- EBP should be used for any residents who meet the above criteria, wherever they reside in the facility

Review of EBP

For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:

- Dressing
- Bathing/showering
- Transferring
- Providing hygiene
- Changing linens
- Changing briefs or assisting with toileting
- Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator
- Wound care: any skin opening requiring a dressing

Review of EBP

In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration.

Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility.

Review of EBP

Residents are not restricted to their rooms or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

Facilities have discretion on how to communicate to staff which residents require the use of EBP. CMS supports facilities in using creative (e.g., subtle) ways to alert staff when EBP use is necessary to help maintain a home-like environment, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities.

Review of EBP

Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room.

New Deficiency Categorization Examples to F880: All Covid related.

F887 COVID-19 Immunization

F887 COVID-19 Immunization

Guidance related to requirements for facilities to educate residents or resident representatives and staff regarding the benefits and potential side effects associated with the COVID-19 vaccine and offer the vaccine released in CMS Memo QSO-21-19-NH on May 11, 2021, was incorporated into Appendix PP.

Questions?

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