HOSPITALITY STEWARDSHIP INTEGRITY RESPECT HUMOR

Financial, Operational, and Clinical Assessment of Fair Meadow Nursing Home Final Report

City of Fertile
Fertile, Minnesota

August 2017

HEALTH DIMENSIONS GROUP
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INTRODUCTION

Health Dimensions Group (HDG) was contracted by the City of Fertile to conduct an assessment of the operations at Fair Meadow to better understand where there may be opportunities to improve the overall operating results of the facility. The assessment was conducted during the month of August 2017.

It was a pleasure to meet the staff and residents during our assessment of the facility. Following are key findings and conclusions from the assessment. Please see specific sections of the report for more detail.

General Observations

Fair Meadow Nursing Home is a 42-bed licensed skilled nursing facility owned and operated by the City of Fertile, Minnesota. The community broke ground in 1967 and opened in 1968 with 83 beds, and celebrated its fiftieth anniversary in 2017. Recently renovated, its current 42 beds were recently redesigned for single occupancy and private bathrooms.

Resident rooms and bathrooms present as fresh and new. Common areas of the facility present as old and tired; however, they are clean. Staff is friendly and experienced, and residents and families are pleased with the service and care provided. The community provides a home-like environment and is well-maintained. The relationship between the residents, families, and staff is excellent. During the assessment, the hospitality provided by the facility to the HDG team was outstanding.

Approximately three years ago, the facility added a 19-apartment assisted living (AL) wing. The AL is attached to the nursing facility by a long hallway with an entrance accessed from the nursing facility by a secured passage. The AL presents very elegantly. The administrator, human resource (HR) director, and business office manager (BOM) relocated their offices to the AL.

Organizational Structure

Fair Meadow Nursing Home is owned and operated by the City of Fertile, and governed by a volunteer advisory board with the sole purpose of providing the best possible care to aged and disabled persons. Please see Appendix A for the facility's organizational chart regarding the Fair Meadow Advisory Board.

Recommendations

- Develop/revise personnel policy to clearly define administrator's scope of authority (contract management, purchases, capital expenditures, and compensation adjustments).
- Define Advisory Board's role and qualifications of its members to provide clear direction for effective decision-making and structuring a partnership to best serve the City.

FINANCIAL ASSESSMENT

This section outlines the results of HDG's financial assessment of Fair Meadow Nursing Home. HDG received summarized financial data from Fair Meadow and compared the data to regional and national benchmarks and to several local Minnesota communities. These comparison communities were selected based on similar bed size and payor mix. A list of comparison communities is presented in Table 1 below. Facility names have purposely been omitted.

Table 1: Comparison Communities

Community	Beds	Ownership	Urban/Rural
A	43	Proprietary, Corporation	Rural
B	49	Voluntary Nonprofit, Other	Rural
C	70	Voluntary Nonprofit, Other	Rural
D	104	Voluntary Nonprofit, Other	Urban
E	75	Voluntary Nonprofit, Other	Rural
F	74	Voluntary Nonprofit, Other	Rural

Profit and Loss Analysis

Table 2 on the following page provides a summary of the financial summary for year ending September 30, 2016 and year-to-date June 30, 2017. For comparative purposes, the YTD 2017 financial statements have been annualized.

Table 2: Profit and Loss Summary

	9.30.16	2016 Per Patient Day	2017 Year-to-date Annualized (6.30.17)	2017 Per Patient Day	Change from Prior Year	% Change from Prior Year
Census						
Medicare	2.6		2.3		(0.2)	-8.7%
Medicaid	27.6		27.1		(0.6)	-2.1%
Private Pay	7.0		9.9		2.9	41.2%
Other (See Payor List)	1.3		0.3		(0.9)	-73.8%
Total Occupied Beds	**38.4**		**39.6**		**1.1**	**3.0%**
Total Available Beds	**42**		**42**			
Occupancy %	**91.5%**		**94.3%**			
Resident Days						
Medicare	931		850		(81)	-8.7%
Medicaid	10,089		9,880		(209)	-2.1%
Private Pay	2,549		3,599		1,050	41.2%
Other	465		122		(343)	-73.8%
Total Resident Days	**14,034**		**14,451**		**417.0**	**3.0%**
Financials						
Resident Revenues						
Resident Room and Care	3,568,783		3,975,168		406,385	11.4%
Medicare B	150,100		82,025		(68,075)	-45.4%
Other Revenue	48,171		38,729		(9,442)	-19.6%
Total Revenues	**3,767,054**	**268.42**	**4,095,922**	**283.44**	**328,868**	**8.7%**
Operating Expenses						
Nursing	1,620,757	115.49	1,743,124	120.62	122,367	7.6%
Social Services/Activities	221,730	15.80	249,705	17.28	27,975	12.6%
Ancillary	106,514	7.59	77,178	5.34	(29,336)	-27.5%
Plant Operations	288,714	20.57	353,845	24.49	65,131	22.6%
Housekeeping/Laundry	163,666	11.66	178,359	12.34	14,693	9.0%
Dietary	339,954	24.22	309,914	21.45	(30,040)	-8.8%
G&A	456,110	32.50	485,025	33.56	28,915	6.3%
Benefits	706,565	50.35	728,437	50.41	21,872	3.1%
Total Operating Expenses	**3,904,010**	**278.18**	**4,125,587**	**285.49**	**221,577**	**5.7%**
EBITDA	**(136,956)**	**(9.76)**	**(29,665)**	**(2.05)**	**107,291**	**-78.3%**
Interest	116,521	8.30	116,521	8.06	-	0.0%
Depreciation	32,674	2.33	32,674	2.26	-	0.0%
Net Income (Loss)	**(286,151)**	**(20.39)**	**(178,860)**	**(12.38)**	**107,291**	**-37.5%**
Assisted Living						
Revenues	450,304		551,234		100,930	22.4%
Assisted Living	378,350		405,653		27,303	7.2%
Operating Income (Loss)	**71,954**		**145,581**		**73,627**	**102.3%**
Depreciation	179,757		179,757		-	0.0%
Net Income (Loss)	**(107,803)**		**(34,176)**		**73,627**	**-68.3%**

Source: 2016 and YTD 2017 Financial Statements

Key Findings

The financial summary shows an annualized 3.0 percent increase in resident days in 2017 and a shift in payor mix to private pay (see Census Analysis). Total revenue per day is on a trend to increase in 2017 from $268.42 per patient day (ppd) in 2016 to $283.44 in 2017 (see Revenue per Patient Day).

Total cost is on track to increase 5.7 percent or $7.31 ppd from the previous year. Some areas that have shown a high increase in cost and cost ppd include nursing, social services/activities, and plant operations (see the Staffing and Hourly Rate Analysis sections of this report, which provide further analysis and discussion regarding nursing expenses). Employee benefits have increased by 3.1 percent in 2017 compared to 2016 (see the Employee Benefit Analysis section of this report for further discussion.

HDG noted that there were no interest, depreciation, or pension expenses recorded in year-to-date 2017 financial statements. Per discussion with the client, these are year-end entries so HDG carried forward the same expense from 2016. HDG also added Public Employees Retirement Association (PERA) costs to the 2017 numbers to equal the 2016 amount.

Overall, Fair Meadow Nursing Home has gone from a net loss of $286,151 in 2016 to an annualized net loss of $178,860 in 2017.

Census Analysis

HDG compared 2016 and YTD 2017 occupancy to several regional competitors and industry benchmarks, as shown in Table 3 below.

Table 3: Occupancy

Community	Year End	Occupancy Percentage
Fair Meadow	**6/30/17**	**94.3%**
Fair Meadow	**9/30/16**	**91.5%**
A	9/30/15	93.5%
B	9/30/15	95.2%
C	9/30/15	94.5%
D	9/30/15	94.8%
E	9/30/16	70.2%
F	9/30/16	78.6%
Comparison Facility Average		**87.8%**
Midwest Benchmark		84.7%
National Benchmark		87.2%

Sources: 2016 and YTD 2017 Financial Statements, CLA 31st Licensed Nursing Facility Cost Comparison, and MN DHS Nursing Provider Portal

Key Findings

Fair Meadow Nursing Home experienced an increase in occupancy over the past year mainly due to an increase in private pay days. Occupancy is comparable to communities A–D, and higher than the Midwest and national benchmarks.

Payor Mix Analysis

HDG compared the 2016 and YTD 2017 payor source percentages to several regional competitors and industry benchmarks; results are shown in Table 4 on the next page.

Table 4: Payor Mix

Community	Year End	Medicare	Medicaid	Other
Fair Meadow	**6/30/17**	**5.9%**	**68.4%**	**25.7%**
Fair Meadow	**9/30/16**	**6.6%**	**71.9%**	**21.5%**
A	9/30/15	8.5%	66.1%	25.4%
B	9/30/15	6.7%	54.9%	38.4%
C	9/30/15	8.9%	62.9%	28.2%
D	9/30/15	8.6%	53.3%	38.1%
E	9/30/16	11.2%	55.8%	33.0%
F	9/30/16	8.0%	62.4%	29.6%
Comparison Facility Average		**8.6%**	**59.2%**	**32.1%**
Midwest Benchmark		10.1%	57.1%	32.8%
National Benchmark		11.7%	64.2%	24.1%

Sources: 2016 and YTD 2017 Financial Statements, CLA 31st Licensed Nursing Facility Cost Comparison, and MN DHS Nursing Provider Portal

Key Findings

The payor mix comparison shows a shift in utilization of Medicare and Medicaid to private pay days. Overall, Fair Meadow Nursing Home has a lower mix of Medicare and a higher mix of Medicaid patient days than the comparison communities and Midwest and national benchmarks. Further analysis would be needed to determine if Fair Meadow could obtain a higher share of higher paying Medicare days. Fair Meadow also has a lower share of "other" days, which includes private pay days.

Revenue per Patient Day Analysis

HDG prepared a more detailed analysis of revenue, which is provided in Table 5 below.

Table 5: Revenue Comparison

Payor	2016			2017 Annualized			Revenue Change	% Revenue Change
	Days	Revenue	PPD	Days	Revenue	PPD		
Blue Plus MSHO	178	55,764	313.28	13	4,359	335.31	(51,405)	-92.2%
Hospice Medicaid	117	23,271	198.89	-	-	-	(23,271)	-100.0%
Humana	26	9,108	350.30	-	-	-	(9,108)	-100.0%
Medica MSHO	47	21,248	452.07	78	24,505	314.17	3,257	15.3%
Medicaid	9,972	2,567,175	257.44	9,880	2,672,220	270.47	105,045	4.1%
Medicare	931	316,973	340.46	850	311,603	366.59	(5,370)	-1.7%
MSHO Non Skilled	136	40,358	296.75	31	7,277	234.74	(33,081)	-82.0%
Private Pay	2,549	690,613	270.93	3,599	1,015,177	282.07	324,564	47.0%
Ucare Medicare Replacement	4	619	154.84	-	-	-	(619)	-100.0%
Ucare Minnesota MSHO	74	15,753	212.88	-	-	-	(15,753)	-100.0%
Total	**14,034**	**3,740,882**	**266.56**	**14,451**	**4,035,141**	**279.23**	**294,259**	**7.9%**

Key Findings

Along with the increase in patient days, the driving factor behind the increased revenue was the increase in Medicaid and private pay rates, with an increase of $13.03 ppd and $11.14 ppd, respectively. Total Medicare revenue is on pace to remain similar to the previous year, even with fewer days driven by a higher rate ppd. HDG noted that the Medicare rate listed in the revenue reconciliation was not the same as revenue that was recalculated in the Medicare Reimbursement section of the report. Other payors days and rates ppd have declined. Medicare B and other revenue have also declined in the current year.

Medicare Reimbursement Analysis

HDG compared Fair Meadow's Medicare RUGs distribution and average reimbursement rates to competitor data, the Minnesota rural facility average, the Minnesota statewide average, and the national average. Results are shown in Table 6 below.

Table 6: RUG Distribution Comparison

RUG Classification	Fair Meadow	A	B	C	D	E	F	Minnesota - Rural	Minnesota - ALL	National - Rural
Rehab Plus Extensive	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.7%	0.7%	1.6%
Rehabilitation	90.2%	92.6%	93.3%	94.7%	88.7%	96.1%	95.9%	89.9%	90.8%	88.3%
Total Rehabilitation	90.2%	92.6%	97.0%	94.7%	88.7%	96.1%	95.9%	90.6%	91.5%	89.9%
Extensive Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.4%	0.3%	0.4%
Special Care High	6.3%	2.4%	1.8%	0.0%	6.1%	1.0%	1.0%	2.6%	1.9%	2.5%
Special Care Low	0.6%	0.1%	0.0%	0.2%	2.9%	0.0%	0.6%	1.8%	2.0%	2.4%
Clinically Complex	2.9%	0.7%	0.6%	4.9%	1.7%	2.4%	0.9%	2.7%	2.6%	2.4%
Behavior	0.0%	0.8%	0.5%	0.0%	0.0%	0.3%	0.8%	0.2%	0.2%	0.4%
Reduced Physical Function	0.0%	3.4%	0.1%	0.2%	0.5%	0.1%	0.8%	1.7%	1.5%	1.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
RU	0.8%	2.5%	2.8%	1.1%	14.6%	11.1%	5.2%	16.8%	36.3%	40.5%
RV	31.4%	37.1%	18.9%	58.0%	42.1%	54.0%	70.7%	38.7%	33.2%	28.2%
Combined RU/RV%	32.2%	39.6%	21.7%	59.2%	56.7%	65.1%	76.0%	55.5%	69.5%	68.7%
Rehab As	24.5%	45.7%	14.2%	28.7%	5.7%	49.7%	44.2%	31.4%	31.0%	29.4%
Rehab Bs	23.3%	28.2%	26.7%	39.9%	14.2%	24.3%	30.8%	36.3%	40.0%	31.7%
Rehab Cs	52.2%	26.1%	59.1%	31.4%	80.1%	26.1%	25.0%	32.3%	29.0%	38.9%
Combined Rehabilitation	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Medicare Rate:	$ 356.15	$ 339.63	$ 363.13	$ 357.25	$ 395.98	$ 366.55	$ 367.25	$ 368.16	$ 392.97	$ 400.84

Sources: YTD 2017 census and www.snfdata.com

HDG noted that the average Medicare rate is low at Fair Meadow due to the low wage index in Polk County. HDG compared the average Medicare rate less additional Medicare costs to the average Medicaid rate and noted the Medicare rate is higher by $24.87.

Table 7: Rate Comparison

	Medicare	Medicaid
Average Rate	$356.15	$252.46
Average Additional Cost	$78.82	-
Net Rate	**$277.33**	**$252.46**

Key Findings

Fair Meadow Nursing Home's percentage of days in rehabilitation categories is lower than the comparison communities and Minnesota benchmarks. The distribution of rehabilitation A, B, and Cs also shows the rehabilitation days are more heavily weighted towards rehabilitation C days. Rehabilitation days are also more heavily weighted towards rehabilitation very high compared to rehabilitation ultra-high.

HDG computed the average Medicare rate for each community based on the October 1, 2016, RUG rates for Polk County, Minnesota. The average rate computed for Fair Meadow is lower than all the comparison communities and benchmarks, due to the distribution of rehabilitation days as noted above.

HDG noted that Fair Meadow is located in the Grand Forks, North Dakota, Metropolitan Statistical Area (MSA) and the wage rate labor index for this region is used in computing the Medicare rate. The wage rate labor index for the Grand Forks region is lower than the rural Minnesota wage rate labor index for the comparison communities and, therefore, actual rates of the comparison communities could vary significantly from the Fair Meadow Medicare rate. Wage indexes for Polk County and rural Minnesota are shown in Table 8.

Table 8: Medicare Wage Index

Wage Index	10/1/14	10/1/15	10/1/16
Polk County	0.7047	0.7351	0.7274
Rural Minnesota	0.9124	0.9020	0.9042

Medicaid Rates

An analysis of the Minnesota Medicaid RUG-IV distribution is shown in Table 9 below.

Table 9: Medicaid RUG-IV Distribution

RUG-IV	Fair Meadow	A	B	C	D	E	F	Minnesota
ES3	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.8%	0.2%
ES2	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	2.9%	0.4%
ES1	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	0.1%
RAE	0.3%	1.9%	0.5%	0.6%	1.6%	0.7%	1.2%	1.9%
RAD	4.8%	1.4%	2.2%	3.3%	1.5%	7.8%	2.2%	9.0%
RAC	0.2%	1.2%	2.5%	2.5%	0.3%	3.4%	1.0%	13.6%
RAB	0.6%	2.4%	0.4%	0.1%	0.5%	3.8%	1.5%	6.9%
RAA	0.0%	3.2%	1.6%	0.0%	0.0%	2.0%	2.2%	3.9%
HE2	0.0%	0.0%	0.0%	1.6%	0.7%	0.1%	0.0%	0.1%
HE1	0.0%	3.8%	0.0%	1.2%	0.0%	0.0%	0.0%	0.6%
HD2	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.2%
HD1	0.8%	0.0%	0.7%	3.2%	1.5%	1.3%	0.4%	1.0%
HC2	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.3%
HC1	0.0%	0.0%	1.0%	1.0%	1.7%	0.8%	1.8%	1.3%
HB2	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.1%
HB1	0.8%	1.4%	1.6%	0.2%	0.8%	1.5%	0.5%	1.2%
LE2	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	0.2%
LE1	0.0%	0.0%	0.0%	6.5%	0.8%	0.0%	1.3%	1.7%
LD2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
LD1	4.1%	7.4%	5.2%	5.8%	3.6%	3.4%	2.8%	2.3%
LC2	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.2%
LC1	3.6%	0.6%	0.0%	10.5%	0.9%	2.4%	6.7%	2.5%
LB2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
LB1	0.0%	0.5%	0.0%	0.0%	0.4%	0.0%	1.1%	0.4%
CE2	0.0%	0.0%	0.0%	0.8%	1.6%	0.0%	0.0%	0.1%
CE1	9.7%	0.0%	0.9%	0.0%	1.5%	0.0%	1.2%	1.2%
CD2	3.8%	0.0%	0.0%	0.0%	1.2%	0.0%	0.0%	0.2%
CD1	4.5%	3.1%	0.0%	2.2%	3.6%	5.1%	3.7%	2.5%
CC2	0.6%	0.3%	0.0%	0.0%	1.4%	0.0%	0.0%	0.2%
CC1	1.0%	6.2%	0.0%	0.4%	5.0%	2.0%	4.5%	2.9%
CB2	0.3%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
CB1	5.6%	0.6%	2.3%	0.0%	0.5%	0.9%	3.7%	0.8%
CA2	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.2%
CA1	5.0%	2.3%	3.9%	4.8%	3.6%	2.2%	5.3%	2.0%
BB2	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%
BB1	1.8%	2.8%	13.3%	0.2%	4.7%	9.9%	0.5%	3.1%
BA2	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
BA1	4.9%	0.6%	19.6%	0.2%	6.5%	9.3%	5.7%	4.0%
PE2	0.0%	0.0%	1.9%	0.0%	3.7%	0.0%	0.0%	0.1%
PE1	7.9%	17.6%	1.0%	5.5%	9.2%	4.0%	16.7%	4.9%
PD2	0.0%	0.0%	0.3%	0.0%	3.5%	0.0%	0.0%	0.1%
PD1	19.7%	9.2%	14.0%	12.0%	8.5%	12.5%	9.9%	7.3%
PC2	0.0%	0.0%	1.9%	0.0%	5.8%	0.0%	0.0%	0.3%
PC1	1.7%	19.9%	10.7%	22.2%	9.0%	14.6%	9.6%	12.6%
PB2	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%
PB1	5.6%	8.5%	2.6%	3.0%	2.3%	3.6%	3.5%	3.0%
PA2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PA1	12.8%	5.1%	11.4%	11.9%	7.1%	7.9%	3.6%	5.8%
AAA	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%
DDF	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Rate	$ 248.34	$ 248.85	$ 233.53	$ 250.22	$ 252.01	$ 246.01	$ 266.04	$ 260.69

Source: MN DHS Provider Portal

Key Findings

HDG computed the average Medicaid rate for Fair Meadow and each comparison community based on the May 1, 2017, rate notice for Fair Meadow Nursing Home. Fair Meadow has a lower calculated average rate than all of the comparison communities except one, and is lower than the state average.

In Table 10, below, HDG computed the average rate per the last four rate notices, which shows an increase in the overall Medicaid rate. The large increase for May 1, 2017, was related to a building project adjustment and an ECPN rate adjustment.

Table 10: Fair Meadow Medicaid Rates

Effective Date	1/1/16	5/1/16	1/1/17	5/1/17
Publish Date	11/17/15	6/9/16	12/29/16	4/26/17
Average Rate	$ 237.79	$ 242.38	$ 242.91	$ 248.34
Rate Components				
Direct Care	106.03	106.03	107.90	107.90
Other Care	19.31	19.31	18.33	18.33
Other Operating	66.08	66.08	65.56	65.56
Operating Rate	**191.42**	**191.42**	**191.79**	**191.79**
Property	11.67	11.67	12.69	12.69
Surcharge	8.86	8.86	8.86	8.86
Other Per Diem	14.80	14.80	18.52	18.52
QIIP	3.50	3.50	-	-
Planned Closure	6.74	7.83	7.83	7.83
Bed Layaway	-	1.02	-	-
Building Project Adjustment	-	-	-	2.31
ECPN Adjustment	-	-	-	7.71
Equity Incentives	0.30	0.30	0.30	0.30
Single-Bed Incentives	4.05	6.53	6.53	6.53
Advisory Council	0.01	0.01	0.01	0.01
DDF Rate	**241.35**	**245.94**	**246.53**	**256.55**

Staffing Costs Analysis

HDG compared the hours worked per patient day (ppd) at Fair Meadow to the comparison communities and regional and national benchmarks. Nursing staffing hours are shown in Table 11 below, and other departments' staffing hours are shown in Table 12.

Table 11: Nursing Hours per Patient Day

Position	2016	A	B	C	D	E	F	Average	Midwest	National
RN	**0.40**	0.21	0.43	0.38	0.27	0.31	0.64	0.37	0.54	0.49
LPN	**1.20**	1.06	0.66	1.31	0.77	1.15	0.63	0.93	0.78	0.89
CNA	**3.57**	2.31	2.44	2.86	2.89	1.92	1.93	2.39	2.41	2.46
Nursing Administration	**0.15**	0.21	0.43	0.38	0.27	0.31	0.64	0.37		
Total Nursing	**5.33**	**3.80**	**3.95**	**4.93**	**4.21**	**3.69**	**3.85**	**4.07**	**3.73**	**3.84**

Sources: CLA 31st Licensed Nursing Facility Cost Comparison and MN DHS Nursing Provider Portal

Table 12: Staffing Hours per Patient Day by Other Department

Department	Fair Meadow Hours PPD per Listing	Benchmark Hours PPD
Activities	0.69	0.22
Housekeeping	0.39	0.39
Laundry	0.19	0.17
Dietary	1.43	0.74
Plant operations	0.29	0.13

Sources: CLA 31st Licensed Nursing Facility Cost Comparison and MN DHS Nursing Provider Portal

Key Findings

Total nursing hours PPD are higher at Fair Meadow than the comparison communities and the benchmarks. This would lead to a higher expense PPD, as noted in the Hourly Rate Analysis section of this report under "expense per patient day". The largest variances in the hours PPD analysis is in the LPN and CNA sections, with CNAs being much higher than comparison communities and the benchmarks.

The hours PPD calculated from the employee listing for other departments are higher than the Midwest benchmark, with the exception of housekeeping.

Hourly Rate Analysis

HDG compared the average hourly rate to competitors and to regional and national benchmarks, as shown in Table 13.

Table 13: Average Hourly Rate

Position	2016	A	B	C	D	E	F	Average	Midwest	National
RN	**$ 27.82**	$ 27.83	$ 27.99	$ 26.93	$ 26.66	$ 26.96	$ 30.00	27.73	$ 29.43	$ 32.97
LPN	**$ 19.97**	$ 19.23	$ 20.13	$ 18.37	$ 19.15	$ 22.87	$ 21.78	20.25	$ 23.24	$ 25.07
CNA	**$ 15.15**	$ 13.56	$ 13.80	$ 14.58	$ 14.31	$ 15.70	$ 15.18	14.52	$ 13.79	$ 14.17

Sources: CLA 31st Licensed Nursing Facility Cost Comparison and MN DHS Nursing Provider Portal

Key Findings

Fair Meadow Nursing Home's average hourly rate for nursing positions is comparable in the RN and LPN categories, and slightly above the average for CNAs. Note the Midwest and national benchmarks include rural and urban communities, which could lead to a higher rate.

Employee Benefits Analysis

HDG reviewed the facility's employee benefits and compared them to nursing hourly rates. A summary of employee benefits as a percentage of salaries is provided in Table 14 below.

Table 14: Employee Benefits Percentage

Community	Year End	%
Fair Meadow	**6/30/17**	**29.7%**
Fair Meadow	**9/30/16**	**31.4%**
Fair Meadow - Less PERA	**6/30/17**	**15.1%**
Fair Meadow - Less PERA	**9/30/16**	**16.0%**
A	9/30/15	15.9%
B	9/30/15	35.0%
C	9/30/15	17.7%
D	9/30/15	20.5%
E	9/30/16	21.1%
F	9/30/16	21.0%
Comparison Facility Average		**21.9%**
Midwest Benchmark		18.3%
National Benchmark		18.6%

Sources: 2016 and YTD 2017 Financial Statements, CLA 31st Licensed Nursing Facility Cost Comparison, and MN DHS Nursing Provider Portal

Percentages in Table 14 were calculated with numbers taken directly from Fair Meadow's financial statements for year ending 9/30/16 and YTD 6/30/17. The summary of all salary accounts was divided by all benefit accounts. The employee benefit percentage equals the employee benefits less pension expense (account 5801 PERA).

Key Findings

Fair Meadow Nursing Home's employee benefits percentage as compared to salaries is above all of the comparison communities except one, and above the regional and national benchmarks. As a significant portion of Fair Meadow's employee benefits percentage is related to pension expense, HDG also computed the employee benefits as a percentage of salaries without the Public Employees Retirement Association (PERA) pension expense included, and noted that the employee benefits percentage without PERA is less than the comparable communities.

Costs per Patient Day (PPD) Analysis

Using the 2016 and YTD 2017 financial statements, HDG compared cost per patient day (PPD) by department for the skilled nursing facility only to several regional competitors and industry averages in Table 15 below, which shows a higher cost per patient day than all of the comparison communities and the industry averages. The largest negative variances by department include nursing, activities, plant operations, dietary, and benefits.

Table 15: Costs per Patient Day

Department	2016	2017	A	B	C	D	E	F	Average	MW 50th	VIG MN
Nursing	**115.49**	**120.62**	79.50	68.86	91.69	83.22	88.49	85.01	82.80	74.86	98.08
Social Services/Activities	**15.80**	**17.28**	6.53	6.46	7.14	9.92	6.38	5.30	6.95	3.88	7.00
Ancillary	**7.59**	**5.34**	18.83	13.21	16.13	13.03	21.65	18.69	16.92	21.04	23.79
Plant Operations	**20.57**	**24.49**	9.00	12.14	13.08	10.83	13.50	9.21	11.29	11.38	12.59
Housekeeping/Laundry	**11.66**	**12.34**	5.41	8.39	8.07	8.83	11.06	9.03	8.47	8.13	9.37
Dietary	**24.22**	**21.45**	13.58	20.51	17.26	19.26	20.83	21.93	18.90	17.88	21.84
G&A	**32.50**	**33.56**	40.79	39.58	27.31	30.34	58.37	61.36	42.96	40.46	38.59
Benefits	**50.35**	**50.41**	15.62	36.74	20.22	25.95	24.77	27.17	25.08	18.83	26.78
Total Operating Expenses	**278.18**	**285.49**	**189.26**	**205.89**	**200.89**	**201.39**	**245.04**	**237.70**	**213.36**	**196.46**	**238.04**

Sources: 2016 and YTD 2017 Financial Statements, CLA 31st Licensed Nursing Facility Cost Comparison, VIG Digest, and MN DHS Provider Portal

OPERATIONAL ASSESSMENT

The following sections outline HDG's findings and recommendations regarding operations of the Fair Meadow Nursing Home.

Operational Leadership

The nursing home administrator (NHA) has served Fair Meadow Nursing Home for over 30 years, the last two as NHA. She has a financial background, and previously was the business office manager. The NHA has a wealth of historical knowledge of the facility, is committed, and acknowledges her limited experience. The NHA's mentoring comes only from the previous administrator who served in that role for the past 36 years.

The director of nursing (DON) has also served Fair Meadow Nursing Home for over 30 years, the last six as DON. She is well liked by her coworkers and appears very organized. The DON presents with a servant leadership style. The servant leadership focuses on the leader as a servant, with the key role being developing, enabling, and supporting team members, similar to a democratic leadership. If there is a nurse opening on the schedule, with three RNs and two LPNs in management positions, the DON usually is the one that works the open shift. The NHA and DON have a cohesive relationship.

Recommendations

- Develop the NHA as the campus leader with a focus on gaining insight into the changing landscape of health care such as clinical integration of care, bundled payments, shared risk, MEGA rule, etc.
- Review the office location for key leadership roles to equally support the nursing home and assisted living.
- Evaluate the DON's interest in developing leadership skills in the area of delegation.

Operating Budget

Fair Meadow Nursing Home's fiscal year is from October 1 to September 30. The facility is currently operating without a budget and has been as long as the NHA can remember. A budget is an itemized summary of likely income and expenses for a given period of time. Its purpose is to help determine whether there is money available to make purchases, provide wage increases, etc. A budget is typically created using a spreadsheet which provides a concrete, organized, and easily understood breakdown of how much money is coming in and how much is going out. It is an invaluable tool to help prioritize spending and manage money. Planning and monitoring a budget will:

- Help identify wasteful expenditures
- Adapt quickly if financial situation changes

- Help achieve financial goals
- Decrease stress levels because with a budget there should be no surprises

Recommendations

- Establish a budget for the fiscal year of October 1, 2017, thru September 30, 2018.
- NHA to establish account control logs for each department with expense control logs that correspond with the budget based on the daily census or per patient day (ppd) costs.
- Develop a purchase order system that requires department manager to communicate with the business office to verify funds are available prior to a purchase, thereby acknowledging they are adhering to department budgets.

CMS Five-Star Staffing Comparison

According to the Centers for Medicare and Medicaid Services (CMS) website, the CMS staffing rating has information about the number of hours of care provided on average to each resident each day by nursing staff. This rating considers differences in the levels of residents' care needs in each nursing home.

Information currently posted in the staffing data file (current as of end of July 2017) is provided in Table 15 below. The reported hours in the table come from the survey 671. The expected numbers are determined through minimum data set (MDS) data submitted around the same time frame as the 671.

The adjusted numbers are calculated based on a formula that is determined by dividing the reported numbers by the expected numbers and then multiplying that by a constant number to equal the adjusted number. The adjusted number is then used as the basis for the staffing star rating. Hours counted toward 5-star staffing are RN hours and total nursing hours. In order to get to a 4-star staffing overall, both have to be at a 4-star level, or one of the two has to be at 4-star, and the other at 3-star.

Current Five-Star Status

Fair Meadow Nursing Home's current 5-Star status is as follows:

- Overall = 3 Stars
- Health Inspection = 3 Stars
- Staffing = 2 Stars
- Quality Measures = 3 Stars

In the posted numbers in Table 16, from the 2016 annual survey, the RN hours are under the 1-star level, and total nursing is a 3-star, so the combined rating is at 2-star.

Table 16: Staffing as currently posted on July 2017 CMS Staffing Data File

	Aides	LPN	RN	Total Licensed	Total Nursing
Reported	2.71	0.99	0.37	1.36	4.07
Expected	2.49	0.64	1.03	1.68	4.17
Adjusted	2.68	1.28	0.27	1.28	3.94
Star Rating			1 Star		3 Star

- Overall Staffing = 2 Star Source: CMS July 2017 Staffing Data File

Projected Five-Star Status

When this most recent July 2017 annual survey is posted, the following changes, as shown in Tables 16 and 17 below, are projected based on review of the facility's reported 671:

- Health inspection will remain at 3-star
- Staffing will go up to 4-star
- Overall will increase to 4-star
- QMs will remain at 3-star at least until the next quarterly QM update

Table 17: Projected Staffing Star Rating Using Current Survey 671 (July 11, 2017), and Expected Hours as Posted (Census: 42)

	Aides	LPN	RN	Total Licensed	Total Nursing
Reported	3.32	0.78	0.77	1.55	4.87
Expected			1.03		4.17
Adjusted			0.55		4.72
Star Rating			4 Star		5 Star

- Overall Staffing = 4 Star

To get to these minimum hours, the calculation used is:

- RN=actual hours PPD divided by expected hours x 0.7472
- Total nursing =actual hours PPD divided by expected hours x 4.0309

Minimum Actual Hours Required to Achieve 4-Star Staffing

Given the current expected hours, in order to achieve 4-star staffing overall, the minimum actual hours would have to average 0.71 for RN, and 3.79 for total nursing, as shown in Table 18 on the next page.

Table 18: Minimum Hours required for 4-Star staffing

Fair Meadow – 4 Star Staffing	RN	Total Nursing
Min actual hours needed	4 Star = 0.71	3 Star = 3.79
Alternate actual hours needed	3 Star = 0.53	4 Star = 4.32

Staffing

Fair Meadow Nursing Home's total nursing hours per patient day (ppd) are higher than the benchmarks; however, staff is not more heavily weighted toward nurse administration than direct care. In 2016, Fair Meadow's total nursing ppd was 5.33 ppd with nursing administration 0.15 ppd, as compared to the average of six similar facilities' total nursing hours of 4.07 ppd with nursing administration 0.37 ppd.

Recommendations

As a result of our assessment, HDG recommends the following staffing adjustments be made:

- Five-star staffing: Staffing at a 4-Star – RN 0.71 ppd and total nursing 3.79 ppd, based on a census of 42
  - Registered Nurse (RN): 0.71 ppd: 1 MDS @ 40 hrs/week and 1 RN on each shift, or 24 hours/day
  - Licensed Practical Nurse (LPN): 0.76 ppd: 2 LPNs on first shift, 2 LPNs on second shift, or 32 hours/day
  - Certified Nursing Assistant (CNA): 2.40 ppd: 5 CNAs on first shift, 5 CNAs on second shift, and 3 CNAs on third shift, or 100.75 hours/day
  - Total nursing of 3.87ppd
- Nurse educator: Eliminate position at 30 hours per week
- Nurse supervisor RN: Realignment of MDS and nurse supervisors
- CNA and TMA: Eliminate 478.75 hours per week
- LPN: Eliminate 20 hours per week
- Rehab coordinator: Eliminate 28 hours per week
- Therapy aides: Eliminate 58 hours per week
- Activity staff: Eliminate 60 hour per week
- Maintenance staff: Eliminate 20 hours per week

Potential cost savings from implementation of the above recommendations is shown in Table 19 below.

Table 19: Savings from Implementation of Staffing Recommendations

Current Staff Positions	Current Staffing (Hours per Week)	Proposed Staffing	Savings
Administrator	40	40	No change
HR /Payroll/Orientation	40	40	No change
Business Office/A/P	40	40	No change
Receptionist	30	30	No change
Clinical – DON	40	40	No change
Nurse Educator – LPN	30	0	Eliminate position = $32,588 annual savings
RN – MDS/infection control	120	40	Reduce to 1 MDS with shared responsibilities with unit supervisors
RN – unit supervisor first and MDS/In-service	0	40	
RN – unit supervisor second and MDS/Restorative	0	40	
Licensed staff: RN, LPN 8 hours /shift	300 (2 nurses on first, 2 nurses on second, 1 nurse on third)	280 or 5 FTE/day (2 nurses on first, 2 nurses on second, 1 RN on third)	Eliminate 20 hrs/wk @ $27/hr = $540/wk or $28,000 annual savings
CNA and TMA 7.75 hours/shift	1,184 CNA and TMA position hired	705.25 or 100.75 hrs/day; (5 CNAs on first, 5 CNAs on second, 3 CNAs on third shifts)	Eliminate 478.75 hrs/wk @ $14.50/hr = $6,942/wk or $360,978 annual savings
HUC/Scheduler/Supplies LPN clerk; rounds with doctors, transportation	40	40 Convert to HUC	Position change
Rehab Coordinator	28	0	Eliminate 28 hrs/wk @ $21.85/hr = $611.80/wk or $31,814 annual savings
Therapy Aides	58	0 (train all CNAs in restorative program)	Eliminate 58 hr/wk @ $14.77/hr =$856.66/wk or $44,546 annual savings
Social Service/Admission	32	32–40	No change unless need for marketing increases
Activity Director	30	30	No change
Activity Staff	120	60	Reduction of 60 hrs/wk @ $14.69/hr avg. = $881.40/wk or $ 45,833 annual savings

Current Staff Positions	Current Staffing (Hours per Week)	Proposed Staffing	Savings
Laundry	54	54	No change
Housekeeping Director	40	40	Change to salary, working supervisor
Housekeeping staff	64	64	No change
Dietary Manager	32	32	Change to salary
Cooks	152	132	Move 20 hrs/wk to AL
Dietary aides	217	197	Move 20 hrs/wk to AL
Maintenance Director	40	30	Move 10 hrs/wk to Al
Maintenance staff	40	20	Eliminate 20 hrs/wk 16 hrs x $27.44 = $439, plus 4 hrs x $19.71 = $79; total of $518 weekly or $26,936 annual savings
		Total savings with reductions	**$570,689 annual savings**

BUSINESS OFFICE ASSESSMENT

On August 2 and 3, 2017, Health Dimensions Group (HDG) conducted an assessment of business office systems and processes at Fair Meadow Nursing Home in Fertile, Minnesota. As part of the assessment, HDG interviewed the business office manager, accounts payable (A/P) manager, and administrator, and reviewed the following systems and processes:

- Admissions and census
- Resident financial file contents
- Billing and collections
- Medicare/Managed Care billing and compliance – triple check/pre-billing audit process
- Accounts receivable (A/R) review process
- Billing and collections software
- Business office issues/training needs

Specific findings and recommendations are presented next.

Admissions and Census

At the time of the assessment, Sara, the social services staff member was responsible for the referral and admissions process. When a referral comes in, Sara reviews the referral, checks the financial payor information, and, if necessary, will ask the business office manager to review the insurance/payor verification.

Social services completes the admission agreement with the resident/family member, and gets the agreement signed. She then enters the new resident demographic information into the computer software system.

The business office manager (BOM) then enters the census information and the payor tree set-up into the software system (PointClickCare®). A formal insurance or payor verification form is not currently being completed by the facility.

Daily input of census changes (admissions, discharges, payor changes, bed holds, transfers, etc.) are crucial for both compliance and accurate billing. Currently, the facility does not conduct a morning meeting (or stand-up meeting) to inform all managers of admissions, discharges, transfers, etc. It was also noted that a midnight census form, typically completed by the nursing department, is not currently being completed.

Recommendations

HDG recommends the following actions to supplement and improve the billings and collections process at Fair Meadow Nursing Home.

- Admissions and business office staff should work together as a team to ensure all necessary information is received and uploaded into the billing software, or emailed and scanned to the billing staff. It is crucial that management communicate daily regarding census and admission information/changes; the morning stand-up meeting is a good place for this communication. This will not only assist in the billing and collections process, but could also decrease the likelihood of bad debt and risk of compliance issues.
- Nursing staff should complete a midnight census form each night which verifies "heads in the beds". The completed midnight census form should be turned in to the BOM or appropriate staff for discussion and verification each morning at the morning meeting.
- An insurance/payor verification form should be completed for each potential admission by the BOM prior to the acceptance of a new resident (see Appendix B). This would ensure verification of payor source(s) (primary and secondary), and would verify insurance benefits, how insurance will pay, and what will be included on the UBO4 claim. It is important that this information be accurate on the front end to alleviate bad debt down the road.
- Admissions team should provide several documents to the BOM prior to submitting any statements or claims. These documents are referred to below in the Resident Financial File Contents section of this report.

Resident Financial File Contents

The HDG consultant performed an audit of resident financial files with the business office manager. The files were reviewed for required documentation and forms that should be included in resident financial files on site, as well as uploaded into the billing software. The information below is necessary for billing and collections and claims submissions and should be included in the files and reviewed by the billing staff:

- Signed copy of the admission agreement
- Copies of insurance, Medicare, and Medicaid cards (front and back)
- Copy of Medicare Secondary Payor (MSP) Screening form
- Signed Assignment of Benefits form
- Payor/Insurance Verification form
- Medicare Technical Denial (if applicable)
- Copy of Hospital Face Sheet (if applicable)

At the time of the assessment, the resident financial files audited were missing pieces of the information recommended above. The MSP Screening form was missing from all financial files, but was being completed by social services upon admissions.

Recommendations

HDG recommends that a checklist be maintained to ensure all necessary documents are completed upon admission, and the appropriate documents needed for billing and collections (see above) are routed to the BOM for the resident financial file.

It was noted that the MSP Screening form was being completed upon admission, but the form was not then being given to the business office director. While HDG was on-site, the staff agreed to start this process immediately.

In addition, the recommended insurance verification form should be filled out prior to an admission, preferably by the BOM, and should be included in the resident financial file.

Billing and Collections

At the time of the on-site assessment, business office policies and procedures specific to billing and collections were reviewed. The policies and procedures available at that time were general in nature.

Recommendations

- Develop formal billing and collections policies and procedures specific to billing and collections guidelines and procedures.
- Some of the duties and responsibilities that are currently being done by social services should be transferred to the billing staff (e.g., completion of the resident insurance/payor verification form on potential admissions). One reason for this is so the billers have more first-hand knowledge of their accounts, and develop a rapport with the families/responsible party.
- Meet with all new admissions to go over financial information and collection of payment information. Also at this meeting, it is important to review expectations of the financial contact to the business office.
- Billing is not currently being done for immunizations. The billing of immunizations for the last 12 months would be a potential revenue opportunity.

Resident Trust Account

At the time of the assessment, the facility maintained a non-interest bearing checking account. Resident fund transactions from this account are tracked manually, in a binder with pen and paper. The staff currently "allows" a resident to have $50 at one time, and if they are over, the additional cash is kept in an "envelope". According to the staff, the reason for this is so they don't have to open an interest-bearing account. Statements are sent to resident/families on a quarterly basis.

Recommendations

According to state of Minnesota guidelines, interest-bearing accounts for private pay and Medicare must be provided at $100 or greater. Interest bearing accounts for Medicaid must be provided at $50 or greater.

- HDG recommends that the facility transfer the resident funds to an interest-bearing checking account.
- HDG also recommends that business office staff begin utilizing the Resident Trust Account module in PCC as soon as possible. Fair Meadow already uses PCC for other functions, so it would just be a matter of set-up and training. With manual entry, and the separate envelope system, there is a high possibility of error, and the account balances are not always current on a daily basis.

Medicare/Managed Care Billing and Compliance

HDG reviewed current Medicare and Managed Care billing was while on-site. Best practice, often called the triple-check or prebilling audit, would constitute a review of claims information prior to submission to ensure accurate, compliant claims. At the time of the assessment, a formal triple check meeting was not being conducted.

Also, copies of the minimum data set (MDS) validation reports are not being shared with the billing staff. These validation reports verify that an MDS has been completed and accepted by CMS. This is very important to know before submitting claims.

Recommendations

HDG recommends that a formal triple check meeting or pre-billing audit meeting be scheduled and conducted monthly, prior to submitting Medicare and Managed Care claims (see Appendix C). Training and education is needed to ensure accuracy of claims information, as well as verification of required information needed prior to submission of claims.

The prebilling audit is designed to review the following items (at a minimum):

- Verification that technical requirements for Medicare A have been met.
- Verification of signed and dated physician certification/recertification.
- Accuracy of all service dates.
- Accuracy of types of assessment and resource utilization group (RUG) scores.
- Ordering of diagnoses on UB04.
- Verification of provided therapy minutes.
- Verification of ancillary charges.

The triple-check team should consist of the following staff members:

- Medicare biller
- MDS coordinator
- Therapy director
- Medical records
- Administrator
- Others as deemed necessary by team

In addition to the prebilling audit, copies of MDS verification reports should be reviewed by the billing office staff to verify that the MDS has been submitted and accepted by CMS prior to submission of any claim.

The triple-check meeting should be scheduled by the Medicare biller at the same time each month, before claims are submitted. Records of these meetings should be maintained in order to defend any potential post-payment reviews by entities engaged in recouping payment and auditing compliance.

It was noted during staff interviews that there are currently three managed care contracts in place: UCare, Medica, and BlueCross BlueShield of Minnesota (BCBS). The business office does have copies of the contracts so they can verify correct payment of claims against the contracted rates.

When reviewing the Medica contract, two conditions were signed off by the facility that are not consistent with the service provided by the facility:

- Therapy is provided 6 days a week
- Admissions will be 7 days a week/24 hours a day

HDG recommends that this contract be reviewed and services modified to be in compliance with the wording of the contract.

Accounts Receivable (A/R) Review Process

At the time of the business office assessment, no formal A/R review meeting was being conducted at the facility. The AR Aging as of August 2, 2017, showed some outstanding balances in the 60 days-and-over columns for Medicare A, Medicare B, and Medica. The rest of the payors were in good shape, other than an account or two.

Recommendations

It is recommended that a monthly A/R review process be implemented as soon as possible. This review/meeting could be held via phone or in person with the admissions billing staff member, business office billing staff, billing consultant, administrator, chief financial officer (CFO), and others as deemed necessary.

The purpose of the meeting is to identify problem accounts, discuss follow-up steps and assign responsibility, and determine collection tasks to be completed prior to the next scheduled A/R review meeting. In addition, the accounts that are potential or true bad debts would be identified for the bad debt write-off process and submitted according to bad debt policy and procedure.

Business Office Opportunities and Training Needs

During the assessment, HDG identified the following training needs and opportunities for improvement.

Software (PointClickCare® [PCC]) Training and Opportunities

To streamline processes and enhance billing processes, HDG recommends training be conducted on the following:

- Medicare/Managed Care billing and collections.
- Consolidated billing process for Medicare claims.
  - At the time of the assessment, some monthly ancillary charges were not being entered on Medicare and Managed Care claims. These charges are part of the consolidated billing process and should be on the claims as they are being paid by the facility.
- Ancillary invoice review process/verification of payors.
- Streamlining admissions process as it pertains to business office.
- Triple check/Pre-billing audit process.
- A/R aging monthly review process.

In addition, HDG recommends the following:

- Schedule business office semiannual audit.
- Review contents of managed care contracts by billing staff.
- Develop cheat sheet or grid of financial pieces (payment due, ancillary services covered, etc.) of each managed care contract for admissions and billing staff.

Training opportunities were identified with the set-up and usage of PCC from a business office perspective. Some of these opportunities include:

- Set-up and utilization of Resident Trust Module
- Set-up and utilization of AP/GL Module
- Set-up and utilization of Collections Module
- General set-up of Admin Module
- Set-up specifics for:
  - Payors
  - Payor rules and rates
  - Contractual adjustments
  - Ancillary set-up
  - Month-end processes
  - Home Page usage
  - Adjustment batches
  - Census and billing & collections for assisted living communities
  - Reports

It was noted during the assessment that many manual adjustments were being done by billing staff, which specifically led to our reviewing the PCC set-up at the facility. HDG reviewed these adjustments with the BOM, and it appears they were done primarily because of set-up issues in PCC. These issues should be corrected as soon as possible so that the software can do its job by automatically generating contractual adjustments through the census and payor tree set-up rather than the BOM manually adjusting account balances. Further audits of these adjustments is recommended.

HDG will submit a separate proposal to work with the BOM and the administrator to assist the facility to fully utilize all modules in PCC, and expand its usage to the assisted living communities.

Managed Care Contracts – Accounts Payable

The human resources director is responsible for Fair Meadow's accounts payable (A/P) activities. During the assessment, HDG identified that the facility does not run the monthly OIG on existing vendors that are non-local, or on new vendors that are not local. This practice is a compliance issue and needs to be rectified immediately. The W9 and OIG verification forms must be attached to all new vendor invoices. Best practice is to check OIG on all vendors monthly.

In accordance with OIG compliance, any new vendors should have been verified through the OIG website **PRIOR** to engaging that vendor: http://exclusions.oig.hhs.gov/.

Processing Invoices

HDG recommends the following A/P process improvements:

- Match up any statements with receipts; do not process for payment unless the statement is for credit card purchases (e.g., VISA, AMEX).
- Review invoices for accuracy and verification that there is no balance forward amount on invoice. Balance forward should never be included with current amount to be paid.
- Verify numerical accuracy of invoices and have department manager review for accuracy.
- If not already coded, department manager codes invoice according to general ledger breakdown. If invoice is already coded, best practice requires the department manager to verify coding according to department budget (which does not exist at Fair Meadow) and then to sign and date. Once department manager has reviewed, coded, and approved, invoices should be routed back to A/P department, who then forwards to administrator for final approval.
  - During HDG's review, a statement was identified with four invoices totaling $1,878.93, which was paid. In review of the invoices attached to the statement, HDG noted that the statement had been overpaid by $751.30.

Segregation of Duties

At the time of the assessment, only one or sometimes two people handled the deposit process for both operations and resident trust accounts. Ideally, there would be three different staff members involved in the cash receipt process. HDG recommends implementing the following segregation of duties to develop a higher level of accountability and accuracy.

- Staff person 1 writes up deposit—cannot be same person who enters it into PCC or takes it to bank.
  - Staff person 1 also copies all receipts for cash/checks for that deposit, and runs a tape to verify that the deposit ticket balances with the cash/checks.
- Staff person 2 enters deposit into PCC—should not be the same person that writes up deposit or takes deposit to bank.
  - Staff person 2 who enters the cash batch into PCC verifies that deposit ticket matches the cash/check copies before posting.
- Staff person 3 takes deposit to bank—this person cannot handle the cash or checks in any other manner.

HUMAN RESOURCES ASSESSMENT

HDG conducted interviews with the human resources (HR) manager and administrator at Fair Meadow Nursing Home. Key findings are presented below.

Personnel Policies

The human resources director has served the facility for over six years. The facility developed a packet of personnel policies to use as guidelines for disciplinary actions which may become necessary. The policies are provided to employees upon hire. As a condition of employment, staff must comply with and work within the current policies and procedures set forth by the facility. HDG found that the policies are vague and open to interpretation; for example: "Attendance – Habitual and chronic tardiness or absence for personal reasons present a handicap to coworkers, the department, and institution. If not corrected, it will result in termination of employment."

Credit for Prior Experience

The facility offers credit for qualified prior experience for employees hired after September 11, 1987. According to the policy, this experience must be hospital, nursing home, clinical, or other applicable related experience as determined by the administrator. The purpose of this policy is to give credit for prior experience when determining starting salaries for new employees.

HDG reviewed employee files and the facility's wage scales, and noted that certified nursing assistant (CNA) wages at the facility range from $13.06 to $18.33. These wages are inconsistent based on the facility's policy. For example, HDG identified a CNA with 23 years' seniority making less than some CNAs hired in 2017. In reviewing the personnel file of a CNA hired in 2017, documents showed 14 years of EMT experience, and no CNA experience. The CNA was hired in May 2017 at an hourly wage of $17.03. Based on the facility's policy and wage scale, this equates to 43,680 hours divided by 2080, or 21 years of service. When reviewing this with the HR director, it was noted that previous wages may have been taken into consideration in determining starting wages for this employee.

In review of nursing department files, HDG also identified that multiple CNAs and other employees have not had an annual performance review in several years. This is a potential citable CMS survey tag (F497). Federal Regulation 42 CFR §483.35(d)(7) Regular In-service Education, states: "The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g)."

Payroll Practices

Fair Meadow Nursing Home does not currently utilize a timekeeping system with an audit trail—payroll is processed manually with pen and paper. This leaves the facility extremely vulnerable to inaccuracies in reporting.

Payroll Process

HDG's payroll specialist recommends that organizations with more than 40 employees utilize an electronic timekeeping system. Until such a system can be installed, HDG recommends implementing the following process:

- Employees fill out weekly timesheets, which run from Sunday through Saturday.
- Employees submit completed timesheets to their supervisor for verification and signature.
- Supervisor submits timesheets to payroll manager for review; payroll manager checks timesheets against work schedule and provides second verification of accuracy.
- Prior to submission for payment, facility administrator reviews and verifies that payroll has been approved by all appropriate parties, then signs off and submits for payment.

Payroll Staff

Under the facility's current system, one person is responsible for the entire payroll process, which is cumbersome and increases the risk for inaccuracies in reporting. HDG recommends segregating the payroll duties as follows:

- Appoint one person to serve as payroll processor, who will be responsible for:
  - Reviewing payroll preview reports to payroll back-up (status change forms, W-4s, direct deposits, etc.) to ensure that all changes have been properly authorized and documented.
- Appoint one person to serve as payroll verifier, who will be responsible for:
  - Verify hours on final payroll
  - Distributing paychecks/deposit slips to each employee on payday. Note: payroll processor should never touch the payroll package until verifier has counted all checks and verified hours on the final payroll.

This will be a new process for the facility and will probably take a few pay periods to implement, but will enhance the facility's checks and balances.

Time Clock

During the assessment, HDG noted that Fair Meadow Nursing Home does not currently have a time clock. This is a pay practice that needs **immediate** attention. All employees' time and the payroll-based journal (PBJ) reporting are calculated manually. All time is tracked by the individual employee on monthly calendars. The facility follows the 40-hour pay rule for overtime. Overtime is calculated weekly; however, employees are paid monthly. After 30 days of employment, each employee is allowed to sign up for a mid-month draw, identified in the employee handbook as Mid-Month Salary Advance. The purpose of the policy is to allow employees who desire to be paid twice a month this option, without doing two complete payrolls. Without a time clock to accurately calculate employee time and overtime, it leaves the facility vulnerable to errors.

HDG has attached a list of timekeeping systems for the facility's consideration, along with budgetary estimates (see Appendix D). According to the vendor, there is room for negotiation with the price, and the implementation fee could be billed in installments.

Recommendations

- Review and revise HR policies and processes and roll out updated policies across the campus.
- Review and revise the wage scale and implement a policy that does not allow arbitrary decisions.
- Complete employee performance reviews to bring all past-due into compliance; also, develop a process to maintain compliance.
- Pay credit for qualified time based on like/similar positions; e.g., RN experience for an RN.
- Clearly define a process for performance reviews that includes HR staff involvement and accountability.
- Contact vendors to obtain pricing for time clocks (e.g., fingerprint time clocks) and payroll systems that integrate with payroll-based journal (PBJ), e.g., SmartLinx, ADP, Ultimate Software-Ultipro.
- Initiate exit interviews with employees and develop process for compiling and reporting turnover data by department.
- Develop and implement a facility orientation program for new hires that includes all department managers.

Employee Benefits

In review of employee benefits, HDG noted the following discrepancies among the documents provided by the facility to newly hired employees:

- Welcome letter from administrator and DON states that minimum-value medical plan does not cover medication. However, according to the summary of benefits that is provided by BCBS of Minnesota, prescription drugs are covered and subject to the deductible/coinsurance.
- Welcome letter also states that Fair Meadow will pay $15 towards the cost of dental insurance; however, employee handbook states that Fair Meadow pays half the cost of the single dental premium. The rates listed do not equate to half the cost of the single dental premium.
  - Neither the letter nor the handbook explains the policy of not charging salaried employees for benefit premiums.
  - Amount that is listed in the welcome letter as being paid towards the medical premium by Fair Meadow is not clear.
  - Eligibility waiting period for benefits varies by benefit plan. Employees are eligible for medical insurance after 60 days of employment if they work 30 hours per week. Employees are eligible for dental insurance after 3 months of employment if they work a minimum of 2 days per month.
  - Vacation is accrued but cannot be used for one year.

Recommendations

- All documents provided to new hires must be accurate. Providing employees with a benefits guide and access to a video describing the benefit plans allows all employees to hear a consistent description of each benefit. HDG recommends revising the employee handbook so that benefit premiums are no longer listed and, instead, refer the employee to the benefits guide. That way if the rates change, the employee handbook will not need to be amended.
- Policy of not charging salaried employees for benefit premiums should be listed in the benefit eligibility section of the employee handbook and benefit guide. It is legal to have two distinct eligibility guidelines and costs associated with a benefit plan; however, it needs to be clearly defined by two separate classes of employees, such as exempt and non-exempt, otherwise it could be deemed discriminatory.
  - According to the Mercer National Survey of Employer-Sponsored Health Plans: In 2016, on average in the state of Minnesota, employees contributed 24 percent towards the cost of single medical premium and 34 percent towards the cost of family medical premiums. Based on results from the same survey, employees pay 53 percent of their single dental premium and 56 percent of their family dental premium.
  - HDG recommends only reflecting the cost that the employee pays towards their benefits in the benefits guide.

- HDG recommends that Fair Meadow have consistent benefit eligibility requirements for ease of administration. It is rare that a dental insurance carrier would allow someone who is only working two days per month to participate in the plan. In addition, it should be defined by hours worked since the definition of an employment day could vary depending on an employee's schedule.
- Industry standard is to allow vacation time to be used once the employee satisfies their benefits eligibility waiting period rather than a waiting period of one year.

Employee Compensation

The facility's employee handbook states that salary scale is adhered to for all employees, yet HDG did not find that to be the case. HDG found many employees are being paid more than the amount listed that corresponds to their job title and tenure.

In addition, salary scales do not appear to be reflective of the pay practices of Fair Meadow's competitors. HDG compared Fair Meadow's current wages to wages gathered from three local and national salary reports. HDG found 16 employees who are being paid slightly higher than the 75th percentile and 20 employees who are being paid substantially higher than the 75th percentile. In addition, HDG found that 31 employees are being paid below the 25th percentile—most of them nursing staff.

Recommendations

- Adjust wage scales to be competitive for qualified staff in the local market.
- Move away from the current tenure-based salary scale, which will allow the facility more flexibility to attract and retain the best talent.

CLINICAL ASSESSMENT

HDG conducted an assessment of clinical systems and processes, including clinical reimbursement and therapy services. Findings and conclusions are provided next.

Clinical Capabilities

HDG conducted interviews with the DON, the medical director, and physician assistant at Fair Meadow Nursing Home. The medical director has been in this role for 32 years. The medical director and physician assistant shared that they enjoy working with Fair Meadow, the residents, and staff. They see a difference in the clinical capabilities of Fair Meadow and other facilities they round. They believe the clinical capabilities can be increased by partnering with the county EMS for on-call support for IVs, INR meter in-house (because the lab is closed on Wednesdays), and working with the pharmacy to provide extended service to cover weekends. Currently, the facility will not accept residents with IV, negative pressure wound treatments (NPWTs), or tracheotomies.

Recommendations

- Increase clinical capabilities to accept residents with IVs, tracheotomies, NPWT, etc.
- Develop clinical programs based on penalty diagnosis for hospitals to market and increase census to include the following :
  - Cardiac: Heart failure is most common cause of readmission.
  - Pulmonary: Chronic obstructive pulmonary disease (COPD), pneumonia, and acute respiratory failure.
  - Sepsis: Prevention and sepsis follow-up.
- Implement electronic medication administration record (MAR) and charting to bring the facility up to current standards.
- Implement interventions to reduce acute care transfers (INTERACT): Evidence-based readmission reduction program which CMS and hospital systems recommend and can also be used for QAPI.
- Implement Abaqis® Medline or McKesson Quality One quality management system
  - Schedule at least two times per year
  - Provide additional staff access
  - Conduct comprehensive review
  - Disseminate results to all staff
  - Review and discuss results during QAPI

- Implement tracking system to monitor readmission into hospital (readmissions in 30 days or less, in 60 days, in 90 days: CMS defined 90-day episode of care).
- Nursing competencies for identified units: Trach care, suctioning, comprehensive physical assessment, central lines, sepsis bundle, NPWT, IVs, and systemic inflammatory response syndrome (SIRS).
- Develop and implement CNA training program onsite as approved by the state of Minnesota.
- Conduct root cause analysis (RCA): Using an evidenced-based tool, RCA should be conducted on all serious events including return to acute (RTA), adverse drug event, facility-acquired infection control, facility-acquired pressure injury, fall with serious injury, and others as appropriate. Root cause analysis is a process to be used by the interdisciplinary team (IDT).
- Integrate facility-specific specialty programs within culture of entire facility:
  - Fall prevention.
  - Skin injury prevention.
  - Behavior management.
  - Infection prevention/control.
  - Incontinence management (therapy can bill for this).
  - Pain management, to include non-medicinal approaches; therapy can use alternative approaches such as acupressure (which is billable), biofeedback, aroma therapy, relaxation techniques, and others.
  - Complex wound management (however, this is a costly program in time, money, and survey issues).
- Clinical morning meeting: Begin meeting earlier, at 8:30 or 9:00 a.m.
- Midnight census: Night nurse prints the census at midnight from PCC, then tours room-to-room to confirm residents on census list are present in their rooms. Night nurse documents any corrections needed and signs and dates the census report. Report is given to business office at morning meeting.
- Restorative nursing: Assign units to CNA responsible and assign RN/OT oversight.
- Discharge planning: Implement evidence-based approach to discharge planning (use of IDEAL process is easy to implement) for any resident planning to return to community, especially rehab patients.
- Unit managers: Unit managers should conduct unit rounds, which would include resident/family visits, medication room, shower room, resident rooms, observation of direct care, monitor call light response time, utility rooms, etc.

- Develop on-call system and responsibilities that include all members of nursing management team (DON, MDS, unit managers, etc.) in on-call rotation.

Interviews with Staff

The HDG consultant interviewed a random selection of CNAs and nurses, who unanimously agreed that Fair Meadow was an excellent place to work because of the residents they care for and their coworkers. Several of the nurses shared that the facility needs new tubs and a new lift. The HDG consultant received additional comments from staff as follows:

- "Facility is top heavy with management staff, which takes away from direct care."
- "Payroll is not accurate with wages, a large number of hours are repeatedly missing from checks."
- "Management creates jobs/positions for certain employees and not others."
- "Management does not post job listings."
- "Money for the remodel of building was misused on offices."

The facility administrator and DON discussed these comments with the City administrator, who communicated to HDG their disagreement with comments made during staff interviews. HDG believes staff may have an inaccurate perception of "top-heavy management" because of extra staff in the nursing department performing non-direct care, such as a nurse rounding with the physician, an LPN doing orientation, a nurse working from home to open MDS, etc.

Clinical Meeting

The HDG consultant and the DON discussed the clinical systems in place at the community. The DON acknowledged that the facility lacks daily communication by not having morning meetings to identify risks or afternoon meetings to confirm resolution of areas identified. The DON is organized with binders in place for each individual system. The facility does not have RN unit managers, rather, it has four RNs that complete the minimum data set (MDS) and care plans, with one working remotely.

Nursing does not implement clinical evidence-based programs. When asked what programs the facility has implemented, the DON shared they have entered into the Infection Control Assessment and Response Program (ICAR) with the Minnesota Department of Health (MDH). They do not use the risk stratification information provided by Abaqis® and INTERACT is not utilized at the facility.

Quality Measures

In review of the quality measures report, the facility is triggering higher than the 75th percentile in state and national average in several areas as stated in Table 20 below:

Table 20: Summary of Quality Measures

Quality Measure	Trigger	Quality Measure	Trigger
06/01/17 to 06/30/17	**Percentile Ranking**	**07/01/17 to 07/31/17**	**Percentile Ranking**
SR Mod/Severe Pain	99	SR Mod/Severe Pain (S)	84
Hi –risk Pres Ulcer (L)	81	*	*
Physical Restraints (L)	95	Phys restraints (L)	98
Falls (L)	81	*	*
Falls w/Maj Injury (L)	92	Falls w/Maj Injury (L)	93
Antipsych Med (L)	84	Antipsych Med (L)	79
Behavior Sx affect Others (L)	75	*	*
Depress Sx (L)	82	*	*
UTI (L)	96	UTI (L)	98

**Blank areas improved below the 75 percentile*

As noted in the table above, the facility shows improvement in their quality measures from June to July. The facility would benefit from running the quality measures report for a six-month time frame, to keep it consistent with the data reviewed by the state surveyors. Each triggered area is to be reviewed with the clinical interdisciplinary team (IDT) in the quality assurance and performance improvement (QAPI) meeting for opportunities for improvement and to address the gaps in the process, develop a corrective action plan, and establish a continuous process to monitor the effectiveness of the interventions. The DON was provided a copy of a Quality Measure Quick Reference Chart to provide helpful tips and education on MDS elements (see Appendix E).

Recommendations

- Conduct daily morning meeting to identify areas of priorities; conduct brief follow-up meeting in the afternoon to determine resolution.
- Run the quality indicator/quality measure (QIQM) reports monthly for a six-month period.
- Review the QIQM's monthly for accuracy using the *Quality Measure Quick Reference Chart.*
- If an error is identified in the MDS, complete a modification.

Regulatory Compliance/MEGA Rule

The Centers for Medicare and Medicaid Services (CMS) have revised the requirements for long-term care (LTC) which facilities MUST meet to participate in Medicare and Medicaid programs. This revision is the most comprehensive overhaul of LTC regulations in over 25 years, and is commonly referred to as the Mega Rule. Providers find themselves in a position of having to not only understand and interpret the new and revised regulations, but provide training; determine costs for implementation; implement each phase by the predetermined CMS required dates; make changes in facility practices; and work with employees, residents, and the resident care representatives to make sure that they understand these changes. The requirements of participation (RoP) will be implemented in a three-year phased-in approach. The Phase 1 implementation date was November 28, 2016.

During HDG's site visit, it was identified that changes in the regulations had not been implemented, such as:

- Three years of surveys were not accessible to visitors and no sign posted to identify they are available upon request.
- Resident's personal fund: Interest-bearing accounts for private pay and Medicare must be provided at $100 or greater. Interest-bearing accounts for Medicaid must be provided at $50 or greater. The facility did not write the notification letter correctly.
- Resident Council president stated she was not made aware of regulatory change that allows residents to consume foods not procured by the facility.
- Grievances: Facility has not addressed how they would ensure that a resident could file a grievance anonymously.

The facility administrator and DON were provided with the following documents for guidance:

- Survey Preparation for Phase I of the new SNF/NF Requirements of Participation by Care Providers of Minnesota (see Appendix F)
- LeadingAge Minnesota Requirements of Participation: Side-by-Side Comparison of Existing and New Regulatory Text (see Appendix G).
- Requirements of participation (RoP) Policy Tracking Log (see Appendix H).

Recommendation

- Administrator should complete audit of RoP regulatory changes to ensure they have all been implemented.

Nursing Supply Management

Establish a nursing supply budget and assign accountability for management to nursing leadership. The facility will require a defined system with par levels for expense management. The facility currently participates in a group purchasing organization (GPO), and a third-party company bills the Part B supplies for wounds dressing and catheter.

The facility uses medical supplies from McKesson. Costs for total nursing supplies from McKesson for the first quarter of 2017 were $4.16 ppd, an increase from the previous quarter of $3.52 ppd, or 18 percent. It was noted that approximately 45 percent of total purchases was for incontinence care supplies. For incontinence briefs, the facility is spending 12 percent for medium, 0 percent for regular, 0 percent for large, and 17 percent for XL. HDG recommended that the facility contact their rep to have the program assessed and residents re-sized.

Recommendations

- Develop a nursing supply budget and establish par levels.
- Expand Medicare Part B billing to include tube feeding, ostomy supplies, etc. (see Appendix I).

Admission Management

The admission process at Fair Meadow Nursing Home is the primary responsibility of the social worker/admission director (SW/AD). Referrals are received either by phone, fax, or electronically from the Stanford Enso-Care system. The SW/AD then follows up on these referrals in collaboration with the nursing department.

During review of the admission process, HDG noted that admission criteria is lacking; all referrals are reviewed by nursing, no weekend admissions are accepted, and no admissions are accepted after 3:00 p.m. daily. There is not currently an expectation that referrals be approved or denied within a 30-minute to one-hour time frame, which is best practice. The clinical criterion is very limiting; the facility will not accept bariatric, negative pressure wound treatment (NPWT), tracheotomies, IVs, pic-line or any activity port, or biPAPs. With the reduction of beds to accommodate all private rooms, the community will need to strive for 100 percent occupancy.

In discussing the lack of admissions on evenings and weekends with the facility administrator and DON, it was noted that there are constraints on after-hours admissions due to the fact that the pharmacy is not open during those times. Although requested at the time of the site visit, contact information for Thrifty White Pharmacy was not provided to HDG in order to verify this information. The facility did bring in a pharmacy consultant from the hospital for HDG to interview; however, this individual was not from Thrifty White, and had no information regarding services provided to the facility by Thrifty White.

The facility's primary referring hospitals are Riverview Hospital in Crookston, Altru Hospital in Grand Forks, with occasional referrals from Stanford Hospital in Fargo. The business office is not currently involved with preadmission financial review. All admission paperwork is completed by the SW/AD. According to the SW/AD, there is not a set rate for private pay residents; rates are determined from the minimum data set (MDS).

The facility does not have collateral material to market the facility; the only advertising is on Facebook and a webpage. Never underestimate the power of the community—the best advertising we have is word of mouth. In a highly competitive market, it is very important to have a complete understanding of the market. By looking at key aspects of its competition, Fair Meadow will be better able to differentiate its product.

HDG recommends that the administrator and marketing team develop a census culture within the facility, and be knowledgeable of the following for every competitor in the market area:

- Census by payor
- Possible niche strategies

Recommendations

- Administrator will champion the census daily by helping staff understand expectations and developing a census culture.
- Implement daily census meeting to review daily/pending referrals and scheduled marketing/hospital activity, using Daily Census Report (see Appendix J).
- Develop collateral material and advertising that supports marketing plan.
- Develop comprehensive, measureable marketing plan for Fair Meadow with strategic goals including branding, market positioning, public relations, community outreach, and service area (see Appendix K).
- Administrator, DON, and SW/AD to create formal current clinical inventory for each service line. Identify areas for improvement in skill and acuity level to meet market needs for increased complexity of care provided, such as IV management, NPWT, trach care, and bariatric.
- Develop process for community to admit residents 24/7 by implementation of off-hours system to address hospital and referring customers and by developing clinical capabilities.

Social Services/Discharge Planning Process

Social services consists of one social worker (SW) whose responsibilities include, but are not limited to, meeting the psychosocial needs of residents and admission and referral management. The social services/admission/discharge planning position is 32 hours per week. HDG feels it would benefit the facility to implement the evidence-based IDEAL discharge planning process (see Appendix L).

Activities

The activity director has been with the facility for three years. Her background is in occupational therapy. Interviews with staff and residents indicate satisfaction with activity programs and positive collaboration and coordination among departments. One resident expressed a concern that baking is scheduled too often. The survey compliance history for the department is positive. The cost per day is running high in combination with social services—Fair Meadow's 2017 cost is $17.28 ppd compared to the average of six similar facilities of $6.95 ppd, with a Midwest 50th percentile average cost of $3.88 ppd.

Recommendation

- Staffing reductions as noted in Staffing section of this report.

Clinical Information Technology (IT)

Fair Meadow Nursing Home utilizes PointClickCare® (PCC) for its clinical electronic medical record, which includes minimum data set (MDS), nursing progress notes, and physician orders. None of the electronic medication administration records (eMAR), electronic treatment administration record (eTAR), clinical assessments, or worksheets are currently part of the electronic medical record (EMR). Fair Meadow has purchased and has available the necessary electronic equipment to implement these processes. The facility also utilizes PCC for financial; this software platform is acceptable by industry standards. The facility shared with HDG that it would benefit from additional training in the finance component of PCC software.

Recommendations

- Implement eMAR, eTAR, and build on clinical assessments in PCC
- Provide additional training on finance component of PCC

Therapy Services

As part of the clinical assessment, HDG reviewed the therapy services and clinical reimbursement processes at Fair Meadow Nursing Home. Findings from the assessment are provided below.

Contracts with Outside Vendors

The facility's contract for physical therapy (PT) and occupational therapy (OT) is with Villa St. Francis in Crookston, Minnesota. The organization does not appear to be a therapy company like HealthPRO or Genesis. Large therapy company contracts are typically set up as a per-diem payment for skilled employees and a percentage of the fee schedule for long-term payors. The facility has a separate contract for speech therapy with an individual speech therapist; rates are hourly for both contracts, rather than per unit, and there is no language in either contract that speaks of productivity. When paying for contracted staff, the facility should have at least some awareness of what services are being provided in the hours for which the facility is paying.

Recommendation

HDG recommends the facility review contract specifics and amend, if necessary, to address productivity.

Therapy Processes and Systems

HDG reviewed the therapy services and processes at the facility. Findings and recommendations are provided below.

- Therapy is provided daily; therapy staff completes sections GG and O of the MDS, and manages minutes. HDG recommends that therapy and nursing collaborate when completing Section GG of the MDS, as it should also include time on the units for all three shifts for three days.
- Included in PT/OT contract is participation in care planning and discharge planning. HDG's interview with therapy manager supports this.
- Therapy caseload has been as high as 8, but is typically 1 to 2. Therapy department completes screenings to look for opportunities for Part B caseload.
- Therapy is included in Medicare/IDT meeting, care plan conference meeting, and fall discussion (not an organized meeting).
- Therapy manager is not aware of therapy compliance program at facility, nor are any audits conducted. HDG recommends the facility audit a sampling of Medicare A and Medicare B claims to ensure compliance and accuracy.

- Therapy currently has no involvement in admissions or marketing. HDG recommends that therapy attend the marketing meeting to assist facility in marketing to perspective rehab patients.
- Therapy department does not take part in any community events.
- Therapy schedule is as follows:
  - Therapy director provides PTA daily, PT every Tuesday, and comes in to do evaluations.
  - Either OT or COTA is on site daily.
  - Speech therapist is on site only when resident is receiving speech therapy; currently, no one on caseload is receiving speech therapy.
  - Therapy is provided 5 days per week and on weekends, if needed to increase RUG; contract does not address provision of therapy 5 days per week. HDG recommends increasing therapy services to include weekends in order to capture higher RUG for Medicare.
    - Therapy manager generally understands therapy RUGs, but is not well versed on nursing RUGs and has only a weak understanding of ADL scoring. HDG recommends providing additional education for therapy manager on RUGs, ADLs, and ADL scoring.
- Alternate therapist is assigned when regular therapist is sick or on vacation.
- MDSs are opened timely; therapy manager is not aware of any issues with assessment not being opened.
- Therapy director stated there is no specified RUG expectation from company she works for or from Fair Meadow. HDG recommends that written expectations be developed and provided to the therapy director regarding RUG utilization and caseload.
- Therapy is not currently involved in QAPI or QM management. HDG recommends that therapy be included in QAPI and QM management.
- Software used for therapy is Rehab Optima; however, staff wishes to switch to SMART, as that is the software used at their home facility.
- Software used for therapy billing and notes is Optima, which does not interface with PCC for entering therapy minutes. HDG recommends contacting PCC and setting up an interface with Optima.
- Therapy has some interaction with restorative, mostly in form of program specifics following therapy. Follow-up from nursing is satisfactory. HDG recommends that therapy attend part of monthly restorative meeting to address increasing current caseload and improvement in restorative programming.

- HDG recommends the facility request a monthly or quarterly report from its contracted therapy vendor addressing benchmarks, utilization, and productivity.

Clinical Reimbursement/RAI Process Management

As part of the on- and off-site clinical assessment, HDG conducted interviews, attended meetings, met one-on-one with MDS completers, and reviewed medical records. Our observations and recommendations are as follows.

MDS Completion, Medicare, and Case Mix Review

- MDS coordinator (MDSC) is at facility on Tuesdays for weekly Medicare/IDT meeting; however, most correspondence with MDSC is via email exchange, as she works remotely.
- MDS assessments were completed timely; HDG's audit of six months' of submission validation reports indicated only one MDS was completed late.
- MDS coordinator/completer completes sections E, G, H, I, J, L, M, N, O, and P and CAA assessments specific to those sections. MDS also completes ICD-10 coding. Social services completes sections B, C, D, and Q and CAA assessments specific to those sections. Activities completes section F and CAA assessment for activities. Dietary manager completes section K and CAA assessment for nutrition. Therapy completes section GG and therapy minutes specific to section O.
- HDG's review of Medicare records indicated all minutes were entered in section O, verified by therapy logs. All certifications and recertifications are in place and all denial letters are complete.

Opportunities for Process Improvement

During the assessment, HDG identified areas that have opportunity for improvement, which are provided below along with corresponding recommendations.

- MDS staffing consists of four nurses involved in MDS completion. One RN works mostly from home, approximately 5 hours per week. She comes in for the weekly IDT/Medicare meeting. She opens and closes all assessments, submits assessments, and completes the MDS calendars. The remaining three nurses are the nurse managers for the three units. Each nurse completes MDS assessments for their assigned units.
  - HDG recommends reducing department staffing down to 1 FTE with AANAC certification, who would be responsible for all scheduling, opening, closing, submission, and completion of MDS; and completion of initial comprehensive care plan along with quarterly and annual updates. It is also recommended that a nurse manager be trained as back-up MDSC for vacations.

- HDG attended facility's Medicare meeting, which was moved to accommodate HDG's visit. A good discussion ensued regarding therapy progress along with nursing needs. Meeting is normally led by MDSC, who works mostly from home; however, DON ran this particular meeting. MDSC takes notes and enters Medicare/IDT progress note in PCC for each resident. Sign-in sheet is utilized to document meeting attendees. No log or tracking form is utilized during the meeting. HDG recommends the following:
  - Include in Medicare meeting a discussion of resident receiving Part B therapy to address case mix opportunities.
  - Institute tracking log to monitor residents' skilled stay, including a space for addressing those residents on part B therapy.
- HDG reviewed Medicare documentation for those residents who were audited. Fair Meadow PCC does not have a Medicare Note option in progress notes tab; staff utilizes the nurses' notes option. Notes are not entered consistently daily and do not address skilled service on a consistent basis. HDG recommends the following:
  - Add a Medicare note in the progress notes tab for ease of review of notes.
  - Institute a Medicare charting guideline sheet to assist nursing with focus of their charting.
  - Provide education to nursing staff on Medicare charting.
- No RUG screening tool is used in the admission process, either for skilled or case mix admissions. HDG recommends utilizing a RUG screening tool as a guideline of what RUG the resident will most likely fall into on their first completed assessment.
- Case mix index and restorative programming: During a recent case mix audit conducted by the State of Minnesota, a total of 20 records were reviewed with a 25 percent error rate; of the five records with errors, all were decreases in RUG levels. All reductions where related to restorative programming and per case mix auditor it was related to care planning and lack of measureable goal. HDG recommends the following:
  - Conduct a full review of all residents on restorative/functional maintenance programming.
  - Develop individual care plans per program; e.g., separate care plans for walking and range of motion (ROM) versus combining into one care plan.
  - Ensure that goals are measureable.
  - Institute monthly meeting between restorative nurse and therapy manager with review of care plan for continued appropriateness of programming.

  - Audit a sampling of case mix index annually—one to two months prior to expected audit date—to ensure compliance, with focus on restorative programming.
  - Review case mix index for those residents in reduced physical function and behavioral/cognitive RUG for possible inclusion in restorative/functional maintenance programming.
- Most interaction between MDS and therapy occurs in the form of email. HDG recommends more interaction between MDSC and managers who complete assessments, perhaps face-to-face meeting for consideration of ADLs when picking ARD dates.

CMI ADL Review

Table 21 shows potential under coding in some ADL areas. Although point-of-care and MDS match, these areas could be up-coded by staff and resident interview to support.

Table 21: CMI ADL Coding Summary

Resident #	Current RUG/ADL	Reason for Change	New RUG/ADLs	Change in CMI**
1791	LC1 ADL (10)	bed mobility under coded	LD1 ADL (12)	LC1-1.02 LD1-1.21
1730	PC2 ADL (10)	transfer under coded	PD2 ADL (12)	PC2-0.91 PD2-1.15
1798	CC1 ADL (10)	transfer under coded	CD1 ADL (12)	CC1-0.96 CD11.15
1794	BA1 ADL (1)	bed mobility under coding	BB1 ADL (2)	BA1-0.53 BB1-0.75

VALUE-BASED MARKET DYNAMICS

Across the country, there has been explosive growth in value-based payment models, whose goal is to promote lower costs and improved quality directly through payment policy. Neither of the two primary referring hospitals noted below are participants in value-based programs such as Bundled Payments for Care Improvement (BPCI), accountable care organizations (ACOs), or are located in a region with mandatory episode payment models (EPMs). This can be a typical scenario for rural locations where scale often presents a challenge in addressing these type of programs

Referring Hospital Profiles

The two primary referring hospitals for the facility are Altru Hospital and Riverview Hospital. Brief profiles are provided below.

Altru Hospital

Altru Hospital is a short-term, acute care hospital with 253 staffed beds, an average daily census of 113, and approximately $557 million in net patient revenue. Located in Grand Forks, North Dakota, Altru is designated as a Level 2 Trauma Center. Approximately 47 percent of its patients receive care covered by the Medicare program, while 19 percent are covered by Medicaid (remainder are managed care or commercial).

According to the latest metrics published by the Centers for Medicare & Medicaid Services (CMS), Altru Hospital is in the upper quartile of hospitals nationally on its Readmissions Penalty, Total Hospital-Acquired Condition, and Medicare Value-Based Purchasing Total Performance Score. A summary of these metrics is provide in the table below.

Table 22: CMS Performance Metrics for Altru Hospital

Metric	Score	National Percentile
Readmission Reduction Adjustment Penalty Score	0.00%	99
Total Hospital-Acquired Condition (HAC) Score	3.3	83
Medicare Value-Based Purchasing Total Performance Score	44.2	79
All Cause Hospital-Wide Readmission Rate	15.20%	56
Serious Complication Rate	0.86	56

Source: Definitive Healthcare

This performance can be important to hospital administrators because it can manifest in rate adjustments (both positive and negative). For example, Altru is expected to experience a positive adjustment in inpatient Medicare revenue of $379,000 as a result of its Medicare Value-Based Purchasing (VBP) Total Performance Score and will experience no negative adjustment as a result of the Hospital Readmissions Reduction Program. In coming years,

the Medicare program is expected to increase its reliance on these type of adjustments to create incentives for improved quality and lower costs.

Fair Meadow Nursing Home is ranked 51st (in terms of volume) among discharges to skilled nursing facilities (SNFs) from Altru. The top 10 SNFs receiving discharges from Altru are shown in Table 23 below.

Table 23: Top Ten Skilled Nursing Facilities Receiving Discharges from Altru Hospital

SNF Name	City	State
Valley Eldercare Center	Grand Forks	ND
Northwood Deaconess Health Center Swing Bed Unit	Northwood	ND
CHI St Alexius Health Devils Lake Hospital Swing Bed Unit	Devils Lake	ND
First Care Health Center Swing Bed Unit	Park River	ND
Unity Medical Center Swing Bed Unit	Grafton	ND
Lifecare Medical Center Swing Bed Unit	Roseau	MN
North Valley Health Center Swing Bed Unit	Warren	MN
Villa St Vincent	Crookston	MN
Sanford Mayville Medical Center (FKA Union Hospital) Swing Bed Unit	Mayville	ND
Sanford Hillsboro Medical Center Swing Bed Unit	Hillsboro	ND

Riverview Hospital

Riverview Hospital is a Critical Access Hospital (CAH) with 25 staffed beds, an average daily census of 8 patients, and net patient revenues of $54 million in 2015. Riverview is located in Crookston, Minnesota. As a CAH, Riverview is generally not subject to the same potential rate adjustments as Short-Term Acute Care Hospitals. Accordingly, there is no data on the hospital's performance on value-based purchasing (VBP) or readmissions reduction.

Fair Meadow Nursing Home is ranked fourth (in terms of volume) among discharges to SNFs from Riverview. The top 10 SNFs receiving discharges from Riverview are shown in Table 24 on the following page.

Table 24: Top Ten Skilled Nursing Facilities Receiving Discharges from Riverview

SNF Name	City	State
Villa St Vincent	Crookston	MN
Riverview Hospital Swing Bed Unit	Crookston	MN
North Valley Health Center Swing Bed Unit	Warren	MN
Fair Meadow Nursing Home	Fertile	MN
Northwood Deaconess Health Center Swing Bed Unit	Northwood	ND
Valley Eldercare Center	Grand Forks	ND
Oakland Park Communities	Thief River Falls	MN
McIntosh Senior Living	McIntosh	MN
Pioneer Memorial Care Center	Erskine	MN
Essentia Health Fosston (FKA: First Care Medical Services) Swing Bed Unit	Fosston	MN

Payor Profiles

Slightly more than half of the Medicare-eligible beneficiaries are enrolled in Medicare Advantage plans in Polk County. This is below the Minnesota state average, but well above the national average, as shown below.

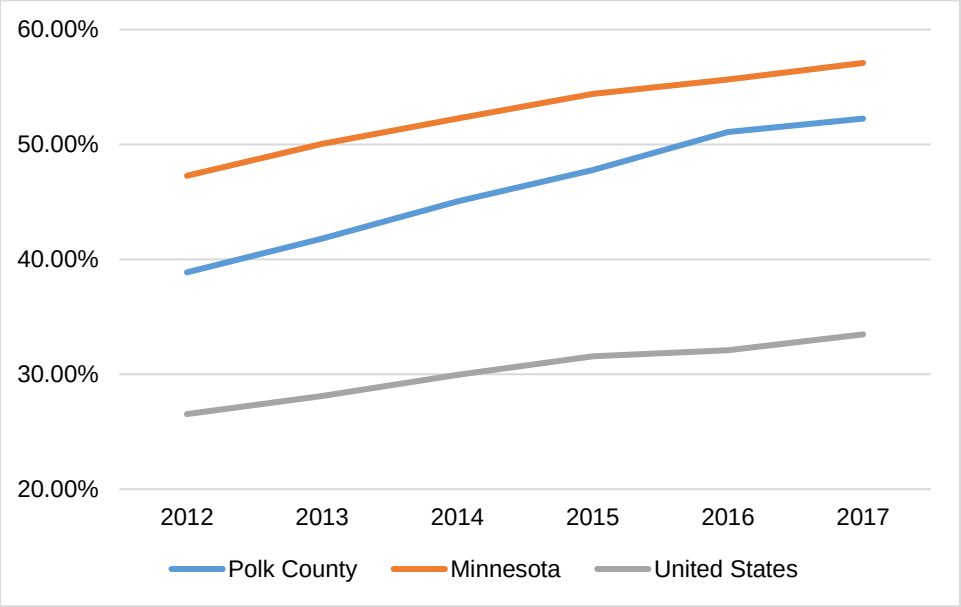
Table 25: Medicare Advantage Enrollment by County, State and Nation

Geography	Eligibles	Enrolled	Penetration
Polk County	6,547	3,421	52.25%
Minnesota	975,846	557,177	57.10%
United States	57,496,520	19,242,894	33.47%

Source: Centers for Medicare & Medicaid Services July 2017 Enrollment

Medicare Advantage enrollment has been growing across the country and in Polk County, as shown in Figure 1 below.

Figure 1: Medicare Advantage Enrollment



Of those enrolled in Medicare Advantage, Blue Cross Blue Shield of MN is the predominant payor.

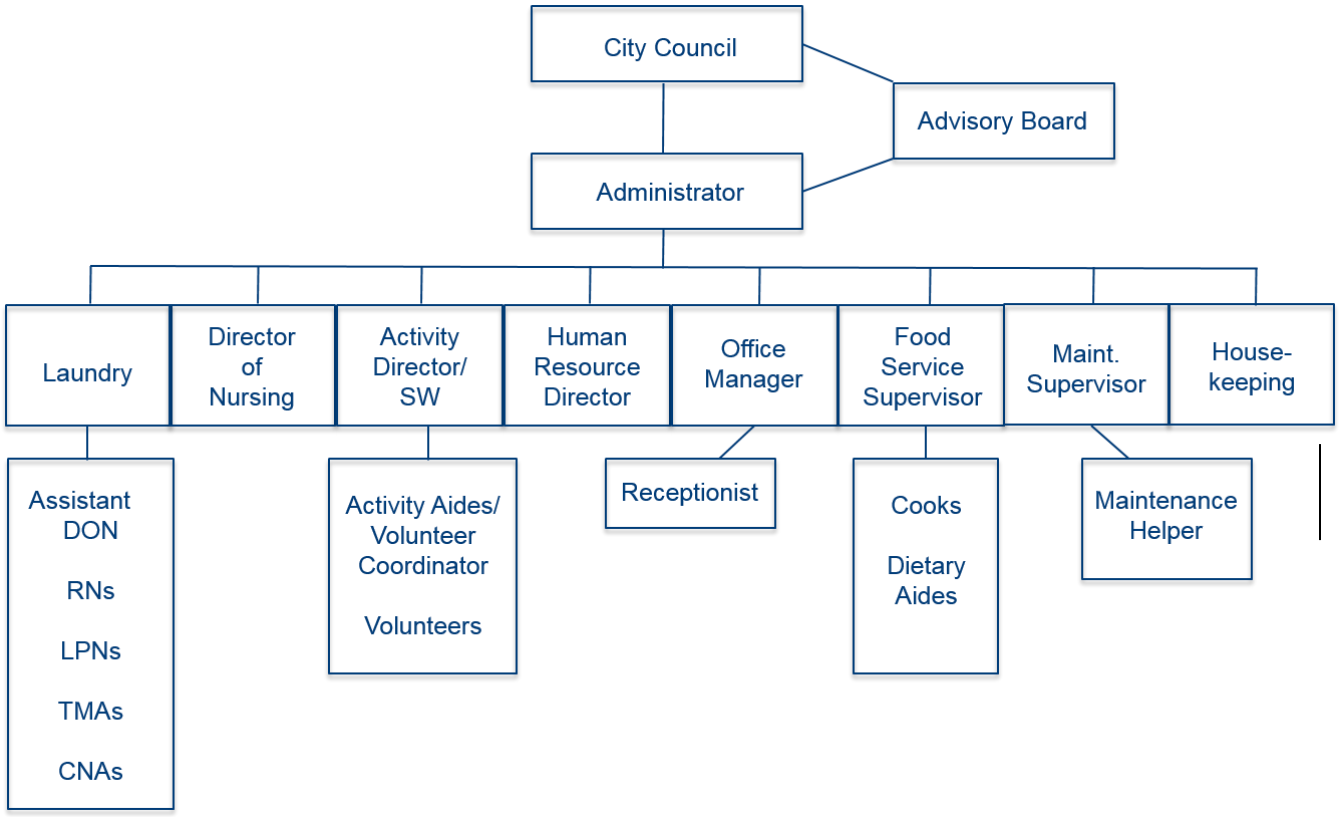
Table 26: Medicare Advantage Payor Summary

Organization Name	Plan Type	Enrolled	Market Share
BLUE CROSS AND BLUE SHIELD OF MN	1876 Cost	1,975	58.0%
MEDICA INSURANCE COMPANY	1876 Cost	668	19.6%
BLUE PLUS	HMO/HMOPOS	226	6.6%
HUMANA INSURANCE COMPANY	Local PPO	216	6.3%
UCARE MINNESOTA	HMO/HMOPOS	132	3.9%
UCARE MINNESOTA	HMO/HMOPOS	81	2.4%
MEDICA HEALTH PLANS	HMO/HMOPOS	76	2.2%
GROUP HEALTH PLAN, INC. (MN)	1876 Cost	34	1.0%
Total		**3,408**	**100.0%**

Source: Centers for Medicare & Medicaid Services, July 2017 enrollment
Polk County, Minnesota, July 2017 enrollment

APPENDIX A: FAIR MEADOW NURSING HOME ORGANIZATIONAL CHART

Fair Meadow Nursing Home Organizational Chart



APPENDIX B: INSURANCE VERIFICATION FORM

New Resident Insurance Information

Name of Resident: _____ Date of Birth: _____

Date of Admit: _____

Medicare #: _____ Medicaid #: _____

Insurance #: _____

Primary Insurance _____ **Secondary Insurance** _____

Name of Insurance Company: _____

Claims Address: _____

Phone #: _____ Fax #: _____

Prior Auth Phone #: _____ Prior Auth Contact: _____

Policy ID #: _____ Group ID #: _____

Insurance Effective Date: _____ **Auth. Number:** _____

In Network ☐ Yes ☐ No Out of Network ☐ Yes ☐ No

3-day hospital stay needed? ☐ Yes ☐ No Deductible met? ☐ Yes ☐ No

Max out of pocket met? ☐ Yes ☐ No Out of pocket Max $_____
100 % paid for _____ days? Co-insurance of _____ after day _____?

Co Pay for Days _____ to _____ Co Pay for Days _____ to _____
Co Pay for Days _____ to _____ Co Pay for Days _____ to _____

Type of Service	Covered	Prior Authorization Needed	Description of Coverage
Skilled Room and Board Medicare RUGs Negotiated Rate	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Occupational Therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Speech Therapy	☐ Yes ☐ No	☐ Yes ☐ No	

APPENDIX C: TRIPLE CHECK POLICY AND FORM

Medicare Triple Check Review

Purpose
Ensure that Medicare is billed accurately on time with all incurred costs allowed under the Medicare program.

Participants
TCU nursing director, MDS coordinator, business office, medical records, rehab, central supply (if needed)

Overall process
- The TCU nursing director or the MDS coordinator facilitates a periodic (bi-weekly or monthly) Medicare Triple Check Review to verify that claims are accurate before submission to the hospital's fiscal intermediary. No claim should be transmitted without this review.
- The review process uses the Triple Check Review Form below to check for completion and accuracy of a range of information critical for the Medicare claim – information where discrepancies are most common. The meeting verifies and cross-checks information primarily from three sources: the medical record, the MDS and the claim itself.
- The Triple Check Review Form should be completed during the session and filed with month-end closing reports. Items verified as correct are recorded as "Y"; incorrect items are recorded as "N", with steps required to correct them noted (if corrected during the meeting, they can be coded "Y"). Corrections can be made during the session, or scheduled for correction immediately following. Claims requiring follow up work should not be transmitted for payment until corrected and reviewed for completion at a subsequent Triple Check Review.
- All claims, whether for Medicare or commercial insurance, should go through the Triple Check Review – and through the entire Medicare process – because Medicare may possibly become a payer after initial claim adjudication and commercial payers may require the hospital to handle their cases under Medicare procedures.

Comparison and verification steps
<u>Business office lead</u>
1. The qualifying stay on UB-04 FL#35-36 and on the medical records face sheet.
2. Patient has benefit days available, per the common working file (CWF).
3. The admissions date on the UB-04 FL#12 and on the manual census log.
4. The covered service dates on UB-04 FL#6 and on the Medicare and manual census logs.
5. A signed and completed MSP form in the patient's financial file.
6. Daily room rate charges documented in FL# 42,43 and 47

Medicare Triple Check Review

Business office lead and MDS coordinator lead

1. The MDS used in claim submission agrees with the validation report received from the state repository.
2. The assessment reference dates on each MDS agree with the dates on UB-04 FL#45.
3. The RUG level on each MDS agrees with RUGs on UB-04 FL#44
4. The assessment type for each MDS agrees with the modifier on UB-04 FL#44
5. The number of accommodation units on UB-04 FL#46 agrees with the assessment type for each MDS.
6. The total number of accommodation units agrees to covered service dates on FL#6.
7. All ancillary services and charges for the billing period are line itemed on FL# 42, 43, and 47.

Rehab lead

1. All therapy minutes per the daily treatment grid agree with the PT service log.
2. Days and minutes on the MDS agree with the treatment grid.
3. Number of units billed on the UB-04 FL# 42,43,44,46 and 47 agree with the service log.

MDS coordinator and/or medical records lead

1. All physician SNF orders obtained and implemented
2. The medication record is complete
3. The UB-04 FL diagnosis codes in FL # 67 correspond to the physician diagnosis on either of the following: hospital discharge summary, transfer order form or via a telephone order obtained on time after admission.

Medical records lead

1. Rehabilitation services are stated on a physician's order.
2. Physician certification/recertification forms completed and signed by physician.
3. The denial letter and expedited review letters have been sent.

Medicare Triple Check Review

Resident Name: Admit Date to Medicare A stay:
Physician: Medical Record #:

Triple Check Review Form				
Discipline	**UB 04 item FL**	**Description**	**Correct? Y/N**	**Comments / follow up**
Business office lead	35-36	Hospital acute stay that leads to the skilled service (3 overnights), excluding observation		
	CWF	Days available, from common working file		
	12	Admit date to SNF		
	6	Statement cover period		
	MSP	Medicare as secondary payer form completed		
	42,43,46,47	Room and board: revenue code, description, # of days and total charges		
Business office lead and MDS coordinator	MDS validation report	Sent and accepted prior to billing		
	45	ARD date on MDS to be billed		
	44	RUG and HIPPS code		
	46	# of days to bill		
	7	Type of bill		
	42,43,44,46,47	Line item of all ancillary services provided during the billing period: Rx, lab, x-rays, med supplies and equipment, etc.		
MDS coordinator and rehab lead	42	PT, OT, speech revenue code		
	43	PT, OT, speech description		
	46	PT, OT, speech # of units		
	47	PT, OT, speech total charges		
MDS coordinator and medical records lead	SNF orders	Upon admission on transfer sheet or via telephone order		
	67-----	ICD 9 codes for skilled services		
Medical records	Rehab orders	Upon admission or with		

Medicare Triple Check Review

Triple Check Review Form				
Discipline	**UB 04 item FL**	**Description**	**Correct? Y/N**	**Comments / follow up**
lead		physician order		
	Certs/recerts	Completed and signed timely		
	Denial letter and expedited review letter	Completed and sent timely (2-day notice), as appropriate		

Triple Check																
Patient Name	**Admit Date**	**Conditions of Participation**			**MDS**			**UB 04**			**Therapy Logs**			**Reconciliation**		
		MSP	AOB	Cert Recert Date	ARD	Modifier	Service Days	Days	Minutes	Units	Days	Minutes	+ -	Denial / Demand Bill	Payment	+ -
Comments:																
Comments:																
Comments:																
Comments:																
Signature_____ Signature_____ Signature_____ Date _____																

APPENDIX D: TIMEKEEPING SYSTEMS

SmartLinx
PEOPLE | PRODUCTIVITY | POWER

Proposal

SmartLinx Solutions, LLC
333 Thornall Street, 4th floor
Edison, New Jersey 08837

Proposal Date: August 14th, 2017
Expiration Date: September 14th, 2017

Customer: City of Fertile
Street Address: 101 North Mill Street
City, State Zip: Fertile,Minnesota 56540

Sales Representative: Gordon Huseth
Contract #: 104388

Software Subscription

Quantity	Item Description	Price/License/ Month		Monthly Fees
100 licenses	Schedule Optimizer	$1.44		$144.00
100 licenses	Time and Attendance	$1.44		$144.00
-	Attest	-		-
-	Mobile Employee Self-Service	-		-
-	Accruals	-		-
100 licenses	Payroll	$2.00		$200.00
-	Human Resources	-		-
-	ACA Director	-		-
100 licenses	Payroll Based Journal (PBJ)	$1.20		$120.00
-	Applicant Tracker*	-		-
-	Business Analytics	-		-
	Total Software Subscription Fees			**$608.00**

Other Subscription Services

Quantity	Item Description	Price/Month		Monthly Fees
150 licenses	Hosting	$0.80		$120.00
Up to 5000 messages per month	SMS Notifications	$250.00		$250.00
-	SmartLinx Phone Punch	-		-
	Total Other Subscription Services Fees			**$370.00**

Hardware

Quantity	Item Description	Price per Unit	One-Time Purchase Fees	Monthly Fees
1	SLX 5500 Time Clock : Net New			$220.11
1	Hardware Host Platform	$2,000.00	$2,000.00	
	Total Hardware		**$2,000.00**	**$220.11**

Implementation, Training & Support Services

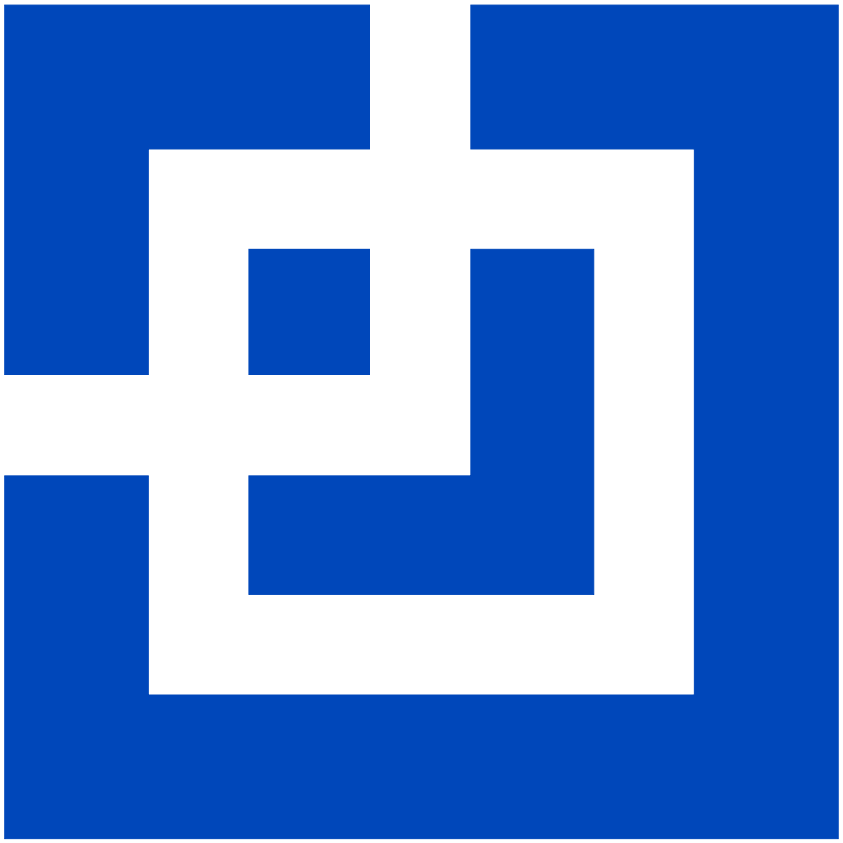
Quantity	Item Description	Price per Unit	One-Time Purchase Fees	Monthly Fees
212	Implementation : Time & Materials	$165.00	$34,980.00	*Estimate
	Smartlinx University		$3,150.00	$125.00
-	Smartlinx University - Addt'l Seats	-		-
	Interfaces Standard Employee HR Data Import			$30.40
-	Support for Subscription Services are included at no additional cost	-	-	
	Total Professional Services		**$38,130.00**	**$155.40**

Total

	Total One-Time Purchase Fees	Total Monthly Fees
Total	**$40,130.00**	**$1,353.51**

**Estimate only. Implementation, Training, and Support will be provided, invoiced, and payable in full as provided in the applicable Statement of Work.*

SmartLinx™
PEOPLE | PRODUCTIVITY | POWER



Budgetary Estimate prepared for City of Fertile

SmartLinx Solutions LLC.
333 Thornall Street
4th Floor
Edison NJ 08837
Phone +1 732-851-4433
www.smartlinxsolutions.com

1. DESCRIPTION OF WORK

This document presents only a BUDGETARY ESTIMATE of the work that may be required to meet City of Fertile's (hereafter referred to as 'Customer') requirements as understood by SmartLinx Solutions, LLC (hereafter referred to as 'SmartLinx') at this time.

Once the scope of the project, requirements, assumptions, relative responsibilities of the parties are understood and mutually agreed by the Company and SmartLinx, they will be set forth in a written Statement of Work to be signed by both parties. The parties agree that this document does not constitute a binding offer and shall not be deemed to create any binding obligation whatsoever on either party, or used to interpret or modify either party's rights or obligations under a Statement of Work or any other agreement. Notwithstanding the foregoing, Company agrees to treat this document as confidential and not to disclose it to third parties.

Based on the following general (non-exhaustive) assumptions, SmartLinx has produced an estimate for the implementation of an enterprise Human Workforce Management solution.

2. SCOPE OF SERVICES

The scope of services for this project includes the implementation of the following Products and Add-Ons :

Products and Add-Ons	Scope
Time and Attendance	Included
Schedule Optimizer	Included
Payroll	Included
Human Resources	Excluded
Business Analytics	Excluded
Mobile Employee Self Service	Excluded
Applicant Tracker	Excluded
ACA Director	Excluded
Accruals	Excluded
Attest	Excluded
Payroll Based Journal (PBJ)	Included
1095C Reporting	Excluded
Time Clocks	Included
Integrations with 3rd Party Systems	Included
SMS Notifications	Excluded
Phone Punch	Excluded

The scope of services for this project is based on the following sizing information we gathered about your scope:

Parameter	Number
Total number of facilities	1
Total number of employees (across all facilities)	125
Total number of waves / phases	1

In support of the defined scope, the following deliverables and assumptions have been used in the preparation of your budgetary estimate:

Deliverables and Assumptions	Scope
Pilot and copy deployment; pilot facility will be configured and then duplicated to successive facility rollouts	Included
Delivery of standard, out-of-the-box SmartLinx reports for all purchased products	Included
Scope of delivery assumes standardized, out-of-the-box interfaces	Included
Setup and calibration of up to one (1) SmartLinx time clocks	Included
Payroll configuration of up to one (1) federal tax IDs	Included
Configuration to accommodate up to five (5) pre-tax deductions	Included
Rule and policy configuration to enable Customer to pay in up to two (2) states	Included
Payroll configuration to support local withholdings in all operating states	Included
Configuration enabling Payroll Based Journal (PBJ) reporting	Included
Scope of delivery includes standard import of employee metadata from 3rd party Human Resources system	Included

4. ESTIMATED IMPLEMENTATION COSTS

The following budgetary estimate has been provided based on the scope as it is currently understood and documented.

The total estimated cost for the deployment is between $25,900 and $35,000.

5. ESTIMATED TRAINING COSTS

Required instructor led training and OnDemand eLearning will be delivered through SmartLinx University

Based on the scope as currently defined, the cost of training services is as follows:

Package	One-Time Fees	Monthly Fees
SmartLinx University Year (Onboard Package)	$3,150	$125

Please note that attending training enables your employees to utilize the support channel (phone and web support).

There is a maximum of 10 attendees per online instructor-led training and 20 attendees per onsite instructor-led training to ensure productivity and effectiveness of the training.

The monthly fee covers up to 3 eLearning seats. Additional seats can be purchased separately.

APPENDIX E: QUALITY MEASURE QUICK REFERENCE CHART

Quality Measure Quick Reference Chart

Domain	MDS Elements	Helpful Tips
5 Star QMs		
Self-Report Moderate / Severe Pain (S) = 100 days or less (L) = 101 days or longer MDS look back is 5 days	At least one episode of moderate/severe pain, or horrible/excruciating pain of any frequency in the last 5 days. Based on resident pain assessment interview - will not include staff or if dashed. Meets either or both of the following 2 conditions: **Condition #1:** Resident reports daily pain with at least one episode of moderate/severe pain. • Almost constant or frequent pain (JO400 = 1, 2) *AND* • At least one episode of moderate to severe pain. (JO600A = 05, 06, 07, 08, 09) or JO600B = 2, 3) **Condition #2:** Resident reports very severe/horrible pain of any frequency. (JO600A = 10; or JO600B = 4)	• Pain interview completed at the start of the observation period. • IF resident's answers would trigger QM negatively then complete full clinical pain assessment with notification of MD along with new orders, if appropriate. • Repeat MDS pain interview at the end of the observation period (ARD). • Intent is to address pain positively to effect a positive change on the MDS and positive response for the QM. • Compare standard pain assessment along with MDS interview items to assure continuity in language usage. • Use the same scripted (MDS) language by all team members when discussing pain with resident. • Meet with Medical Director to make it clear that we are working on our pain issues so he can provide clear follow up. • If individual resident continues to be a concern for QM, ongoing assessment and interventions, possible psych involvement?
High Risk Pressure Ulcer (L) MDS look back is 7 days	**Condition #1:** High Risk for pressure ulcer (1 or more of following 3 criteria: (1) Impaired bed mobility or transfer; (2) Comatose, (3) Malnutrition or risk of malnutrition is checked.) *AND* **Condition #2:** Stage II – Stage IV pressure ulcers are present	• Identification of those residents who meet the intent of HIGH risk. • Identify risk level associated with Braden/Norton scale. • There should be correlation between the two, if not investigate which component is off. • Interventions in place to account for risk. • Have a discussion with IDT if there is a question on accuracy of documentation or question at to type/size of ulcer(s). • If QM is flagging suggest addressing each resident with risk during QAPI.
New or Worse Pressure Ulcer (S) MDS look back is 7 days	One or more new or worsening Stage II – Stage IV pressure ulcers (as compared to a previous assessment). Information from MO300 and MO800.	• Review initial assessment carefully to assure accuracy of wound documentation at first MDS. • Assure consistency of personnel completing measurements between assessments. • Review all info with IDT if questions on documentation of wound. • Braden/Norton scale completed x4 post admission then Q month thereafter, through first quarter. • Interventions in place to account for residents individual risk level, based not only on overall risk but individual components of assessment. • Review CAA finding and next steps. • If QM is flagging suggest addressing each resident with mod to high risk in QAPI.
Newly Received an Antipsychotic Medication (S) MDS look back is 7 days	Short stay residents (first 100 days) who are receiving an antipsychotic medication during target period but were not on their initial assessment. NO410A – antipsychotic medication received 1, 2, 3, 4, 5, 6, or 7 days. Exclusions: Coded in Section I – any of the following on any assessments during look back scan: Schizophrenia; Tourette's Syndrome; or Huntingtons's Disease.	• Do we have supportive documentation that the drug is truly necessary? • Why wasn't the resident admitted with the drug? • What are behaviors necessary for the need for the drug? • All identified behaviors upon admission where there is no order for medications. • Assure monitoring in place, i.e. behaviors, dose reduction, AIMS/DISCUS testing in place.
Fall with Major Injury (L) MDS look back is since last scheduled assessment. That could be 3 months, 1 month, or a couple of weeks. Just depends on when the last assessment was completed.	Long stay residents who have experienced one or more falls with major injury. Will continue to trigger the QM for up to one year after the incident. MDS – J1800 and J1900 Major injury = bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.	• Safety/Fall risk assessment and findings/ level of risk, i.e. High, Medium, and Low. • Interventions in place to account for risk level. • History of injuries associated with falls especially major. Should automatically make resident high risk. • Address those resident with history of major injuries of those residents with a high percentage of falls at QAPI. • Review of those resident who trigger the CAA for fall risk and findings. • Make sure all team members are clear on the definition of major injury per the MDS so coding is accurate.

Quality Measure Quick Reference Chart

Domain	MDS Elements	Helpful Tips
Long Stay Residents with a Urinary Tract Infection MDS look back is within the last 30 days	Residents who have had a urinary tract infection within the last 30 days. MDS I2300 is checked. Excluded for admission assessment, PPS 5 day, or readmission/return assessment. To code for UTI per MDS – must include all of the following: Physician diagnosis; S/S; "significant laboratory findings"; and current meds or treatment in the last 30 days.	• First and foremost assure MDS is accurate. RAI manual is very specific on coding of UTI, if you are not meeting the RAI specifics do not code as UTI. • Track those resident with history of UTI's to assure interventions are in place to reduce potential for repeats and address at QAPI. • Consider doing another assessment when out of timeframe if appropriate.
Residents who have a catheter inserted and left in their bladder (L) MDS look back is 7 days	Long stay residents who have had an indwelling catheter at any time in the past 7 days. MDS – H0100A = checked Exclusions: Section I diagnoses – Neurogenic Bladder; or Obstructive Uropathy.	• Diagnosis coded accurately, if not an excluded one then appropriate for use of catheter. • Due diligence for removal of catheter, i.e. urology appointment, trial removal of catheter. • How often do we attempt removal of catheter or follow up with urology? • Suprapubic, nephrostomy, and urethral inserted all count in this area.
Residents who were physically restrained (L) MDS look back is 7 days	Physically restrained on a daily basis within the 7 day look-back period. MDS – P0100 B, C, E, F, or G	• Pay attention to possibility of hidden restraints. • It is truly the least restrictive device. • Historically what have we tried?
Need for help with Activities of Daily Living has increased (L) MDS look back is 7 days	Residents whose need for help with late-loss ADLs has increased when compared to the prior assessment. Late Loss ADLs: (self-performance) • Bed mobility • Transfer • Eating • Toileting Increase = 2 or more late loss ADL items. Residents meet the definition if **either** of the following is true: **(1)** Increase of one point in coding in 2 of the late loss ADLs; **(2)** Increase in 2 points in one of the late loss ADLs. Exclusions include: Life expectancy less than 6 months on the target assessment (J1400); or Hospice Care on the target assessment (O0100K2).	• First and foremost assure MDS section G is accurate when compared to medical record and it depicts the resident as they truly are. • Assess those residents who flag for potential for significant change. • Provide listing to therapy of those residents who flag for review and possible inclusion on case load. • Compare other ADL's for decline as this might point to residents who are "at risk" by running a response analyzer in PCC to look for changes not yet flagging. • Review those residents who trigger the CAA for finding and next steps. • If coded as an 8 – activity did not happen in last 7 days, will be scored as if a 4 for total dependence.
Residents who received an antipsychotic medication (L) MDS look back is 7 days	Will trigger measure if the most recent MDS assessment indicates that antipsychotic medications were received. NO410A = 1, 2, 3, 4, 5, 6, 7. Exclusions – any of the following related conditions present on the target assessment (Section I) • Schizophrenia • Tourette's Syndrome • Tourette's Syndrome on prior assessment • Huntington's Disease	• Appropriate condition for drug? • Reduction schedule? • Psych evaluation to determine appropriate diagnosis?

Quality Measure Quick Reference Chart

Domain	MDS Elements	Helpful Tips
CASPER QMs		
Prevalence of Falls (L) MDS look back is since last scheduled assessment. That could be 3 months, 1 month, or a couple of weeks. Just depends on when the last assessment was completed.	Residents who have had one or more falls reported on one or more scan assessments. These measures trigger if the event occurred any time during a one year period. The resident will still trigger the measure for up to one year after the initial fall, even if current MDS is coded as no fall in J1800.	• Safety/fall risk assessment and findings, i.e. high, medium and low. • Appropriate interventions in place based on fall risk. • Review of those residents who trigger the CAA for fall risk and findings. • Address those resident with high risk for falls with QAPI. • Is resident receiving medication that could be contributing to falls?
Low risk resident lose control of bowel or bladder	Residents will trigger if the most recent MDS indicates frequently or always incontinent of bladder or bowel. Resident will be excluded if they have **any** of the following high-risk conditions: • Severe cognitive impairment (BIMS is 7 or less; or staff assessment = memory problem and severely impaired). • Totally dependent bed mobility • Totally dependent transfer • Totally dependent locomotion Other exclusions: • Resident is comatose • Has indwelling catheter • Has an ostomy	• Accuracy in coding of frequency? Need to validate this info as it is frequently not well documented. • Care plan addresses toileting needs in effort to improve continence level if possible? • Risk factors addressed? • Has resident declined with B&B function?
Residents who lose too much weight	Weight loss of 5% or more in last month, or 10% or more in the last 2 quarters (6 months) who were not on a physician prescribed weight-loss regimen. No exclusions to this. It is the most recent weight in the last 30 days.	• Are weights accurate? Reweights done? • Has the resident been assessed by the RD? • Has resident experienced a change in condition or a change in eating ability? • Is the resident ill or refusing to eat, depressed or having a medical problem that makes eating difficult? • Is the resident being assisted as needed? • Are staff spending enough time feeding residents if they
Prevalence of Antianxiety / Hypnotic Use	Residents who receive antianxiety medication or hypnotics but do not have evidence of psychotic or related conditions in the target period. Residents are excluded if any of the following related conditions are present (checked) on the target assessment unless otherwise indicated: • Schizophrenia (I6000) • Psychotic (I5950) • Manic Depression (bipolar disease) (I5950) • Tourette's syndrome (I5350) • Huntington's Disease (I5250) • Hallucinations (E0100A) • Delusions (E0100B) • Anxiety disorder (I5700) • Post-traumatic stress disorder (I6100) Must be an active diagnosis	• Interventions that do not involve medications should be used first, if possible and the continued use of antianxiety / hypnotic medications should be carefully monitored. • Is there an active diagnosis that can be checked for an exclusion? • Is the drug classified as an anxiolytic or hypnotic? • Is resident experiencing pain that is contributing to anxiety or a sleep disturbance? If so, are they on an effective pain management program? • Have causal factors for sleep disturbance been reviewed for hypnotic use? • Non-pharmacological interventions identified and used?
Behavior Symptoms Affecting Others	Most recent MDS indicates presence of any of the following conditions: • Physical behavioral symptoms directed toward others; • Verbal behavioral symptoms directed toward others; • Other behavioral symptoms not directed toward others; • Rejection or care; • Wandering. For rejection of care – once coded and car planned do not code on next assessment.	• Treat behaviors appropriately with non-medication interventions if possible. • Use of medications may be required and should be carefully monitored. • Are there issues with adjustment, separation from family, frustration, etc. that could be addressed? • Are staff reviewing behavior symptoms as possible attempts to communicate needs or feelings? • Review your behavior tracking system.

Quality Measure Quick Reference Chart

Domain	MDS Elements	Helpful Tips
Residents who have depressive symptoms Lookback period: 2 weeks	Most recent MDS meet either condition A or B: (Resident mood interview **or** staff assessment of resident mood). **Condition A:** Resident interview: Symptom Presence – Little interest of pleasure in doing things half or more of the days over the last 2 weeks. D0200A2 = (2,3) *OR* Feeling down, depressed or hopeless half or more of the days over the last 2 weeks. D0200B2 = (2,3) *AND* Total mood severity score indicates the presence of depression. Total score between 10 and 27. D0300 **Condition B**: Staff assessment of resident mood: Symptom Presence – Little interest or pleasure in doing things half or more of the days over the last 2 weeks. *OR* Feeling down, depressed or hopeless half or more of the days over the last two weeks. *AND* Total mood severity score indicates the presence of depression. Total score between 10 and 30.	• Attempt resident interview if possible. • Follow the script for the interview questions. • Who is asked the questions for the staff interview? • Check to see if resident needs a psychological referral. • Are there adjustment issues or grief issues? • Is chronic pain or illness a factor? • Is resident receiving any medication for these symptoms? Is it effective? Have antidepressants been tried before? • Are these usual traits that the resident displays? Is this a change in personality? Has a referral been considered in the past? Does the medical record have documentation regarding these traits? • Should the resident be on behavior monitoring? • Is there documentation in the care plan regarding these symptoms and approaches?

Quality Measure Quick Reference Chart

Domain	MDS Elements	Helpful Tips
New 5 Star QMs – Added July 2016		
Residents whose ability to move independently has worsened Long stay	Decline in independence of locomotion as compared to a prior assessment. Measures loss of independence with locomotion among residents of the nursing home for more than 100 days. Loss of independence in locomotion is itself an undesirable outcome. Increases risk of hospitalization, pressure ulcers, pneumonia, reduced quality of life, etc. Decline in locomotion on unit: self-performance. Increase in one or more points between target assessment and prior assessment. 7s (occurred only once or twice) and 8s (activity did not occur) are recoded to 4s (total dependence).	
Resident rehospitalized after a nursing home admission Short stay	Medicare claims based short stay: Rehospitalized within 30 days of entry or reentry. Admitted to an inpatient or observation stay. Planned inpatient readmissions are excluded. Includes inpatient or observation stays occurring after discharge from the nursing home but in the 30 day timeframe. Medicare Part A claims included. Medicare Advantage plans not included. Hospice not included. (planned readmissions = pre-specified list of procedures, etc.)	• Are residents admitted from the hospital properly assessed? • Receive appropriate care? • Discharge planning
Residents who have had an ED visit Short stay	Medicare claims based short stay: ED visit within 30 days of entry or reentry. Number of nursing home stays where resident had one or more outpatient claims for an ED visit within 30 days of entry/reentry. Includes output ED visits occurring after discharge from the facility but within the 30 timeframe. If resident is admitted for inpatient or observation stay, will count in that QM but not in the ED visit QM.	• Preventive care • Access to physicians and nurse practitioners may reduce rates of ED visits. • Discharge planning
Residents successfully discharged to the community Short stay	Medicare claims based short stay: Discharged to the community within 100 calendar days of entry, and for 30 subsequent days did not die, was not admitted to hospital for unplanned inpatient stay, and not readmitted to a nursing home. Outpatient ED visits, outpatient observations stays, and planned admissions are not counted as failed community discharges. Medicare Part A claims only. Medicare Advantage plans are excluded. Hospice is excluded.	• Discharge planning • Residents adequately prepared for transition back to community.
Residents whose physical function improves from admission to discharge Short stay	MDS Based. Independence in transfer, locomotion, and walking increases over the course of the nursing home care episode. • Transfer – self performance; • Locomotion on unit – self performance; • Walk in corridor – self performance. Compares earliest initial assessment to the discharge assessment (when return to the nursing home is not anticipated).	

APPENDIX F: PHASE 1 OF NEW SNF/NF REQUIREMENTS OF PARTICIPATION

SURVEY PREPARATION

for Phase 1 of the new SNF/NF Requirements of Participation

Care Providers of Minnesota

Surveyor Training Focus for Phase 1 of the new SNF/NF Requirements of Participation

Summary Prepared by Care Providers of Minnesota – 11-28-16

This document contains information regarding Phase 1 of the new SNF/NF Requirements of Participation that will be effective starting November 28, 2016 (Phase 1). This information highlights how surveyors will implement Phase 1 via the State Operations Manual, F-Tags, and survey process. This document is a modified version of the webinar and YouTube training transcript prepared by CMS as required for state surveyors to complete with passing scores.

The five Regulatory Sections that are fully implemented in Phase I are:

- Resident Assessment
- Quality of Life
- Physician Services
- Laboratory, radiology and other diagnostic services
- Specialized Rehabilitation

15 of the 21 Regulatory Sections are partially implemented in Phase I. **Phase 1 requirements are effective November 28, 2016.**

Because Phase 1 implementation of the new nursing home regulations are effective starting November 28th 2016, you'll find there is no new interpretive guidance. The new regulatory language was incorporated into the existing F-Tag numbering system. New F-Tags and guidance will be available in November 2017.

The following documents highlight key areas of surveyor focus regarding *new regulations* in effect for Phase 1 as identified by CMS for surveyors, along with survey tips provided by Care Providers of Minnesota. Previous regulations remain in effect – this document only summarizes additional or modified requirements.

§ 483.5 Definitions

CMS has added or revised the following definitions:

Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Adverse event: were defined to ensure clarity in our requirements related to proposed requirements for QAPI.

Exploitation: the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats, or coercion.

Misappropriation of resident property: defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

Mistreatment: means "to inappropriately treat or exploit a resident."

Neglect: the facility and its employees are neglectful when a reasonable person would conclude that a deprivation of the omitted goods and services would cause, among other things, emotional distress (rather than mental disorder)

Person-centered care: focusing on the resident as the locus of control and supporting the resident in making their own choices and having control over their daily lives.

Resident representative: include both an individual of the resident's choice who has access to information and participates in healthcare discussions, as well as personal representative with legal standing, such as a power of attorney for healthcare, legal guardian, or health care surrogate, or proxy appointed in accordance with state law to act in whole or in part on the resident's behalf.

Sexual abuse: defined as non-consensual sexual contact of any type with a resident, and

Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§ 483.10 Resident Rights

All existing resident rights have been retained. The language and organization of the resident rights provisions have been updated to improve logical order and readability, such as replacing the term "legal representative" with "resident representative". Regulations have been clarified where necessary, such as adding information regarding physician credentials. Provisions have been updated to include advances such as electronic communications. New combined MN and Federal Bill of Rights must be used for all admissions beginning 11-28-16. Admissions prior to 11-28-16 must be provided with the updated Bill of Rights by 3-01-17.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F151	Documentation should confirm the facility's efforts to support the resident in the exercise of his or her rights.	
F152	Key points to look for are that the resident who was not adjudged incompetent had the right to designate a resident representative and equal treatment of a same-sex spouse who is a designated resident representative. To ensure the resident representative only exercises their decision-making responsibilities as delegated by the resident or court and in accordance with the applicable law, and in accordance with the resident's wishes and preferences. The resident retains the right to make those decisions outside the representative's authority.	Verify that your facilities policies and procedures use the "new" term "Resident Representative" (see definitions section). Verify same-sex relationships are not prohibited and are protected.
F153	Personal and medical records are provided as requested by the individual. Records are provided in a manner the resident can understand.	Verify both printed and electronic version are made available. Verify translation is available for non-English persons.
F154	Residents are informed of the type of caregiver or professional furnishing care, and residents are informed of the risk and benefits of the proposed care and to choose the alternative or option he or she prefers.	
F155	New regulatory language was added. This regulation will move to Quality of Life and new guidance will appear at Phase II implementation (November 28, 2017). The resident also has the right to request and/or discontinue treatment, or to participate in experimental research. If the facility did not provide the information about Advance Directives, the facility needs to ensure an outside contractor did and met the requirements of this section. If the adult individual was incapacitated at the time of admission, the information was provided to the resident representative and then to the resident, if the resident condition changed, was no longer incapacitated, and was able to understand the information.	Verify information regarding advance directives is made available to all residents.
F156	The resident was made aware of who or how to contact other primary care professionals involved in their care. The resident received both an oral and written notification containing the specific information, such as the expanded resources, home and community based service programs, etc. The resident could request information about returning to the community, and the facility had identified that information to provide upon request. The resident was made aware of changes to charges for services not covered under Medicare or Medicaid, or by facility's per diem rate, meeting the stated requirements. And refunds were made to the	Document that appropriate home and community based service option were provided.

	resident, resident representative, or estate, as applicable, meeting the stated requirements. An admission contract did not conflict with the requirements of this regulation.	
F158	The resident is informed of charges in advance that are imposed.	
F159	There are now differing dollar amounts for Medicaid residents and other residents.	Interest bearing accounts for private pay and Medicare must be provided at $100+. Interest bearing accounts for Medicaid must be provided at $50+.
F160	Key points to look for are conveyance of funds for discharged or evicted residents.	Verify the terms discharge and eviction have been added to your policy for return of funds (not just death).
F162	Residents receiving services under Medicaid or Medicare must not be charged for food, nutrition, or hospice services. Items and services that may be charged to residents if not required to achieve resident's goals have been expanded to include: cellphones, computers and other electronic devices. Facility has taken into consideration resident food and cultural preferences when preparing meals. And lastly, the resident was informed orally and in writing for any item or service where there is a charge.	Verify for compliance.
F163	Facilities must verify that attending physicians selected by residents are licensed to practice (Verify at: https://mn.gov/boards/medical-practice/licensees/verification/), determine if resident was informed that their attending physician is unable or unwilling to meet the requirements, and that the facility is seeking an alternate physician, ensure the resident's choice of physician is honored as long as they meet the requirements, and at F164, ensure medical records are kept confidential except in cases cited in this regulation.	Generate list of all current primary physicians and verify MN licenses. Add physician license verification to pre-admission process.
F166	Verify that residents have information on how to file grievances or complaints. Verify that there is grievance policy that includes at a minimum requirements at 483.10(j)(4)(i – vii) and that that there is prompt resolution of all grievances. Verify that posting in prominent locations notify of the right to file grievances orally or in writing and the right to file a grievance anonymously. Verify the facility has identified a Grievance Official. Grievance documents must be maintained for three years.	• Update grievance and complaint policy for compliance. • Identify a Grievance Official and add name to forms. • Verify completed grievance forms are kept for 3 years. • Verify complaints can be filed anonymously.
F167	Verify that the most recent survey results of the facility are posted. Verify that the 3 preceding years of surveys and complaint investigations are available for any individual to review upon request. Verify a notice is posted regarding the availability of such reports in an area of the facility that is prominent and accessible to the public. Ensure that identifying information about complaints or residents are not available in documents made available to the public.	• Verify most recent survey is posted. • Verify you have a binder with 3 years of surveys and completed OHFC investigations available. • Update posting regarding availability.
F168	Verify that the facility did not or does not prohibit or discourage a resident from communicating with external entities.	
F169	Verify the facility does not require a resident to perform services for that facility.	
F170	Privacy of electronic communications is to be provided, and the resident can receive mail and packages from other than the postal service.	Verify that use of internet (if provided) is secure and residents can use cell phones in privacy.
F171	Ensure the facility supported resident's right to communication, including the ability to send mail and access to the internet, to the extent available to the facility.	If you are able to get internet access in your building, verify you have made it available to your residents (can charge for this service)

F172	The surveyor should determine if residents have the right to receive visitors of their choosing and at the time of their choosing, and that they do not impose on the rights of other residents. The surveyor will need to determine that the facility has a policy that includes visitation rights and clinically necessary or reasonable restrictions. The facility will need to ensure that a resident or their visitors are informed of the visitation policies, and that facility staff do not restrict, limit or deny visitation privileges and that privileges are consistent with the resident's preferences.	Verify visitor policy compliance and proof of sharing such policy is provided to residents.
F174	Key points to look for are: expanded access to cell phone use (at the resident's own expense), and TTY and TTD services.	Are TTY and TTD services made available?
F175	Look for are the right to choose a roommate.	How will you document this in your resident records?
F176	Identify how the facility determined self-administration was clinically appropriate.	Verify that assessment documentation for residents who self-administer medications includes the term that the determination was "clinically appropriate."
F240	Verify that every resident is treated with respect and dignity, and the facility has policies for practices such as transfer, discharge, and equal access to services regardless of payment source.	Verify facility policies and procedures do not contradict these requirements.
F242	Verify the facility promotes and facilitates resident self-determination through support of resident choice.	
F243	Verify reasonable steps were taken to notify residents and family members of upcoming resident group meetings or family group meetings in a timely manner.	Document that such efforts are made by staff.
F244	Verify the facility provides prompt responses and rationale to resident group or family group views, grievances, or recommendations.	Have a system to review resident/family group meeting minutes, complaints, and requests. Verify that responses and rationale are provided to the group(s) timely.
F247	Verify a notice regarding change in room or roommate was provided to the resident in writing and included the reason for the change.	Verify how you document this process and that the form indicates the reason for the room transfer.
F252	Ensure the environment maximizes resident independence, and responsibility for the protection of the resident's property from loss of theft.	What options do you provide to residents to secure belongings?

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.12 Freedom from Abuse, Neglect, and Exploitation

The new regulatory language strengthens existing protections, in addition to review of policies and procedures. Language was added related to resident "right to be free from neglect" and "exploitation." The regulation requires facilities to investigate and report all allegations of abusive conduct. New reporting timeframes that align with the Federal Elder Justice Act are implemented. Individuals who had a disciplinary action due to abuse, neglect, mistreatment of residents, or misappropriation of their property taken against their professional license by a state licensure body cannot be hired by facilities.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F221	Deficiencies related to physical restraints will be cited at F221.	
F222	Involves deficiencies related to chemical restraints. The facility must use the least restrictive alternative for the least amount of time, and documenting ongoing re-evaluation of the need for restraints.	
F223	Verify the new definitions for abuse and sexual abuse are used in policies and procedures.	Verify P/P have been updated using the new definitions.
F225	The facility must not employ/engage any individuals with: (1) A finding of exploitation or misappropriation of resident property, or (2) Disciplinary action in effect against his or her professional license that is related to a finding of abuse, neglect, exploitation, mistreatment, or misappropriation. Verify policies and procedures, as well as history of submitting timely reports regarding suspected Abuse, Neglect, Exploitation, and Misappropriation of resident property are accurate. Suspected Abuse shall be reported to the Administrator (or designated representative) and OHFC online reporting process <u>not later than 2 hours</u> after forming the suspicion of abuse. Suspicion of Neglect, Exploitation, or Misappropriation of resident property must be reported to the Administrator (or designated representative) and OHFC online reporting process <u>not later than 2 hours if the incident resulted in serious bodily injury. If the suspected Neglect, Exploitation, or Misappropriation of resident property did not result in serious bodily injury, the reports must be made within 24 hours. Five-day follow-up reports are still required.</u>	• Verify the facility has a system to confirm (and document) professional licenses of staff are current with no findings or restrictions related to abuse, neglect, exploitation, mistreatment, or misappropriation. • Update P/P. Remove old reporting decision trees (new ones are under development). • Retrain staff on new reporting requirement. • Note definition of "serious bodily injury": Serious Bodily Injury is an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. In the case of "criminal sexual abuse", serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is sexual abuse, aggravated sexual abuse or any similar offense under State law. *(Serious Bodily*

		Injury definition taken from CMS S&C: 11-30-NH.)
F226	The regulation more specifically requires developing and implementing policies and procedures for: Prohibiting, preventing, and timely reporting of abuse, neglect, exploitation, and misappropriation of resident property. Requires Investigating all alleged violations. Requires all staff training for prevention of abuse, neglect, exploitation, and misappropriation or resident property, which includes those activities that constitute abuse, neglect, exploitation, and misappropriation. Verify training for all staff training has occurred covering: (1) activities that constitute Abuse, Neglect, Exploitation, and Misappropriation of resident property, (2) procedures for reporting Abuse, Neglect, Exploitation, and Misappropriation of resident property, and (3) dementia management and resident abuse prevention.	• Verify P/P also use the term “prevent”. • Train staff on prevention of abuse, neglect, exploitation, and misappropriation or resident property, which includes those activities that constitute abuse, neglect, exploitation, and misappropriation. • Train staff on reporting. • Train staff on dementia management and resident abuse prevention.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.15 Admission, Transfer, and Discharge Rights

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F201	Verify the facility does not transfer or discharge residents when the resident exercises his or her right to an appeal while the appeal is pending (unless endangerment to health and safety to self or others).	Verify P/P and current practice when appeals are filed.
F202	Verify increased documentation of involuntary transfers and discharges as required under 483.15(c)(2).	Verify P/P as well as sample facility forms and letters contain all required elements.
F203	Requires the facility to send a copy of transfer or discharge notice to the Office of Ombudsman for Long-Term Care. Requires the facility to provide resident and/or the resident representative with additional information in the notice regarding the process for appealing transfer or discharge. And requires the facility to update recipients of transfer/discharge notice of any changes to the notice as soon as possible (if those changes occur prior to the transfer or discharge).	Verify P/P and practice complies.
F204	New regulatory language at F204 adds that the orientation facilities provided to residents regarding transfer or discharge must be in a manner that they understand, such as at an appropriate educational level, in the resident's language and/or taking into consideration other communication barriers, and physical and mental impairments.	Verify P/P and practice complies. Access to a translator?
F205	Changes "readmission" language to "return". New language requires facilities to provide written information to resident or resident representative about payment needed to hold a bed if the individual state requires payment to hold the bed.	Update P/P to use new term.
F206	If the facility decides a resident cannot return to the facility, the facility would then discharge a resident. A facility can only discharge a resident for the reasons listed under 483.15 paragraph c. The medical record should show documentation of the reason for the discharge. The documentation regarding the basis for transfer or discharge should also be in the notice to the resident or resident representative. If a resident is transferred, and then the facility cannot/does not take them back, then the individual is considered a discharge, and the facility must meet all discharge requirements.	Nothing really new, but surveyor training emphasized this.
F208	Verify the facility has an admissions policy. Cannot request or require residents or potential residents to waive potential facility liability for losses of personal property. Facility must disclose any special characteristics or service limitations. Surveyors may identify concerns related to this provision through interviews or complaints. For example, a facility may have a religious affiliation that guides its practices and routines which must be communicated to any potential resident or a facility may have limitations in the type of medical care it can provide which must be communicated prior to admission.	• Verify admission policy exists and is accurate. • Verify admissions agreement and resident handbook do not request or require residents or potential residents to waive potential facility liability for losses of personal property. • Any limitations to services provided should be declared.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.20 Resident Assessment

Clarification to what constitutes appropriate coordination of a resident's assessment with the Preadmission Screening and Resident Review program under Medicaid.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F272	Verify that resident assessments include resident strengths, goals, life history, and preferences. Verify the assessment process indicates direct observation of the resident as well as communication with licensed and non-licensed direct care staff on all shifts.	• Determine if assessment process or software uses the terms resident strengths, goals, life history, and preferences. • Verify the assessment process indicates direct observation of the resident as well as communication with licensed and non-licensed direct care staff on all shifts.
F285	Key points to look for: Coordination includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	Verify compliance with Level II PASARR requirements.
F286	There are no new regulatory language requirements at F286, the language was updated to read "use the results of the assessments to develop, review and revise the resident's comprehensive care plan."	Verify the MDS aligns with the plan of care.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.21 Comprehensive Person-Centered Care Planning

Comprehensive Person-Centered Care Planning includes the addition of nurse aide and member of the food and nutrition services staff to required members of the interdisciplinary team that develops care plans.

It also requires facilities to develop and implement a discharge planning process focusing on resident's discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable re-admissions.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F279	The care plan must be centered on the resident's needs including measurable objectives and time frames. The care plan must include specialized services facility will provide as a result of the PASARR. The facility must have a documented rationale in medical record if they disagree with the PASARR findings. And the Care plan must include goals for admission and discharge preferences. 48-hour baseline care plan goes into effect November 28, 2017.	• Verify that PASARR recommendations (if any) are implemented in the plan of care, or reason for disagreeing with the PASARR findings. • Verify that care plans include resident discharge preferences. • Start to plan how you will implement 48-hour baseline care plans effective 11-28-17.
F280	Verify the facility involved a nurse aide responsible for resident and member of the food and nutrition service, along with the attending physician and a registered nurse were on the interdisciplinary team. Any other professionals needed in development of the care plan as based on the residents' care needs would also be involved in the interdisciplinary team. And if the facility has reviewed and revised care plan after each assessment for both comprehensive and quarterly assessments. Verify that the resident has participation in his or her person-centered care plan. Verify that residents have the right to view their care plan and that residents are provided the opportunity to sign the care plan after a significant change to the plan of care.	• Update care planning P/P to include input from both a nurse aide responsible for resident and a member of the food and nutrition service department. How will you gather information from these individuals and how will their involvement be documented? • Document that residents reviewed their care plan or were provided the opportunity to view their care plan. • Develop P/P to provide residents the opportunity to sign their care plan whenever significant changes are made to the plan of care.
F281	Key points to look for: The services outlined in the comprehensive care plan meet professional standards of quality. In F283, when discharge is anticipated for a resident facility must have a discharge summary.	
F283	Verify discharge summaries include diagnoses, course of illness/treatment or therapy, as well as lab, x-ray, and consultation results. Discharge summaries shall also include a reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and OTC).	• Review discharge summary P/P for compliance with all required elements – update if needed. • Add medication reconciliation to discharge summaries.

F284	Discharge planning begins on admission with comprehensive assessment of resident's discharge goals. Discharge plan part of the care plan and must be re-evaluated with each comprehensive assessment and significant change assessment. The Discharge plan must involve resident and/or the representative, and be developed by the interdisciplinary team including the physician. The discharge plan must include documentation of contacts or communications with local agency agencies if the resident wishes to be discharged to the community. If discharge to the community is not feasible, facility must document. Facilities must assist residents and resident representatives wishing to be discharged to another SNF, Home Health Agency, Inpatient Rehabilitation Facility, or Long-Term Care Hospital by providing them with standardized patient assessment data (where available), data on quality measures, and resource use, such as staffing, to assist the resident representative in selecting a provider.	• How do you document resident discharge expectations/desires beginning at admission to the facility? • Review care plan P/P to determine if discharge planning is included. How is the resident involved in this planning? • Create files of local agencies that can provide post-discharge assistance. If available, include standardized patient assessment data on each agency. • Document appropriate files were provided to residents for assistance with discharge planning (when feasible).

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.24 Quality of Life

There are no new requirements in this section. The "Highest Practicable Well-Being" language continues in this section. Each resident is to receive and the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F309	Includes the provision for assuring that all care and services that a resident receives enhances his or her quality of life. Although, the regulation language at F309 doesn't specifically address end of life and/or hospice care and services provided by a Medicare certified hospice, the surveyor is directed to survey the concerns related to end of life or hospice services at this outcome tag. The regulation for a hospice agreement between the nursing home and a Medicare certified hospice is found at F526. Pain management is now specifically identified in F309. It states 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. Dialysis is now specifically identified in F309. It states 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.	• Review hospice agreements. • Focus additional attention on pain management and the residents' goals and preferences in relation to pain management. • Review dialysis protocols – communication with dialysis provider, emergency procedures with respect to residents receiving dialysis services, training of staff regarding dialysis services.
F310	This area was moved to quality of life, it adds oral care, walking, meals, snacks and communication.	Surveyors will place special emphasis on reviewing oral cares, walking schedules, and the offering of snacks. Verify P/P and compliance.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.25 Quality of Care

Special care issues, many of which were previously cited under F309, were added here. Specific areas such as restraints, pain management, bowel incontinence, and dialysis services. Based on comprehensive assessment of a resident, facilities required to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F315	Residents who are continent of bladder and bowel receive necessary services and assistance in order to maintain continence. Residents admitted with, or subsequently receiving a catheter are assessed for removal as soon as possible. Residents with fecal incontinence receive appropriate treatment and services to restore as much normal bowel function as possible. Expanded emphasis on removing catheters as soon as possible unless contraindicated.	Two new areas of emphasis: • Bowel incontinence • Removal of catheters Verify P/P are in place for both
F318	Verify residents with limited mobility receive appropriate services, equipment, and assistance.	Anticipate increased surveyor focus on equipment and assistance (walking assistance) for residents with limited mobility.
F323	The facility must attempt to use appropriate alternatives prior to installing a side or bed rail and must ensure the correct installation, use, and maintenance including, but not limited to: Assessing the resident for risk of entrapment, review risks and benefits of the bedrails with the resident or resident representative and obtain informed consent prior to installation. Ensure the bed's dimensions are appropriate for the resident's size and weight.	Review P/P pertaining to side rail use. Do you have the following documentation in place for each side rail in use? • Assessment of resident entrapment risk • Review of risks v. benefits with resident /resident representative regarding side rail use • Informed consent (signature) for use of side rails Verification that bed system is appropriate for size and weight of each resident
F328	Expanded regulatory language in the areas of: foot care, colostomy, ureterostomy, ileostomy, parental fluids, respiratory care, and prostheses. Expanded regulatory language includes professional standards and care provided in accordance to the comprehensive person-centered care plan.	Review P/P for each identified area. Verify P/P reflect current standards of practice and that care plans are in alignment with current standards of practice.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.30 Physician Services

Attending physicians are now permitted to delegate dietary orders to qualified dietitians or other clinically qualified nutrition professionals and therapy orders to therapists.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F385	A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders to meet the immediate care and needs of the resident.	Update P/P.
F390	If the dietitian, other clinically qualified nutrition professional, or a qualified therapist has been delegated the task of writing orders: They are to do so in accordance with State law; the written order when delegated by physician; and they are acting under the supervision of a physician.	Update P/P.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.35 Nursing Services

Addition of competency and skill requirement for determining the sufficiency of nursing staff.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F334	While not specifically noted in the regulatory update, providers should incorporate Prevnar 13 into their pneumococcal immunization protocols (CDC recommended).	
F353	The facility shall determine if there is sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to each resident. The facility provides a sufficient number of nurse aides, along with other nursing personnel, on a 24-hour basis to provide nursing care to all residents in accordance with the resident's care plans. Nursing staff shall have the appropriate competencies and skills to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	• Do you have a system for staffing that is aligned with resident assessments and plans of care (acuity and staff time needed)? Surveyors may ask you how you determine that you have sufficient nursing staff. • Review how you conduct and document competencies for nursing staff. Begin a program for conducting competency verification on higher skill areas or areas of identified risk or weakness.
F498	Verify CNA/NA-R training includes dementia management training and resident abuse prevention training.	Add these two topics to your CNA training – consider retraining on an annual basis as part of required 12 hours per year training.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.40 Behavioral Health Services

An addition of new section focusing on requirement to provide necessary behavioral health care and services to residents, in accordance with their comprehensive assessment and care plan.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F319	Residents who display or are diagnosed with mental disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.	Review what you make available to residents with mental disorders or psychological adjustment difficulties. Consider additional staff training in this area.
F320	Residents who do not have diagnosis of a mental disorder or psychosocial adjustment difficulty, do not have an avoidable decrease in social interaction and/or increased withdrawn angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development or such a pattern was unavoidable.	Verify that your facility identifies residents who experience a decrease in social interaction and/or increased withdrawn angry, or depressive behaviors – how do you respond?

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Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.45 Pharmacy Services

Revision of existing requirements regarding "antipsychotic" drugs to refer to "psychotropic" drugs; defines "psychotropic drug" as any drug that affects brain activities associated with mental processes and behavior (anti-psychotic, anti-depressant, anti-anxiety, and hypnotic); Requiring several provisions intended to reduce or eliminate the need for psychotropic drugs, if not clinically contraindicated, to safeguard the resident's health.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F428	Requires new process for medication regimen review (MRR) and requires facilities to develop and maintain policies and procedures to address all aspects of the medication regimen review. The pharmacist must now report medication regimen review irregularities to the medical director as well as the attending physician and director of nursing (DON). Irregularities are defined as medications that meet the criteria for unnecessary medications. The attending physician must document in the resident's medical record that he/she reviewed the identified irregularity, the action taken to address the irregularity, or the reason for not changing the medication related to the identified irregularity.	Develop and maintain P/P for the monthly drug reviews that include; 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. Verify that MMR is sent to: (1) Medical Director, (2) Attending Physician, and (3) DON/DNS.

§483.50 Laboratory, Radiology, and other Diagnostic Services

A physician assistant, nurse practitioner, or clinical nurse specialist may order laboratory, radiology, or other diagnostic services for a resident.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F504 & **F510**	Facility provides or obtains laboratory services by a physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Update P/P
F505 & **F511**	Facility staff promptly notifies 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.	Does your facility have available clinical reference ranges for common diagnostic services? How do these references relate to your P/P for notification of practitioners?

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Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.55 Dental Services

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F411	Assistance is not only provided when deemed necessary by the facility, but also when requested by the resident. Transportation is provided to any location providing dental services, not just the dentist office.	Document transportation assistance provided if dental services are necessary or requested by the resident.
F412	The facility submits applications for reimbursement of dental services under the State plan, if the resident is eligible and wishes to participate.	Verify P/P

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Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.60 Food and Nutrition Services

Facilities to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

Facilities to employ sufficient staff, including the designation of a director of food and nutrition service, with the appropriate competencies and skills sets to carry out the functions of dietary services while taking into consideration resident assessments and individual plans of care, including diagnoses and acuity, as well as the facility's resident census.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F361	The facility shall determine if there is sufficient food and nutrition staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services department. Requires proof regarding resident dietary preferences and qualified dietitian. For a qualified dietitian or other clinically qualified nutrition professional hired prior to November 28, 2016, the facility has 5 years to ensure they have the regulatory required qualifications if hired after November 28, 2016. There is no one-year grace period for meeting the requirements if hired after November 28, 2016. For the position of director of food and nutrition services hired prior to November 28, 2016, the facility has five years to ensure they have the regulatory required qualifications. For the position of director of food and nutrition services hired after November 28, 2016, the facility has one year to ensure they have the regulatory required qualifications. Explicit regulatory requirement to meet State requirements for food service or dietary managers- surveyors must be aware of what the specific requirements are for the State they are surveying in to determine compliance.	Verify you have a system to determine sufficient dietary and nutrition staff. How do you document resident dietary preferences? Verify that your dietitian is qualified using the new requirements and create a 5-year plan if he/she is not qualified. Verify that your food and nutrition services manager is currently enrolled in or completed a Dietary Manager Course (MN §4658.0605 Subp.2) - if hired after May 28, 1995. Suggested - Minnesota Certified Food Manager and – ServSafe Certification.
F362	Changes "competent" to "safely and effectively." Verify who from the Food and Nutrition Services staff is participating on the interdisciplinary team as required.	Who from dietary provides input to care conferences? How is this documented?
F363	The facility must ensure the menu reflects the religious, cultural, and ethnic needs of the resident population and takes into account input from residents and resident groups.	
F364	Expanded to include meeting hydration needs and preferences regarding fluids.	Focus on hydration.
F366	How does the facility meet explicit requirements for accommodating resident allergies, intolerances, and preferences. Alternatives must also now be appealing to the resident.	How are resident allergies, intolerances, and preferences identified and responded to?
F368	Key points to look for are that the meals are meeting resident needs, preferences, and requests. Alternative meals/snacks must be provided to residents eating outside of traditional/scheduled times. Food must be suitable, nourishing, and consistent with care plan.	
F369	Appropriate assistance is provided to the resident to use assistive devices when consuming meals and snacks.	

F371	Foods from local producers can now be used assuming they meet applicable state and local laws or regulations. Produce from facility gardens are now permitted to be used assuming they are grown and handled safely. Residents are able to have foods brought in from outside the facility. Facility must have a policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	Talk to your local farmers and farmer markets! Develop P/P regarding resident food brought in from the "outside" – how will it be stored, labeled, dated, etc.
F373	The interdisciplinary team is responsible for assessing if residents are appropriate for having a feeding assistant, not just the charge nurse; and the rationale for resident being in feeding assistant program should be reflected in the comprehensive care plan of the resident.	

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.65 Specialized rehabilitative services

Respiratory service was added to those services identified in this section.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F406	The facility provides, either directly or from an outside resource, respiratory services or services of a lesser intensity as required at §483.12. If any specialized rehabilitative services are provided by an outside resource, the requirements at §483.70 should be met.	What services do you have available for respiratory services? Do you have available on staff or via an outside resource?

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.70 Administration

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F251	A bachelor's degree in gerontology now qualifies as a "qualified social worker".	
F492	Regulatory language now provides additional protection against discrimination and protection for health information.	
F493	Verify that the administrator reports to and is accountable to the governing body.	The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management of operation of the facility. Verify the facility organizational chart and administrator's job description indicates that the administrator reports to and is accountable to the governing body.
F514	The medical record should include the resident's representative (if one is identified). The facility shall ensure that records be kept confidential and only released as authorized by the regulations.	
F519	When a resident is transferred to the hospital in an emergency situation by another practitioner, it is in accordance with facility policy and consistent with state law. Also, ensure the exchange of resident care information regardless of resident care setting to determine if they can return to the community or be placed in less restricted setting.	
F523	Written notification of an impending closure must be submitted by the facility to the following: State Survey Agency; Office of Ombudsman for Long-Term Care; Residents of the facility; legal representative of the residents (or other responsible parties); and ensure the facility does not admit any new residents on or after the date the written notification is submitted. Note – need to coordinate with Minnesota closure requirements.	
F525	Pre-dispute agreements for binding arbitration are prohibited (note – while this is the published requirement – it has been suspended by the courts until a legal conclusion is reached by the courts).	Voluntary (not required for admission) pre-dispute arbitration agreements are currently permissible pending outcome of court proceedings.
F526	Hospice Services is a new process tag which is meant to identify what processes and procedures must be in place in order for Medicare certified hospice to be able to provide hospice services for a resident who elects the hospice benefit. This written agreement must be in place prior to a nursing home allowing a hospice to provide hospice care to a nursing home resident.	Verify hospice contracts are valid and in place.
F527	Facilities must electronically submit to CMS complete and accurate staffing information (via the Payroll Based Journal process), including information for agency and contract staff, based	Verify PBJ submissions are being conducted.

	on payroll and other variable and audible data in a uniform format according to specifications established by CMS. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.75 Quality Assurance and Performance Improvement

Facilities must begin to develop a comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care, and quality of care. Surveyors will ask provider to "present its QAPI" plan beginning November 28, 2017.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F520	The QA & A Committee must meet at least and must report to their governing body or designated persons regarding its activities. The QA & A committee must consist of the DON/DNS, the Medical Director or his/her designee, at least three other members of the facility's staff, at least one who must be the Administrator, Owner, Board Member, or other individual in a leadership role, and the infection prevention and control officer.	• Verify quarterly meetings are being held • Verify all required QAA participants are reflected in the meeting minutes or meeting summary
		Start developing a QAPI program in anticipation of the 11-28-17 and 11-28-2019 QAPI requirements.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.80 Infection Control

Facilities are to develop an Infection Prevention and Control Program (IPCP).

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F441	The facility must develop and implement an infection prevention and control program such as written policies and procedures to identify surveillance requirements: When and to whom to report infections; What types of transmission-based precautions will be used and when to use them; Infection control incidents and the facility's corrective actions. Appropriate use of standard precautions including: Hand hygiene; Respiratory and cough etiquette; Use of personal protective equipment; injection practices; Safe handling of potentially contaminated equipment or surfaces are used and implemented. The IPCP policies and procedures are reviewed and updated annually.	• Verify P/P use the term "Infection Prevention and Control Program (IPCP)". The person in charge of the IPCP should be called the Infection Preventionist (IP). • Verify IPCP P/P include all required elements (see §483.80(a)(2)) • Verify IPCP P/P are reviewed and updated annually
		• Start working on an antibiotic stewardship program (required 11-28-1017) • Begin identifying an Infection Preventionist (IP) who has primary training in nursing, medical technology, microbiology, epidemiology, or other related field. Plan on having this person be at least part-time at the facility and have "specialized training" in infection prevention and control by 11-28-2019.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.90 Physical Environment

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F454	Compliance with 2012 Version of the NFPA 101 (Life Safety Code) and 2012 Version of NFPA 99 (Health Care Facility Codes) are now required.	Do you have the correct NFPA codes and have you made changes to comply? We went from the 2000 versions to the 2012 versions.
F457	For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, resident sleeping rooms/bedrooms must accommodate no more than two residents.	This could affect any remodeling plans if your facility currently has rooms that sleep more than two persons per room and you remodel to such an extent that a wing or unit must be vacated to conduct the remodeling.
F461	The facility must conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frames are compatible.	Staff must create forms and P/P to document regular bed system inspections. CMS and MDH continue to use the FDA hospital bed entrapment measurements for side rails on hospital beds.
F462	Each resident room must be equipped with/or located near toilet and bathing facilities. If the facility received approval of construction or reconstruction plans or are newly certified after November 28, 2016, each sleeping room/bedroom room must have its own bathroom equipped with at least a commode and sink.	This could affect any remodeling plans if your facility currently has sleeping rooms that share a bathroom with another sleeping room and you remodel to such an extent that a wing or unit must be vacated to conduct the remodeling.

SNF/NF Requirements of Participation (RoP)
Phase 1 Changes that go into effect November 28, 2016
Column 1 & 2 Based on CMS Surveyor Training for Providers and Surveyors (with some additional observations)

§483.95 Training Requirements

Facilities must develop, implement, and maintain an effective training program for all new and existing staff. Other individuals must be trained consistent with their specific roles including contract staff and volunteers.

F-TAG	NEW RoP REQUIREMENT & SURVEY EXPECTATION	SURVEY HINT
F495	In-service training for nurse aides now also required dementia management training and resident abuse prevention training.	Verify you have added these training topics to CNA/NA-R inservice plan. Recommended to be included in the annual 12 hours of CNA/NA-R training.
F373	A facility must not use an individual working in the facility as a paid feeding assistant unless the individual has successfully completed a State-approved training program for feeding assistants.	

APPENDIX G: REQUIREMENTS OF PARTICIPATION SIDE-BY-SIDE COMPARISON OF EXISTING AND NEW REGULATORY TEXT

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Notes: (i) The table below follows the numbering sequence of the existing regulations, meaning the new sections are not always grouped together; (ii) it includes only the text of the regulations themselves, and not interpretive guidance; (iii) "re-designated" means a numbering change only; "revised" means a language change only; "revised and re-designated" means a language change and a numbering change; (iv) bolded text in the fifth column shows new or changed language compared to the existing language; if there is no bolded text in the fifth column, it means the new language is identical to or substantively the same as the current language; we generally have not bolded updated section cross-references in the fifth column; (v) where entries in the fourth and fifth columns do not correspond to any language in the first and second columns, it means the language is new (but, in some cases, that new language may be consistent with existing survey guidance). Please send us your ideas for improvements to the table, and let us know of any errors you find.

Watch for Updates: We will update this table periodically to provide new information from CMS or to correct any errors we discover. Please note the date on the bottom of the page, then turn to the last page of this document for a listing of edits made with each revision.

The color coding relates to the timing of implementation. **We are still working to verify some of the exact specifications of the Phase 2 and Phase 3 items, where CMS has not been as clear as it needs to be. We will update this table ASAP.**

Yellow highlighting indicates a Phase 1 regulation:	Phase 1 regulations must be implemented by Nov. 28, 2016
Green highlighting indicates a Phase 2 regulation:	Phase 2 regulations must be implemented by Nov. 28, 2017
Blue highlighting indicates a Phase 3 regulation:	Phase 3 regulations must be implemented by Nov. 28, 2019

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
483.1	(a) Statutory basis. Omitted from this table.	Revised	483.1	(a) Statutory basis. Omitted.
483.5(a)-(c), (d), (e)	These are definitions of (a) Facility defined (b) Distinct part (c) Composite distinct part; text omitted from this table.	Re-designated	483.5	Omitted
483.5(d)	(d) Common area. Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather	Re-designated & revised	483.5	Common area. Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff **or engage in individual pursuits, apart from their residential rooms**. This includes but is not limited to

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Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
	together with other residents, visitors, and staff.			**living rooms, dining rooms, activity rooms, outdoor areas, and** meeting rooms where residents are located on a regular basis.
483.5(e)-(f)	These are definitions of (e) Fully sprinklered and (f) Major modification; text omitted from this table.	Re-designated	483.5	Omitted from this table.
			483.5	**New definitions:** **Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.** **Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.** **Exploitation. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.** **Licensed health professional. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.**

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Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
				Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. **Mistreatment means inappropriate treatment or exploitation of a resident.** **Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.** **Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.** **Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.** **Resident representative. For purposes of this subpart, the term resident representative means any of the following:** **(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;** **(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-**

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
				making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; **(3) Legal representative, as used in section 712 of the Older Americans Act; or** **(4) The court-appointed guardian or conservator of a resident.** **(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.** **Sexual abuse is non-consensual sexual contact of any type with a resident.** **Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.**
483.10	Resident rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:	Revised	483.10	(a) Residents Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. **(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.** (2) The facility must provide equal access to quality care regardless of **diagnosis, severity of condition, or** payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.
483.10(a)(1)	(a) Exercise of rights. (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	No change	483.10(b)	(b) Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

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Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
			483.10(b)(1)	**(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.**
483.10(a)(2)	(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.	Revised	483.10(b)(2)	(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights **and to be supported by the facility in the exercise of his or her rights as required under this subpart**.
483.10(a)(3)	(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.	Re-designated and revised	483.10(b)(7)	(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident **devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law** **(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.** **(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.** **(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.**
483.10(a)(4)	(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	Re-designated and revised	483.10(b)(3)	(3) In the case of a resident who has not been adjudged incompetent by the state court, **the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.** **(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative.**

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				(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.
			483.10(b)(4)	**(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.**
			483.10(b)(5)	**(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.**
			483.10(b)(6)	**(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.**
483.10(b)(1)	(b) Notice of rights and services. (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;	Re-designated & revised	483.10(g)(1), 483.10(g)(16)	(g) Information and communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. * * * (16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

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483.10(b)(2)	(2) The resident or his or her legal representative has the right— (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.	Re-designated & revised	483.10(g)(2)	(2) The resident has the right to access **personal and medical records** pertaining to him or herself. (i) The facility must provide the resident with access to **personal and medical records** pertaining to him or herself, upon an oral or written request, **in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and** (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof **(including in an electronic form or format when such records are maintained electronically)** upon request and 2 working days advance notice to the facility. **The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:** **(A) Labor for copying the records requested by the individual, whether in paper or electronic form;** **(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and** **(C) Postage, when the individual has requested the copy be mailed**.
483.10(b)(3)	(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;	Re-designated	483.10(c)(1)	(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
			483.10(c)(2)	**(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:**

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				(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. **(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.** **(iii) The right to be informed, in advance, of changes to the plan of care.** **(iv) The right to receive the services and/or items included in the plan of care.** **(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.**
			483.10(c)(3)	**(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—** **(i) Facilitate the inclusion of the resident and/or resident representative.** **(ii) Include an assessment of the resident's strengths and needs.** **(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.**
			483.10(c)(4)	**(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.**
			483.10(c)(5)	**(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.**

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483.10(b)(4)	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and	Revised	483.10(c)(6)	**(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:** (6) The right to **request**, refuse, **and/or discontinue** treatment, to **participate in o**r refuse to participate in experimental research, and to formulate an advance directive.
483.10(b)(5)	(5) The facility must— (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of— (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i) (A) and (B) of this section.	Re-designated & revised	483.10(g)(17)	(17) The facility must— (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of— (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in § 483.10(g)(17)(i)(A) and (B) of this section.
483.10(b)(6)	(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	Re-designated & revised	483.10(g)(18)	(18) 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/Medicaid or by the facility's per diem rate. **(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.**

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				(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. **(iii) 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.** **(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.** **(v) 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.**
	Editor's note: New sections 483.10(g)(1)-(18) (Information and Communication) were the most difficult to find logical places for in this table. For example, this §483.10(g)(3) might also have been inserted elsewhere in the table. It may be worthwhile to review those new sections in order. Here is a link to 483.10(g)(1) (https://www.federalregister.gov/d/2016-23503/p-2064), and you may read sequentially from there.		**483.10(g)(3)**	**(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.**
483.10(b)(7)	(7) The facility must furnish a written description of legal rights which includes— (i) A description of the manner of protecting personal funds, under paragraph (c) of this section;	Re-designated & revised	483.10(g)(4)(i)	**(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including;** (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes—

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	(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels; (iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and (iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.			(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses **(mailing and email**), and telephone numbers of **all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit;** and (D) A statement that the resident may file a complaint with the State Survey Agency **concerning any suspected violation of state or federal nursing facility regulations, including but not limited to** resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements **and requests for information regarding returning to the community**.
			483.10(g)(4)(ii)-(v)	**(ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.);** **(iii) Information regarding Medicare and Medicaid eligibility and coverage;**

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				(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program **(v) Contact information for the Medicaid Fraud Control Unit; and**
			483.10(g)(4)(vi)	**(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.**
			483.10(g)(5)	**(5) The facility must post, in a form and manner accessible and understandable to residents, and resident representatives:** **(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and network, home and community based service programs, and the Medicaid Fraud Control Unit; and** **(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.**

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483.10(b)(8)	(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	Re-designated & revised	483.10(g)(5)(i)-(v)	(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's **resident representative** in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
483.10(b)(9)	(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	Re-designated & revised	483.10(d)(3)	(3) The facility must ensure that each resident **remains informed of** the name, specialty, and way of contacting the physician **and other primary care professionals** responsible for his or her care.

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483.10(b)(10)	(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	Re-designated & revised	483.10(g)(13)	(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
483.10(b)(11)	(11) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a) (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is— (A) A change in room or roommate assignment as specified in § 483.15(e)(2); or	Re-designated & revised	483.10(g)(14)	(14) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the **resident representative(s)**, when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue **or change** an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in § 483.15(c)(1)(ii). **(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in § 483.15(c)(2) is available and provided upon request to the physician.** (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is— (A) A change in room or roommate assignment as specified in § 483.10(e)(6); or

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (**mailing and email**) and phone number of the **resident representative(s).**
483.10(b)(12)	(12) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in § 483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.12(a)(8).	Re-designated	483.10(g)(15)	(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.15(c)(9).
483.10(c)(1)	(c) Protection of resident funds. (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.	Re-designated & revised	483.10(f)(10)	(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
483.10(c)(2)	(2) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)–(8) of this section.	Re-designated	483.10(f)(10)(i)	**(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.**
483.10(c)(3)	(3) Deposit of funds. (i) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	Re-designated & revised	483.10(f)(10)(ii)	(ii) Deposit of funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds

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	resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) (ii) Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.			that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.
483.10(c)(4)	(4) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	Re-designated	483.10(f)(10)(B)(iii)(A)-(C)	(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C) The individual financial record must be available to the resident through quarterly statements and upon request.
483.10(c)(5)	(3) Deposit of funds. (i) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	Re-designated	483.10(f)(10)(B)(iv)	(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits— (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

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	resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) (ii) Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.			(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
483.10(c)(6)	(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.	Re-designated & revised	483.10(f)(10)(B)(v)	(v) Conveyance upon **discharge, eviction, or** death. Upon the **discharge, eviction, or** death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, **to the resident, or** in the case of death, the individual or probate jurisdiction administering the resident's estate, **in accordance with State law**.
483.10(c)(7)	(7) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	Re-designated	483.10(f)(10)(B)(vi)	(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.
483.10(c)(8)	(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts) The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)	Re-designated & revised	483.10(f)(11)	(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:

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	(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: (A) Nursing services as required at § 483.30 of this subpart. (B) Dietary services as required at § 483.35 of this subpart. (C) An activities program as required at § 483.15(f) of this subpart. (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. (F) Medically-related social services as required at § 483.15(g) of this subpart.			(A) Nursing services as required at § 483.35. (B) Food and Nutrition services as required at § 483.60. (C) An activities program as required at § 483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at § 483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
483.10(c)(8)	(ii) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident	Re-designated & revised	483.10(f)(11)	(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the

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	that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone. (B) Television/radio for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (G) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Social events and entertainment offered outside the scope of the activities program, provided under § 483.15(f) of this subpart. (J) Noncovered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control) (L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by § 483.35 of this subpart.			resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (G) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under § 483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) **Except as provided in (e)(11)(ii)(L)(1) and (2) of this section**, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by § 483.**60**. **(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician**

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				assistant, nurse practitioner, or clinical nurse specialist, as these are included in accordance with § 483.60. **(2) In accordance with § 483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.**
483.10(c)(8)	(iii) Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. (B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay. (C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.	Re-designated & revised	483.10(f)(11)	(iii) Requests for items and services. (A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, **orally and in writing**, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
483.10(d)	(d) Free choice. The resident has the right to –	Re-designated & revised	483.10(d)	(d) Choice of attending physician. The resident has the right to choose his or her attending physician.
483.10(d)(1)	(1) Choose a personal attending physician;	Re-designated & revised	483.10(d)	(d) Choice of attending physician. The resident has the right to choose his or her attending physician. **(1) The physician must be licensed to practice, and** **(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician**

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				participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. **(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. [Note: this paragraph also ties to existing 483.10(b)(9).]** **(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.** **(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.**
483.10(d)(2)	(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	Re-designated & revised	483.10(c)	**Editor's note: See new sections 483.10(c)(2)-(c)(4) on pp. 8-9 above.**
483.10(d)(3)	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	Re-designated & revised	483.10(b)(7)(iii), 483.10(c)(2)	(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, **the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law …. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.** **Editor's note: See also 483.10(c)(2) above.**

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483.10(e)	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	Re-designated & revised	483.10(h), (h)(3)	(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. … (h)(3) The resident has a right to secure and confidential personal and medical records.
483.10(e)(1)	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;	Re-designated	483.10(h)(1)	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
483.10(e)(2)	(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;	Re-designated & revised	483.10(h)(3)(i)	(i) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(i)(2) or other applicable federal or state laws.
483.10(e)(3)	(3) The resident's right to refuse release of personal and clinical records does not apply when—	Re-designated & revised	483.10(h)(3)(i)	See above.
483.10(e)(3)(i)	(i) The resident is transferred to another health care institution; or	Re-designated & revised	483.10(h)(3)(i)	See above.
483.10(e)(3)(ii)	(ii) Record release is required by law.	Re-designated & revised	483.10(h)(3)(i)	See above.
483.10(f)	(f) Grievances. A resident has the right to—	Re-designated & revised	483.10(j)	See below.
483.10(f)(1)	(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and	Re-designated & revised	483.10(j)(1)	(j) Grievances. (1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to **care and** treatment which has been furnished as well as that which has

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				not been furnished, **the behavior of staff and of other residents; and other concerns regarding their LTC facility stay.**
483.10(f)(2)	(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	Re-designated & revised	483.10(j)(2)	(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.
			483.10(j)(3)	**(3) The facility must make information on how to file a grievance or complaint available to the resident.**
			483.10(j)(4)	**(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**

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				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(g)	(g) Examination of survey results. A resident has the right to—	Re-designated	483.10(g)(10)	(10) The resident has the right to—

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483.10(g)(1)	(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and	Re-designated & revised	483.10(g)(10)(i), and 483.10(g)(11)(i)-(iv)	(g)(10)(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; (11) The facility must— **(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.** **(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and** **(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.** **(iv) The facility shall not make available identifying information about complainants or residents.**
483.10(g)(2)	(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	Re-designated	483.10(g)(10)(ii)	(g)(10)(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
483.10(h)	(h) Work. The resident has the right to—	Re-designated & revised	483.10(f)(9)	See below.
483.10(h)(1)	(1) Refuse to perform services for the facility;	Re-designated & revised	483.10(f)(9)	See below.
483.10(h)(2)	(2) Perform services for the facility, if he or she chooses, when—	Re-designated & revised	483.10(f)(9)	See below.

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483.10(h)(2)(i)-(iv)	(i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	Re-designated	483.10(f)(9)(i)-(iv)	**(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. . . . .** (9) The resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when— (i) The facility has documented the resident's need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.
483.10(i)	(i) Mail. The resident has the right to privacy in written communications, including the right to—	Re-designated & revised	483.10(h)-(g)	See 10(h)(2) and 10(g)(8) below.
483.10(i)(1)	(1) Send and promptly receive mail that is unopened; and	Re-designated & revised	483.10(h)(2)	(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.
			483.10(g)(7)	**(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:** **(i) A telephone, including TTY and TDD services;**

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				(ii) The internet, to the extent available to the facility; and **(iii) Stationery, postage, writing implements and the ability to send mail.**
483.10(i)(2)	(2) Have access to stationery, postage, and writing implements at the resident's own expense.	Re-designated & revised	483.10(g)(8)	(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.
			483.10(g)(9)	**(9) The 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.** **(i) If the access is available to the facility** **(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.** **(iii) Such use must comply with state and federal law.**
483.10(j)(1)	(j) Access and visitation rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following:	Re-designated & revised	483.10(f)(4)	**(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. …** **(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.**

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483.10(j)(1)(i) -(vi)	(i) Any representative of the Secretary; (ii) Any representative of the State: (iii) The resident's individual physician; (iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965); (v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); (vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);	Re-designated & revised	483.10(f)(4)(i)(A)-(F)	(i) The facility must provide immediate access to any resident by— (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.), (F) Any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and **(G) The resident representative.**
483.10(j)(1)(vii)	(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and	Re-designated & revised	483.10(f)(4)(ii)	(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;
483.10(j)(1)(viii)	(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.	Re-designated & revised	483.10(f)(4)(iii)	(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, **subject to reasonable clinical and safety restrictions and** the resident's right to deny or withdraw consent at any time;
483.10(j)(2)	(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or	Re-designated	483.10(f)(4)(iv)	(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

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	other services to the resident, subject to the resident's right to deny or withdraw consent at any time.			
			483.10(f)(4)(v)	**(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.**
			483.10(f)(4)(vi)	**(vi) A facility must meet the following requirements:** **(A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.** **(B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.** **(C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.** **(D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.**
			483.10(k)	**(k) Contact with external entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials,**

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				including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman, and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.
483.10(j)(3)	(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.	Re-designated & revised	483.10(h)(3)(ii)	(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's **medical, social, and administrative records** in accordance with State law. [Editor's note: the new language drops the phrase "with the permission of the resident or the resident's legal representative; we will work to confirm this intent.]
483.10(k)	(k) Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.	Re-designated & revised	483.10(g)(6)	(6) The resident has the right to have reasonable access to the use of a telephone, **including TTY and TDD services**, and a place in the facility where calls can be made without being overheard. **This includes the right to retain and use a cellular phone at the resident's own expense.**
483.10(l)	(l) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	Re-designated & revised	483.10(e)(2)	**(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: …** (2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
483.10(m)	(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	Re-designated	483.10(e)(4)	**(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: …** (4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

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			483.10(e)(5)	**(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.**
483.10(n)	(n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(k)(2)(ii), has determined that this practice is safe.	Re-designated & revised	483.10(c)(7)	**(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: …** (7) The right to self-administer medications if the interdisciplinary team, as defined by § 483.21(b)(2)(ii), has determined that this practice is **clinically appropriate**.
			483.10(c)(8)	**(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.**
483.10(o)(1)-(2)	(o) Refusal of certain transfers. (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate— (i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.	Re-designated & revised	483.10(e)(7)(i)-(iii) 483.10(e)(8)	(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: … (7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is: (i) To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. **(iii) solely for the convenience of staff.** (8) A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.
483.12(a)	Admission, transfer and discharge rights. (a) Transfer and discharge –	Re-designated & revised	483.15(c)	See below.

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
483.12(a)(1)	(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.	Re-designated	483.5	Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
483.12(a)(2)	(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—	Re-designated & revised	483.15(c)(1)(i)	See below.
483.12(a)(2)(i)-(vi)	(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered; (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (vi) The facility ceases to operate.	Re-designated & revised	483.15(c)(1)(i)(A)-(F)	(c) Transfer and discharge—(1) Facility requirements— (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered **due to the clinical or behavioral status of the resident;** (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. **Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.** For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

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				(F) The facility ceases to operate. **(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.**
483.12(a)(3)	(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—	Re-designated & revised	483.15(c)(2)	(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs **(c)(1)(i)(A) through (F)** of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record **and appropriate information is communicated to the receiving health care institution or provider.**
483.12(a)(3)(i)	(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and	Re-designated & revised	483.15(c)(2)(i)(A)	(i) Documentation in the resident's medical record must include: **(A) The basis for the transfer per paragraph (c)(1)(i) of this section.** **(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).**
483.12(a)(3)(ii)	(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.	Re-designated & revised	483.15(c)(2)(ii)(B)	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by— (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

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			483.15(c)(2)(iii)	**(iii) Information provided to the receiving provider must include a minimum of the following:** **(A) Contact information of the practitioner responsible for the care of the resident** **(B) Resident representative information including contact information.** **(C) Advance Directive information.** **(D) All special instructions or precautions for ongoing care, as appropriate.** **(E) Comprehensive care plan goals,** **(F) All other necessary information, including a copy of the residents discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.**
483.12(a)(4)(i)-(iii)	(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. (ii) Record the reasons in the resident's clinical record; and (iii) Include in the notice the items described in paragraph (a)(6) of this section.	Re-designated & revised	483.15(c)(3)(i)-(iii)	(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident **and the resident's representative(s)** of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. **The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.** (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section.
483.12(a)(5)(i)	(5) Timing of the notice. (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under	Re-designated & revised	483.15(c)(4)	(4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

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	paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.			
483.12(a)(5)(ii)(A)-(E)	(ii) Notice may be made as soon as practicable before transfer or discharge when— (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or (E) A resident has not resided in the facility for 30 days.	Re-designated & revised	483.15(c)(4)(ii)(A)-(E)	(ii) Notice must be made as soon as practicable before transfer or discharge when— (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this secton; or (E) A resident has not resided in the facility for 30 days.
483.12(a)(6)(i)-(vii)	(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman;	Re-designated & revised	483.15(c)(5)(i)-(vii)	(5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; **(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;**

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	(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.			(v) The name, address (**mailing and email**) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.
			483.15(c)(6)	**(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.**
483.12(a)(7)	(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	Re-designated & revised	483.15(c)(7)	(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. **This orientation must be provided in a form and manner that the resident can understand.**
483.12(a)(8)	(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.75(r)	Re-designated & revised	483.15(c)(8)	(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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483.12(a)(9)	(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.	Re-designated & revised	483.15(c)(9)	(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.
483.12(b)(1)(i)-(ii)	(b) Notice of bed-hold policy and readmission – (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies— (i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.	Re-designated & revised	483.15(d)(1)(i)-(iii)	(d) Notice of bed-hold policy **and return**— (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies— (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; **(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;** (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(3) of this section, permitting a resident to return; and **(iv) The information specified in paragraph (c)(3) of this section.**
483.12(b)(2)	(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	Re-designated & revised	483.15(d)(2)	(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the **resident representative** written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section.

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483.12(b)(3)(i)-(ii)	(3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident— (i) Requires the services provided by the facility; and (ii) Is eligible for Medicaid nursing facility services.	Re-designated	483.15(e)(1)(i)(A)-(B)	(e)(1) Permitting residents to return to facility. **A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave.** The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility **to their previous room if available or** immediately upon the first availability of a bed in a semi-private room if the resident (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
			483.15(e)(1)(ii)	**(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.**
483.12(b)(4)	(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in § 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.	Re-designated & revised	483.15(e)(2)	2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
483.12(c)(1)	(c) Equal access to quality care. (1) A facility must establish and maintain identical policies and practices regarding transfer,	Re-designated & revised	483.15(b)(1)	(b) Equal access to quality care. (1) A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, as defined in § 483.5 and the provision

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	discharge, and the provision of services under the State plan for all individuals regardless of source of payment;			of services for all individuals regardless of source of payment, consistent with § 483.10(a)(2);
483.12(c)(2)	(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and	Re-designated & revised	483.15(b)(2)	(2) The facility may charge any amount for services furnished to non-Medicaid residents **unless otherwise limited by state law and** consistent with the notice requirement in § 483.10(g)(3) and (g)(4)(i) describing the charges; and
483.12(c)(3)	(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.	Re-designated	483.15(b)(3)	(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.
			483.15(a)(1)	**(a) Admissions policy. (1) The facility must establish and implement an admissions policy.**
483.12(d)(1) (i)-(ii)	(d) Admissions policy. (1) The facility must— (i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.	Re-designated & revised	483.15(a)(2)(i)-(ii)	(2) The facility must— (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. **(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.**
483.12(d)(2)	(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability,	Re-designated & revised	483.15(a)(3)	(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

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	to provide facility payment from the resident's income or resources.			
483.12(d)(3)(i)-(ii)	(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,— (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.	Re-designated	483.15(a)(4)(i)-(ii)	(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,— (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.
483.12(d)(4)	(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	Re-designated	483.15(a)(5)	(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

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			483.15(a)(6)	**(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.**
			483.15(a)(7)	**(7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (b)(10) of this section.**
483.13(a)	Resident behavior and facility practices. (a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	Re-designated & revised	483.10(e), 483.12, 483.25(d)(1)	**(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:** (1) 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, consistent with § 483.12(a)(2). 483.12: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms Editor's note: See also 483.25(d)(1) below.
483.13(b)	(b) Abuse.	Re-designated & revised	483.12	§ 483.12Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

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483.13(c)	(c) Staff treatment of residents	Re-designated & revised	483.12(b)	See below.
483.13(c)(1)	(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	Re-designated	483.12(b)	483.12(b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, **and exploitation** of residents and misappropriation of resident property, **(2) Establish policies and procedures to investigate any such allegations, and** **(3) Include training as required at paragraph § 483.95.** **(4) Establish coordination with the QAPI program required under § 483.75.** **(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.** **(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.** **(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.** **(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.**

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				(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. **(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.**
483.13(c)(1)(i)	(1) The facility must— (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	Re-designated	483.12(a)(1)	The facility must— (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
483.13(c)(1)(ii)	(ii) Not employ individuals who have been—	Re-designated & revised	483.12(a)(3)	The facility must – (3) Not employ **or otherwise engage** individuals who—
483.13(c)(1)(ii)(A)	(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or	Re-designated & revised	483.12(a)(3)(i)	(i) Have been found guilty of abuse, neglect, **exploitation, misappropriation of property, or** mistreatment by a court of law;
483.13(c)(1)(ii)(B)	(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and	Re-designated & revised	483.12(a)(3)(ii)	(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or **(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.**
483.13(c)(1)(iii)	(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	Re-designated & revised	483.12(a)(4)	(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
483.13(c)(2)	(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other	Re-designated & revised	483.12(c)(1)	(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, **exploitation** or mistreatment, including injuries of unknown source and misappropriation of

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	officials in accordance with State law through established procedures (including to the State survey and certification agency)			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,** to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
483.13(c)(3)	(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	Re-designated & revised	483.12(c)(2)-(3)	(2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, **neglect, exploitation, or mistreatment** while the investigation is in progress.
483.13(c)(4)	(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	Re-designated & revised	483.12(c)(4)	(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
483.15	Quality of life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.	Re-designated & revised	483.24	**§ 483.24 Quality of life. Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.**
483.15(a)	(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Re-designated & revised	483.24	See above.

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483.15(b)	(b) Self-determination and participation. The resident has the right to—	Re-designated & revised	483.10(f), 483.10(f)	**(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.**
483.15(b)(1)	(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	Re-designated & revised	483.10(f)(1)	(1) The resident has a right to 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**.
483.15(b)(2)	(2) Interact with members of the community both inside and outside the facility; and	Re-designated & revised	483.10(f)(3)	(3) The resident has a right to interact with members of the community **and participate in community acti**vities both inside and outside the facility.
483.15(b)(3)	(3) Make choices about aspects of his or her life in the facility that are significant to the resident.	Re-designated	483.10(f)(2)	(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.
483.15(c)(1)	(c) Participation in resident and family groups groups. (1) A resident has the right to organize and participate in resident groups in the facility;	Re-designated & revised	483.10(f)(5)	(5) The resident has a right to organize and participate in resident groups in the facility.
483.15(c)(2)	(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;	Re-designated & revised	483.10(f)(6)-(7)	(6) The resident has a right to participate in family groups. (7) **The resident has a right to have family member(s) or other resident representative(s) meet** in the facility with the families or resident representative(s) of other residents in the facility.
483.15(c)(3)	(3) The facility must provide a resident or family group, if one exists, with private space;	Re-designated	483.10(f)(5(i))	(i) The facility must provide a resident or family group, if one exists, with private space; **and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.**

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483.15(c)(4)-(6)	(4) Staff or visitors may attend meetings at the group's invitation; (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; (6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	Re-designated & revised	483.10(f)(5)(ii)-(iv)	(ii) Staff, visitors, or other guests may attend resident group or family group meetings **only** at the respective group's invitation. (iii) The facility must provide a designated staff person **who is approved by the resident or family group and the facility and** who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must **consider** the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning **issues of resident care and life in the facility**. **(A) The facility must be able to demonstrate their response and rationale for such response.** **(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.**
483.15(d)	(d) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.	Re-designated& revised	483.10(f)(8)	(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
483.15(e)	(e) Accommodation of needs. A resident has the right to—	Re-designated & revised	483.10(e)	**(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: ….**
483.15(e)(1)	(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and	Re-designated & revised	483.10(e)(3)	(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
483.15(e)(2)	(2) Receive notice before the resident's room or roommate in the facility is changed.	Re-designated & revised	483.10(e)(6)	(6) The right to receive written notice, **including the reason for the change,** before the resident's room or roommate in the facility is changed.
483.15(f)(1)	(f) Activities. (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the	Re-designated & revised	483.24(c)(1)	(c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing

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	comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.			program **to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities**, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, **encouraging both independence and interaction in the community.**
483.15(f)(2)	(2) The activities program must be directed by a qualified professional who—	Re-designated & revised	483.24(c)(2)	(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—
483.15(f)(2)(i)	(i) Is a qualified therapeutic recreation specialist or an activities professional who—	Re-designated & revised	483.24(c)(2)	See above.
483.15(f)(2)(i)(A)	(A) Is licensed or registered, if applicable, by the State in which practicing; and	Re-designated	483.24(c)(2)(i)	(i) Is licensed or registered, if applicable, by the State in which practicing; and
483.15(f)(2)(i)(B)	(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or	Re-designated & revised	483.24(c)(2)(ii)(A)	(ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
483.15 (f)(2)(ii)-(iv)	(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.	Re-designated & revised	483.24(c)(2)(ii)(B)-(D)	(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.
483.15(g)(1)	(g) Social Services. (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	Re-designated & revised	483.40(d)	(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.
483.15(g)(2)	(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.	Re-designated & revised	483.70(p)	(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis.

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483.15(g)(3)(i)-(ii)	(3) Qualifications of social worker. A qualified social worker is an individual with— (i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and (ii) One year of supervised social work experience in a health care setting working directly with individuals.	Re-designated & revised	483.70(p)(1)-(2)	A qualified social worker is: (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, **gerontology**, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals.
483.15(h)	(h) Environment. The facility must provide—	Re-designated & revised	483.10(i)	**(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide—**
483.15(h)(1)	(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	Re-designated & revised	483.10(i)(1)	(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. **(i) This 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.** **(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.**
483.15(h)(2)	(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	Re-designated	483.10(i)(2)	(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
483.15(h)(3)	(3) Clean bed and bath linens that are in good condition;	Re-designated	483.10(i)(3)	(3) Clean bed and bath linens that are in good condition;
483.15(h)(4)	(4) Private closet space in each resident room, as specified in § 483.70(d)(2)(iv) of this part;	Re-designated & revised	483.10(i)(4)	(4) Private closet space in each resident room, as specified in § 483.90(d)(2)(iv);
483.15(h)(5)	(5) Adequate and comfortable lighting levels in all areas;	Re-designated	483.10(i)(5)	(5) Adequate and comfortable lighting levels in all areas;

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483.15(h)(6)	(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81°F; and	Re-designated	483.10(i)(6)	(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 °F; and
483.15(h)(7)	(7) For the maintenance of comfortable sound levels.	Re-designated	483.10(i)(7)	(7) For the maintenance of comfortable sound levels.
483.20	Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.	No change	483.20	Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
483.20(a)	(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.	No change	483.20(a)	(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.
483.20(b)	(b) Comprehensive assessments— (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence.	Revised	483.20(b)	(b) Comprehensive assessments— (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, **strengths, goals, life history and preferences**, using the resident assessment instrument (RAI) specified by **CMS**. The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence.

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	(x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge potential. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. (2) When required. Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this			(x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. (2) When required. Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) (ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a

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Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
	section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) (ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) Not less often than once every 12 months.			major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) Not less often than once every 12 months.
483.20(c)-(d)	(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.	No change	483.20(c)-(d)	(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.
483.20(e)	(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	Revised	483.20(e)	(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. **Coordination includes—**

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				(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. **(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.**
483.20(f)-(j)	(f) Automated data processing requirement— (1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically	No change	483.20(f)-(j)	(f) Automated data processing requirement— (1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment.

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	transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. (5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			(ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. (5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. (g) Accuracy of assessments. The assessment must accurately reflect the resident's status. (h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification. (1) A registered nurse must sign and certify that the assessment is completed.

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
	(g) Accuracy of assessments. The assessment must accurately reflect the resident's status. (h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification. (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for falsification. (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 of not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.			(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for falsification. (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 of not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.
			§ 483.21(a)	**Comprehensive person-centered care planning.** **(a) Baseline care plans.**

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
				(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— **(i) Be developed within 48 hours of a resident's admission.** **(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:** **(A) Initial goals based on admission orders.** **(B) Physician orders.** **(C) Dietary orders.** **(D) Therapy services.** **(E) Social services.** **(F) PASARR recommendation, if applicable.** **(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—** **(i) Is developed within 48 hours of the resident's admission.** **(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).** **(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:** **(i) The initial goals of the resident.** **(ii) A summary of the resident's medications and dietary instructions.**

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				(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. **(iv) Any updated information based on the details of the comprehensive care plan, as necessary.**
483.20(k)(1)	(k) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and (ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4)	Re-designated & revised	483.21(b)(1)	(b) Comprehensive care plans. (1) The facility must develop and implement a comprehensive **person-centered** care plan for each resident, **consistent with the resident rights set forth at § 483.10(c)(2) and § 483.10(c)(3),** that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required **under § 483.24, § 483.25, or § 483.40**; and (ii) Any services that would otherwise be required **under § 483.24, § 483.25, or § 483.40** but are not provided due to **the resident's exercise of rights under § 483.10, including the right** to refuse treatment under § 483.10(c)(6). **(iii) Any specialized services or specialized rehabilitative 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.** **(iv) In consultation with the resident and the resident's representative(s)—** **(A) The resident's goals for admission and desired outcomes.** **(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was**

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				assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. **(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.**
483.20(k)(2)	(2) A comprehensive care plan must be—	Re-designated	483.21(b)(2)	(2) A comprehensive care plan must be—
483.20(k)(2)(i)	(i) Developed within 7 days after completion of the comprehensive assessment;	Re-designated	483.21(b)(2)(i)	(i) Developed within 7 days after completion of the comprehensive assessment.
483.20(k)(2)(ii)	(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and	Re-designated & revised	483.21(b)(2)(ii)(A)-(F)	(ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. **(C) A nurse aide with responsibility for the resident.** **(D) A member of food and nutrition services staff.** (E) To the extent practicable, the participation of the resident and the resident's representative(s). **An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.** **(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.**
483.20(k)(2)(iii)	(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Re-designated & revised	483.21(b)(2)(iii)	(iii) Reviewed and revised by the interdisciplinary team after each assessment, **including both the comprehensive and quarterly review assessments.**
483.20(k)(3)(i)-(ii)	(3) The services provided or arranged by the facility must— (i) Meet professional standards of quality; and	Re-designated	483.21(b)(3)(i)-(ii)	(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

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	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.			(i) Meet professional standards of quality. (ii) Be provided by qualified persons in accordance with each resident's written plan of care.
			483.21(b)(3)(iii)	**(iii) Be culturally-competent and trauma-informed.**
			483.21(c)(1)	**(c) Discharge planning—(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at § 483.15(b) as applicable and—** **(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.** **(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.** **(iii) Involve the interdisciplinary team, as defined by § 483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.** **(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.** **(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.**

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				(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.** **(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.** **(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.** **(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.** **(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the 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. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.**

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483.20(l)	(l) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—	Re-designated & revised	483.21(c)(2)	(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, **but is not limited to**, the following:
483.20(l)(1)	(1) A recapitulation of the resident's stay;	Re-designated & revised	483.21(c)(2)(i)	(i) A recapitulation of the resident's stay **that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results**.
483.20(l)(2)	(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and	Re-designated & revised	483.21(c)(2)(ii)	(ii) A final summary of the resident's status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or **resident's representative**.
			483.21(c)(2)(iii)	**(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).**
483.20(l)(3)	(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	Re-designated & revised	483.21(c)(2)(iv)	(iv) A post-discharge plan of care that is developed with the participation of the resident **and, with the resident's consent, the resident representative(s),** which will assist the resident to adjust to his or her new living environment. **The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.**
483.20(m)	(m) Preadmission screening for mentally ill individuals and individuals with intellectual disability.	Re-designated	483.20(k)(1)	(k) Preadmission screening for individuals with a mental disorder and individuals with intellectual disability.
483.20(m)(1)(i)-(ii)	(1) A nursing facility must not admit, on or after January 1, 1989, any new resident with— (i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	Re-designated	483.20(k)(1)(i)-(ii)	(1) A nursing facility must not admit, on or after January 1, 1989, any new resident with— (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

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	(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual Disability, as defined in paragraph (f)(2)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission— (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.			(B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission— (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.
			483.20(k)(2)	**(2) Exceptions. For purposes of this section—** **(i) The preadmission screening program under paragraph (k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.** **(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual—** **(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,** **(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and**

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				(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.
483.20(m)(2)(i)-(ii)	(2) Definition. For purposes of this section— (i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in § 483.102(b)(1) (ii) An individual is considered to be mentally retarded if the individual is mentally retarded as defined in § 483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.	Re-designated & revised	483.20(k)(3)(i)-(ii)	(3) Definition. For purposes of this section— (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder as defined in § 483.102(b)(1). (ii) An individual is considered **to have an intellectual disability** if the individual has an **intellectual disability** as defined in § 483.102(b)(3) or is a person with a related condition as described in § 435.1010 of this chapter.
			483.20(k)(4)	**(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review.**
483.25	Quality of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	Revised	483.25	**§ 483.25 Quality of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following ….** (see below).
483.25(a)	(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that—	Re-designated & revised	483.24(a)	(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

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483.25(a)(1)	(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—	Re-designated and revised	483.24(a)	See above.
483.25(a)(1)(i)	(i) Bathe, dress, and groom;	Re-designated and revised	483.24(b)(1)	(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) of this section for the following activities of daily living: (1) Hygiene—bathing, dressing, grooming, and oral care,
483.25(a)(1)(ii)	(ii) Transfer and ambulate;	Re-designated and revised	483.24(b)(2)	(2) **Mobility**—transfer and ambulation, **including walking**,
483.25(a)(1)(iii)	(iii) Toilet;	Re-designated and revised	483.24(b)(3)	(3) **Elimination**—toileting,
483.25(a)(1)(iv)	(iv) Eat; and	Re-designated and revised	483.24(b)(4)	(4) **Dining—eating, including meals and snacks**,
483.25(a)(1)(v)	(v) Use speech, language, or other functional communication systems.	Re-designated and revised	483.24(b)(5)	(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.
483.25(a)(2)		Re-designated and revised	483.24(a)(1)	**(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:**

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	(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and			(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section,
483.25(a)(3)	(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	Re-designated	483.24(a)(2)	(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and
			483.24(a)(3)	**(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.**
483.25(b)	(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—	Re-designated	483.25(a)	**§ 483.25 Quality of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following ….** (a) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—
483.25(b)(1)	(1) In making appointments, and	Re-designated	483.25(a)(1)	(1) In making appointments, and
483.25(b)(2)	(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	Re-designated	483.25(a)(2)	(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.
483.25(c)	(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—	Re-designated & revised	483.25(b)(1)	(b) Skin integrity—(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that—

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483.25(c)(1)	(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and	Re-designated & revised	483.25(b)(1)(i)	**(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and**
483.25(c)(2)	(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	Re-designated & revised	483.25(b)(1)(ii)	(ii) A resident with pressure ulcers receives necessary treatment and services, **consistent with professional standards of practice**, to promote healing, prevent infection and prevent new ulcers from developing.
			483.25(e)(1)	**(e) Incontinence. (1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.**
483.25(d)	(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that—	Re-designated & revised	483.25(e)(2)	(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—
483.25(d)(1)	(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and	Re-designated	483.25(e)(2)(i)	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
483.25(d)(2)	(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	Re-designated	483.25(e)(2)(ii)	(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary, and
			483.25(e)(2)(iii)	**(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.**
			483.25(e)(3)	**(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is**

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				incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
483.25(e)	(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that—	Re-designated & revised	483.25(c)	(c) Mobility.
483.25(e)(1)	(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	Re-designated	483.25(c)(1)	(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and
483.25(e)(2)	(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	Re-designated	483.25(c)(2)	(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
			483.25(c)(3)	**(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.**
			483.40	**§ 483.40 Behavioral health services.** **Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.**
			483.40(a) **This includes both Phase 2 and Phase 3 language.**	**(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as**

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				determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with § 483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: **(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to § 483.70(e), and** **(2) Implementing non-pharmacological interventions.**
483.25(f)	(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—	Re-designated & revised	483.40(b)	(b) Based on the comprehensive assessment of a resident, the facility must ensure that—
483.25(f)(1)	(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and	Re-designated & revised	483.40(b)(1)	(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;**
483.25(f)(2)	(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty 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 such a pattern was unavoidable.	Re-designated & revised	483.40(b)(2)	(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; and
			483.40(b)(3)	**(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.**

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			483.40(c)	**(c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—** **(1) Provide the required services, including specialized rehabilitation services as required in § 483.65; or** **(2) Obtain the required services from an outside resource (in accordance with § 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.**
483.25(g)	(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that—	Re-designated & revised	483.25(g)(4)	**(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—**
483.25(g)(1)	(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and	Re-designated & revised	483.25(g)(4)	(4) A resident who has been able to eat enough alone or with assistance is not fed **by enteral methods** unless the resident's clinical condition demonstrates that **enteral feeding** was clinically indicated and consented to by the resident; and
483.25(g)(2)	(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	Re-designated & revised	483.25(g)(5)	(5) A resident who is fed **by enteral means** receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of **enteral feeding** including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
483.25(h)	(h) Accidents. (h) Accidents. The facility must ensure that—	Re-designated	483.25(d)	(d) Accidents. The facility must ensure that—
483.25(h)(1)	(1) The resident environment remains as free of accident hazards as is possible; and	Re-designated	483.25(d)(1)	(1) The resident environment remains as free of accident hazards as is possible; and

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483.25(h)(2)	(2) Each resident receives adequate supervision and assistance devices to prevent accidents.	Re-designated	483.25(d)(2)	(2) Each resident receives adequate supervision and assistance devices to prevent accidents.
483.25(i)	(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—	Re-designated & revised	483.25(g)	**(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—**
483.25(i)(1)	(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	Re-designated & revised	483.25(g)(1)	(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible **or resident preferences indicate otherwise**;
483.25(i)(2)	(2) Receives a therapeutic diet when there is a nutritional problem.	Re-designated & revised	483.25(g)(3)	(3) **Is offered** a therapeutic diet when there is a nutritional problem **and the health care provider orders a therapeutic diet**.
483.25(j)	(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	Re-designated & revised	483.25(g)(2)	(2) **Is offered** sufficient fluid intake to maintain proper hydration and health; and
483.25(k)	(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:	Re-designated & revised	483.25(d)	**Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:**
483.25(k)(1)	(1) Injections;	Deleted		N/A
483.25(k)(2)	(2) Parenteral and enteral fluids;	Re-designated & revised	483.25(h)	(h) Parenteral fluids. **Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.**

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483.25(k)(3)	(3) Colostomy, ureterostomy, or ileostomy care;	Re-designated	483.25(f)	(f) Colostomy, urostomy, or ileostomy care. **The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.**
483.25(k)(4)	(4) Tracheostomy care;	Re-designated & revised	483.25(i)	(i) Respiratory care, including tracheostomy care and tracheal suctioning. **The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and § 483.65 of this subpart.**
483.25(k)(5)	(5) Tracheal suctioning;	Re-designated & revised	483.25(i)	See above.
483.25(k)(6)	(6) Respiratory care;	Re-designated & revised	483.25(i)	See above.
483.25(k)(7)	(7) Foot care; and	Re-designated & revised	483.25(b)(2)	(2) Foot care. **To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must—** **(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and** **(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.**
483.25(k)(8)	(8) Prostheses.	Re-designated	483.25(j)	(j) Prostheses. **The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, to wear and be able to use the prosthetic device.**
			483.25(k)	**(k) Pain management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional**

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				standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
			483.25(l)	**(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.**
			483.25(m)	**(m) Trauma-informed care. The facility must ensure that residents who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.**
			483.25(n)	**(n) Bed rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.** **(1) Assess the resident for risk of entrapment from bed rails prior to installation.** **(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.** **(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.** **(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.**
483.25(l)	(l) Unnecessary drugs. (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	Re-designated	483.45(d)	(d) Unnecessary drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—

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483.25(l)(1)(i) -(vi)	(i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above.	Re-designated	483.45(d)(1)-(6)	(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
483.25(l)(2)(i) -(ii)	(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that— (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	Re-designated & revised	483.45(e)(1)-(2) [CMS says the changes relating to psychotropic drugs are Phase 2. But current regs re anti-psychotics continue in effect.]	(e) **Psychotropic** drugs. Based on a comprehensive assessment of a resident, the facility must ensure that— (1) 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; (2) Residents who use **psychotropic** drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
			483.45(e)(3)-(5) **(Phase 2 subject to confirmation.)**	**(3) 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; and** **(4) 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.**

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
				(5) 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.
483.25(m)(1)-(2)	(m) Medication Errors. The facility must ensure that— (1) It is free of medication error rates of five percent or greater; and (2) Residents are free of any significant medication errors.	Re-designated & revised	483.45(f)(1)-(2)	(f) Medication errors. The facility must ensure that its— (1) Medication error rates are not 5 percent or greater; and (2) Residents are free of any significant medication errors.
483.25(n)	(n) Influenza and pneumococcal immunizations –	Re-designated	483.80(d)(1)	See below.
483.25(n)(1)(i)-(iv)	(1) Influenza. The facility must develop policies and procedures that ensure that— (i) Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and	Re-designated & revised	483.80(d)(1)(i)-(iv)	(d) Influenza and pneumococcal immunizations—(1) Influenza. The facility must develop policies and procedures to ensure that— (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the **resident's representative** has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or **resident's representative** was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

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	(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			
483.25(n)(2)	(2) Pneumococcal disease. The facility must develop policies and procedures that ensure that—	Re-designated	483.80(d)(2)	See below.
483.25(n)(2)(i)-(iv)	(i) Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	Re-designated & revised	483.80(d)(2)(i)-(iv)	(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that— (i) Before offering the pneumococcal immunization, each resident or the **resident's representative** receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the **resident's representative** has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or **resident's representative** was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
483.25(n)(2)(v)	(v) Exception. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first	Deleted		Editor's note: This provision is no longer part of the regulations.

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	pneumococcal immunization, unless medically contraindicated or the resident or the or the resident's legal representative refuses the second immunization.			
483.30	Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	Re-designated & revised	483.35	§ 483.35 Nursing services. The facility must have sufficient nursing staff **with the appropriate competencies and skills sets** to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care **and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).**
483.30(a)	(a) Sufficient staff.	Re-designated	483.35(a)	(a) Sufficient staff.
483.30(a)(1)(ii)	(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24–hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel.	Re-designated & revised	483.35(a)(1)(ii)	(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24–hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, **including but not limited to nurse aides**.
483.30(a)(2)	(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	Re-designated	483.35(a)(2)	(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
			483.35(a)(3)	**(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.**

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			483.35(a)(4)	**(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.**
483.30(b)(1)	(b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	Re-designated	483.35(b)(1)	(b) Registered nurse. (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
483.30(b)(2)	(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	Re-designated	483.35(b)(2)	(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.
483.30(b)(3)	(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	Re-designated	483.35(b)(3)	(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
483.30(c)	(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—	Re-designated	483.35(e)	(e) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—
483.30(c)(1)-(5)	(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel; (2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; (3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a	Re-designated	483.35(e)(1)-(5)	(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel; (2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; (3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

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	physician is obligated to respond immediately to telephone calls from the facility; (4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review; (5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;			(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review; (5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;
483.30(c)(6)	(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and	Re-designated & revised	483.35(e)(6)	(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and
483.30(c)(7)	(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.	Re-designated & revised	483.35(e)(7)	(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their **resident representatives** of the waiver.
483.30(d)(1)	(d) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week: (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—	Re-designated	483.35(f)(1)	(f) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week: (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—
483.30(d)(1)(i)	(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;	Re-designated	483.35(f)(1)(i)	(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

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483.30(d)(1)(ii)	(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and	Re-designated	483.35(f)(1)(ii)	(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
483.30(d)(1)(iii)	(iii) The facility either—	Re-designated	483.35(f)(1)(iii)	(iii) The facility either—
483.30(d)(1)(iii)(A)	(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48–hours period, or	Re-designated	483.35(f)(1)(iii)(A)	(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48–hours period, or
483.30(d)(1)(iii)(B)	(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.	Re-designated	483.35(f)(1)(iii)(B)	(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.
483.30(d)(1)(iv)	(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and	Re-designated & revised	483.35(f)(1)(iv)	(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and
483.30(d)(1)(v)	(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.	Re-designated & revised	483.35(f)(1)(v)	(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.
483.30(d)(2)	(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.	Re-designated	483.35(f)(2)	(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.
483.30(e)(1)(i)-(iv)	(e) Nurse staffing information—	Re-designated	483.35(g)(1)(i)-(iv)	(g) Nurse staffing information—

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	(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.			(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.
483.30(e)(2)(i)-(ii)	(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	Re-designated	483.35(g)(2)(i)-(ii)	(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.
483.30(e)(3)	(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	Re-designated	483.35(g)(3)	(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

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483.30(e)(4)	(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	Re-designated	483.35(g)(4)	(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
483.35	Dietary services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	Re-designated & revised	483.60	§ 483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, **taking into consideration the preferences of each resident.**
483.35(a)	(a) Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.	Re-designated & revised	483.60(a)(1) Includes both Phase 1 and Phase 2 requirements.	(a) Staffing. 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 and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).** This includes: (1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. Editor's note: See below for specific qualifications.
483.35(a)(1)	(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.	Re-designated & revised	483.60(a)(2) [We have not used yellow, green or blue shading here, since there is a five-year grandfathering for the new qualifications.]	(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who— **(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:** **(A) A certified dietary manager; or** **(B) A certified food service manager, or**

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				(C) Has similar national certification for food service management and safety from a national certifying body; or **(D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and** **(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and** **(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.**
483.35(a)(2)	(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	Re-designated & revised	483.60(a)(1)(i)-(iv) [We have not used yellow, green or blue shading here, since there is a five-year grandfathering for the new qualifications.]	A qualified dietitian **or other clinically qualified nutrition professional** is one who— **(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.** **(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.** **(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.**

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				(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.
483.35(b)	(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	Re-designated & revised	483.60(a)(3)	(3) Support staff. The facility must provide sufficient support personnel to **safely and effectively** carry out the functions of the food and nutrition service.
			483.60(b)	**(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).**
483.35(c)	(c) Menus and nutritional adequacy. Menus must –	Re-designated	483.60(c)	(c) Menus and nutritional adequacy. Menus must—
483.35(c)(1)-(3)	(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed.	Re-designated & revised	483.60(c)(1)-(3)	(1) Meet the nutritional needs of residents in accordance with **established national guidelines**.; (2) Be prepared in advance; (3) Be followed;
			483.60(c)(4)-(7)	**(4) 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;** **(5) Be updated periodically;** **(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and** **(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.**
483.35(d)	(d) Food. Each resident receives and the facility provides—	Re-designated	483.60(d)	(d) Food and drink. Each resident receives and the facility provides—

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483.35(d)(1)	(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	Re-designated	483.60(d)(1)	(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;
483.35(d)(2)	(2) Food that is palatable, attractive, and at the proper temperature;	Re-designated & revised	483.60(d)(2)	(2) Food **and drink** that is palatable, attractive, and at a **safe and appetizing** temperature;
483.35(d)(3)	(3) Food prepared in a form designed to meet individual needs; and	Re-designated	483.60(d)(3)	(3) Food prepared in a form designed to meet individual needs;
			483.60(d)(4)	**(4) Food that accommodates resident allergies, intolerances, and preferences;**
483.35(d)(4)	(4) Substitutes offered of similar nutritive value to residents who refuse food served.	Re-designated & revised	483.60(d)(5)	**(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and**
			483.60(d)(6)	**(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.**
483.35(e)	(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.	Re-designated & revised	483.60(e)	(e) Therapeutic diets. (1) Therapeutic diets must be prescribed by the attending physician. **(2) 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.**
483.35(f)(1)	(f) Frequency of meals. (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.	Re-designated & revised	483.60(f)(1)	(f) Frequency of meals. (1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.
483.35(f)(2)	(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.	Note: CMS says this section is deleted but see 483.60(f)(2).	**483.60(f)(2)**	(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, **except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.**

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483.35(f)(3)	(3) The facility must offer snacks at bedtime daily.	Re-designated	483.60(f)(3)	**(3) 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.**
483.35(f)(4)	(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	Note: CMS says this section is deleted but see 483.60(f)(2)-(3)	See above.	See above.
483.35(g)	(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.	Re-designated & revised	483.60(g)	(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.
483.35(h)(1)	(h) Paid feeding assistants—	Re-designated	483.60(h)(1)	(h) Paid feeding assistants—
483.35(h)(1)(i)-(ii)	(1) State-approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if— (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.	Re-designated	483.60(h)(1)(i)-(ii)	(1) State-approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if— (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.
483.35(h)(2)(i)	(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN)	Re-designated	483.60(h)(2)(i)	(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
483.35 (h)(2)(ii)	(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.	Re-designated & revised	483.60(h)(2)(ii)	(ii) In an emergency, a feeding assistant must call a supervisory nurse for help. **[Editor's note: it deletes "on the resident call system.]**

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483.35(h)(3)(i)-(ii)	(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.	Re-designated & revised	483.60(h)(3)(i)-(ii)	(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
483.35(h)(3)(iii)	(iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.	Re-designated & revised	483.60(h)(3)(iii)	(iii) The facility must base resident selection **on the interdisciplinary team's assessment** and the resident's latest assessment and plan of care. **Appropriateness for this program should be reflected in the comprehensive care plan**
483.35(i)	(i) Sanitary conditions. The facility must—	Re-designated & revised	483.60(i)	(i) Food safety requirements. The facility must—
483.35(i)(1)	(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;	Re-designated & revised	483.60(i)(1)	(1) Procure food from sources approved or considered satisfactory by federal, state, or local authorities; **(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.**
483.35(i)(2)	(2) Store, prepare, distribute, and serve food under sanitary conditions; and	Re-designated & revised	483.60(i)(2)	(2) Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.

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			483.60(i)(3)	**(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, and**
483.35(i)(3)	(3) Dispose of garbage and refuse properly.	Re-designated	483.60(i)(4)	(4) Dispose of garbage and refuse properly.
483.40	Physician services. 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.	Re-designated & revised	483.30	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. **A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.**
483.40(a)	(a) Physician supervision. The facility must ensure that—	Re-designated	483.30(a)	(a) Physician supervision. The facility must ensure that—
483.40(a)(1)-(2)	(1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable.	Re-designated	483.30(a)(1)-(2)	(1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable.
483.40(b)	(b) Physician visits. The physician must—	Re-designated	483.30(b)	(b) Physician visits. The physician must—
483.40(b)(1)	(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	Re-designated	483.30(b)(1)	(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;
483.40(b)(2)	(2) Write, sign, and date progress notes at each visit; and	Re-designated	483.30(b)(2)	(2) Write, sign, and date progress notes at each visit; and
483.40(b)(3)	(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	Re-designated & revised	483.30(b)(3)	(3) Sign and date all orders with the exception of influenza and pneumococcal **[deletes "polysaccharide"]** vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
483.40(c)(1)-(4)	(c) Frequency of physician visits.	Re-designated	483.30(c)(1)-(4)	(c) Frequency of physician visits. (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

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	(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. (4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.			(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. (4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.
483.40(d)	(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.	Re-designated	483.30(d)	(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.
483.40(e)(1)	(e) Physician delegation of tasks in SNFs. (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—	Re-designated	483.30(e)	(e) Physician delegation of tasks in SNFs. (1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—
483.40(e)(1)(i)-(iii)	(i) Meets the applicable definition in § 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician.	Re-designated	483.30(e)	(i) Meets the applicable definition in § 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician.

Existing CFR §	Existing Language	Impact on Existing §	New CFR §	New Language
			483.30(e)(2)	**(2) 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.**
			483.30(e)(3)	**(3) 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.**
483.40(e)(2)	(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	Re-designated	483.30(e)	(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.
483.40(f)	(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.	Re-designated	483.30(g)	(g) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.
483.45	Specialized rehabilitative services. (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—	Re-designated & revised	483.65(a)	§ 483.65 Specialized rehabilitative services. (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, **respiratory therapy**, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at § 483.120(c), are required in the resident's comprehensive plan of care, the facility must—

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483.45(a)(1)-(2)	(1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with § 483.75(h) of this part) from a provider of specialized rehabilitative services.	Re-designated & revised	483.65(a)(1)-(2)	(1) Provide the required services; or (2) In accordance with § 483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services **and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.**
483.45(b)	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	Re-designated	483.65(b)	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.
483.55	Dental services. The facility must assist residents in obtaining routine and 24–hour emergency dental care.	No change	483.55	Dental services. The facility must assist residents in obtaining routine and 24–hour emergency dental care.
483.55(a)(1)	(a) Skilled nursing facilities. A facility (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;	Re-designated	483.55(a)(1)	(a) Skilled nursing facilities. A facility (1) Must provide or obtain from an outside resource, in accordance with **§ 483.70(g)** of this part, routine and emergency dental services to meet the needs of each resident;
483.55(a)(2)	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	Re-designated	483.55(a)(2)	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;
			483.55(a)(3)	**(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;**
483.55(a)(3)	(3) Must if necessary, assist the resident—	Re-designated	483.55(a)(4)	(4) Must if necessary **or if requested**, assist the resident—
483.55(a)(3)(i)	(i) In making appointments; and	Re-designated	483.55(a)(4)(i)	(i) In making appointments; and
483.55(a)(3)(ii)	(ii) By arranging for transportation to and from the dentist's office; and	Re-designated & revised	483.55(a)(4)(ii)	(ii) By arranging for transportation to and from the **dental services location**; and

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483.55(a)(4)	(4) Promptly refer residents with lost or damaged dentures to a dentist.	Re-designated & revised	483.55(a)(5) Shaded language is Phase 2.	(5) Must promptly, **within 3 days**, refer residents with lost or damaged dentures **for dental services**. **If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.**
483.55(b)	(b) Nursing facilities. The facility	Re-designated	483.55(b)	(b) Nursing facilities. The facility
483.55(b)(1)(i)-(ii)	(1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	Re-designated & revised	483.55(b)(1)(i)-(ii)	(1) Must provide or obtain from an outside resource, in accordance with § 483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;
483.55(b)(2)	(2) Must, if necessary, assist the resident—	Re-designated & revised	483.55(b)	(2) Must, if necessary **or if requested**, assist the resident—
483.55(b)(2)(i)-(ii)	(i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and	Re-designated & revised	483.55(b)(2)(i)-(ii)	(i) In making appointments; and (ii) By arranging for transportation to and from the **dental services locations**;
483.55(b)(3)	(3) Must promptly refer residents with lost or damaged dentures to a dentist.	Re-designated & revised	483.55(b)(3) Shaded language is Phase 2.	(3) Must promptly, **within 3 days**, refer residents with lost or damaged dentures **for dental services**. **If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;**
			483.55(b)(4)	**(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and**

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			483.55(b)(5)	**(5) 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.**
483.60	Pharmacy services. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	Re-designated & revised	483.45	Pharmacy services. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.
483.60(a)	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	Re-designated	483.45(a)	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
483.60(b)	(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—	Re-designated	483.45(b)	(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—
483.60(b)(1)-(3)	(1) Provides consultation on all aspects of the provision of pharmacy services in the facility; (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	Re-designated	483.45(b)(1)-(3)	(1) Provides consultation on all aspects of the provision of pharmacy services in the facility; (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
483.60(c)(1)	(c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	Re-designated	483.45(c)(1)	(c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

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			483.45(c)(2)	**(2) This review must include a review of the resident's medical chart.**
			483.45(c)(3)	**(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:** **(i) Anti-psychotic;** **(ii) Anti-depressant;** **(iii) Anti-anxiety; and** **(iv) Hypnotic.**
483.60(c)(2)	(2) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.	Re-designated & revised	483.45(c)(4)	(4) 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.**
			483.45(c)(5)	**(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames**

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				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.
483.60(d)	(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	Re-designated	483.45(g)	(g) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
483.60(e)(1-(2)	(e) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	Re-designated	483.45(h)(1)-(2)	(h) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
483.65	Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	Re-designated & revised	483.80	The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
483.65(a)(1)-(3)	(a) Infection control program. The facility must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility;	Re-designated & revised	483.80(a)(1)-(4)	(a) 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:

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	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		Includes both Phase 1 and Phase 2 requirements.	**(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 based upon the facility assessment conducted according to § 483.70(e) and following accepted national standards;** **(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.** **(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.**

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				(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. **(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.**
483.65(b)(1)	(b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	Re-designated & revised	483.80(a)(2)(iv)	**(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: …** **(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.**
483.65(b)(2)	(2) 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.	Re-designated & revised	483.80(a)(2)(v)	**(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: …** **(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**
483.65(b)(3)	(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	Re-designated & revised	483.80(a)(2)(vi)	**(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: …** **(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.**
			483.80(b)	**(b) Infection preventionist. The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must:**

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				(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; **(2) Be qualified by education, training, experience or certification;** **(3) Work at least part-time at the facility; and** **(4) Have completed specialized training in infection prevention and control.**
			483.80(c)	**(c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.**
483.65(c)	(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	Re-designated	483.80(e)	(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
			483.80(f)	**(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.**
			483.85(a)	**New section:** **§ 483.85 Compliance and ethics program.** **(a) Definitions. For purposes of this section, the following definitions apply:** **Compliance and ethics program means, with respect to a facility, a program of the operating organization that—** **(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and**

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				(2) Includes, at a minimum, the required components specified in paragraph (c) of this section. **High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.** **Operating organization means the individual(s) or entity that operates a facility.**
			483.85(b)	**(b) General rule. Beginning on November 28, 2017, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.**
			483.85(c)	**(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:** **(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.** **(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer**

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				(CEO), members of the board of directors, or directors of major divisions in the operating organization. **(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures.** **(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.** **(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at § 483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program.** **(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.** **(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as**

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				appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program. **(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.**
			483.85(d)	**(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:** **(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in § 483.95(f).** **(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.** **(3) Designated compliance liaisons located at each of the operating organization's facilities.**
			483.85(e)	**(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating**

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				organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.
483.70	Physical environment. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	Re-designated	483.90	Physical environment. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.
Editor's note: CMS designates life safety provisions as unchanged under this rule. That is correct in terms of this specific "mega rule". But providers should be aware that CMS has adopted the 2012 editions of NFPA 101 and NFPA 99 under a separate federal rule, with enforcement effective November 1, 2016. Review all of the following *ITALICIZED LANGUAGE* in light of those newly-adopted requirements.				
483.70(a)(1)-(8)	*(a) Life safety from fire.* *(1) Except as otherwise provided in this section—* *(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_ locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.*	*Re-designated*	*483.90(a)(1)-(8)*	*(a) Life safety from fire.* *(1) Except as otherwise provided in this section—* *(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_ locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.* *(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.* *(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in*

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	(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities. *(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.* *(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.* *(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.* *(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.* *(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—* *(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;* *(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;* *(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;*			*unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.* *(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.* *(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.* *(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.* *(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—* *(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;* *(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;* *(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;* *(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS*

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	(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and *(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.* *(7) A long term care facility must:* *(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.* *(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.* *(iii) Exception:* *(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and*			*Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and* *(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.* *(7) A long term care facility must:* *(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.* *(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.* *(iii) Exception:* *(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or* *(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.* *(8) A long term care facility must:* *(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information*

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	maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or *(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.* *(8) A long term care facility must:* *(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.* *(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water–Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water–Based Fire*			*Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.* *(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water–Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water–Based Fire Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.* *(iii) Subject to approval by CMS, a long term care facility may be granted an extension of the sprinkler installation deadline for a time period not to exceed 2 years from August 13, 2013, if the facility meets all of the following conditions:* *(A) It is in the process of replacing its current building, or undergoing major modifications to improve the living conditions for residents in all unsprinklered living areas that requires the movement of corridor, room, partition, or structural walls or supports, in addition to the installation of a sprinkler system; or, has had its planned sprinkler installation so impaired by a disaster or emergency, as*

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	Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA) For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. *(iii) Subject to approval by CMS, a long term care facility may be granted an extension of the sprinkler installation deadline for a time period not to exceed 2 years from August 13, 2013, if the facility meets all of the following conditions:* *(A) It is in the process of replacing its current building, or undergoing major modifications to improve the living conditions for residents in all unsprinklered living areas that requires the movement of corridor, room, partition, or structural walls or supports, in addition to the installation of a sprinkler system; or, has had its planned sprinkler installation so impaired by a disaster or emergency, as indicated by a declaration under section 319 of the Public Health Service Act, that CMS finds it would be impractical to meet the sprinkler installation due date.* *(B) It demonstrates that it has made the necessary financial commitments to complete the building replacement or modification; or pursuant to a declared disaster or emergency,*			*indicated by a declaration under section 319 of the Public Health Service Act, that CMS finds it would be impractical to meet the sprinkler installation due date.* *(B) It demonstrates that it has made the necessary financial commitments to complete the building replacement or modification; or pursuant to a declared disaster or emergency, CMS finds it impractical to make reasonable and necessary financial commitments.* *(C) Before applying for the deadline extension, it has submitted plans to State and local authorities that are necessary for approval of the replacement building or major modification that includes the required sprinkler installation, and has received approval of the plans from State and local authorities.* *(D) It agrees to complete interim steps to improve fire safety, as determined by CMS.* *(iv) An extension granted under paragraph (a)(8)(iii) of this section may be renewed once, for an additional period not to exceed 1 year, if the following conditions are met:* *(A) CMS finds that extenuating circumstances beyond the control of the facility will prevent full compliance with the provisions in paragraph (a)(8)(i) of this section by the end of the first waiver period.* *(B) All other conditions of paragraph (a)(8)(iii) of this section are met.*

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	CMS finds it impractical to make reasonable and necessary financial commitments. *(C) Before applying for the deadline extension, it has submitted plans to State and local authorities that are necessary for approval of the replacement building or major modification that includes the required sprinkler installation, and has received approval of the plans from State and local authorities.* *(D) It agrees to complete interim steps to improve fire safety, as determined by CMS.* *(iv) An extension granted under paragraph (a)(8)(iii) of this section may be renewed once, for an additional period not to exceed 1 year, if the following conditions are met:* *(A) CMS finds that extenuating circumstances beyond the control of the facility will prevent full compliance with the provisions in paragraph (a)(8)(i) of this section by the end of the first waiver period.* *(B) All other conditions of paragraph (a)(8)(iii) of this section are met.*			
483.70(b)(1)-(2)	(b) Emergency power. (1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. (2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.	Re-designated	483.90(b)(1)-(2)	(b) Emergency power. (1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. (2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

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483.70(c)(1)-(2)	(c) Space and equipment. The facility must— (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	Re-designated & revised	483.90(c)(1)-(2)	(c) Space and equipment. The facility must— (1) Provide sufficient space and equipment in dining, health services, recreation, living, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's assessment and plan of care; and (2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (3) Conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.
483.70(d)	(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.	Re-designated	483.90(d)	(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.
483.70(d)(1)	(1) Bedrooms must—	Re-designated	483.90(d)(1)	(1) Bedrooms must—
483.70(d)(1)(i)	(i) Accommodate no more than four residents;	Re-designated & revised	483.90(d)(1)(i)	(i) Accommodate no more than four residents. 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.
483.70(d)(1)(ii)-(vii)	(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; (iii) Have direct access to an exit corridor;	Re-designated	483.90(d)(1)(ii)-(vii)	(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; (iii) Have direct access to an exit corridor; (iv) Be designed or equipped to assure full visual privacy for each resident;

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	(iv) Be designed or equipped to assure full visual privacy for each resident; (v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; (vi) Have at least one window to the outside; and (vii) Have a floor at or above grade level.			(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; (vi) Have at least one window to the outside; and (vii) Have a floor at or above grade level.
483.70(d)(2)	(2) The facility must provide each resident with—	Re-designated	483.90(d)(2)	(2) The facility must provide each resident with—
483.70(d)(2)(i)	(i) A separate bed of proper size and height for the convenience of the resident;	Re-designated & revised	483.90(d)(2)(i)	(i) A separate bed of proper size and height for the **safety and** convenience of the resident;
483.70(d)(2)(ii)-(iv)	(ii) A clean, comfortable mattress; (iii) Bedding appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	Re-designated	483.90(d)(2)(ii)-(iv)	(ii) A clean, comfortable mattress; (iii) Bedding appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.
483.70(d)(3)(i)-(ii)	(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations— (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety.	Re-designated	483.90(d)(3)(i)-(ii)	(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations— (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety.

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483.70(e)	(e) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities.	Re-designated & revised	483.90(f)	(f) Bathroom facilities. Each resident room must be equipped with or located near toilet and bathing facilities. **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.**
483.70(f)(1)	(f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from— (1) Resident rooms; and	Re-designated & revised	483.90(g)(1) Includes both Phase 1 and Phase 3 requirements.	(g) Resident call system. The facility must be adequately equipped to allow residents to call for staff assistance through a communication system **which relays the call directly to a staff member or to a centralized staff work area** from— (1) **Each resident's bedside**; and
483.70(f)(2)	(2) Toilet and bathing facilities.	Re-designated	483.90(g)(2)	(2) Toilet and bathing facilities.
483.70(g)(1)	(g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must— (1) Be well lighted;	Re-designated	483.90(h)(1)	(h) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must—
483.70(g)(2)	(2) Be well ventilated, with nonsmoking areas identified;	Re-designated & revised	483.90(h)(2)	(2) Be well ventilated;
483.70(g)(3)-(4)	(3) Be adequately furnished; and (4) Have sufficient space to accommodate all activities.	Re-designated	483.90(h)(3)-(4)	(3) Be adequately furnished; and (4) Have sufficient space to accommodate all activities.
483.70(h)(1)-(4)	(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	Re-designated	483.90(i)	(i) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

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	(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two; (3) Equip corridors with firmly secured handrails on each side; and (4) Maintain an effective pest control program so that the facility is free of pests and rodents.			(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two; (3) Equip corridors with firmly secured handrails on each side; and (4) Maintain an effective pest control program so that the facility is free of pests and rodents. **(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.**
483.75	Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	Re-designated	483.70	Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
483.75(a)	(a) Licensure. A facility must be licensed under applicable State and local law.	Re-designated	483.70(a)	(a) Licensure. A facility must be licensed under applicable State and local law.
483.75(b)	(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	Re-designated	483.70(b)	(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.
483.75(c)	(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR	Re-designated & revised	483.70(c)	(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92);

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	part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.			protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) **and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.** **[Editor's note: The new section drops this phrase: "Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds."]**
483.75(d)(1)	(d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	Re-designated	483.70(d)(1)	(d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
483.75(d)(2)(i)-(ii)	(2) The governing body appoints the administrator who is— (i) Licensed by the State where licensing is required; and (ii) Responsible for management of the facility.	Re-designated & revised	483.70(d)(2)(i)-(ii)	(2) 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.**
			483.70(d)(3)	**(3) The governing body is responsible and accountable for the QAPI program, in accordance with § 483.75(f).**
			483.70(e)	**New section:** **(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or**

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				the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: **(1) The facility's resident population, including, but not limited to,** **(i) Both the number of residents and the facility's resident capacity;** **(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;** **(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;** **(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and** **(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.** **(2) The facility's resources, including but not limited to,** **(i) All buildings and/or other physical structures and vehicles;** **(ii) Equipment (medical and non-medical);** **(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;** **(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;**

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				(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and **(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.** **(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.**
483.75(e)	(e) Required training of nursing aides—	Re-designated & revised	483.95(g) Incudes Phase 1 and Phase 2 requirements.	**(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 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.**
483.75(e)(1)	(1) Definitions. Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.	Re-designated & revised	483.5	Licensed health professional. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; **or registered respiratory therapist or certified respiratory therapy technician.**

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483.75(e)(1)	Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.	Re-designated & revised	483.5	Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. **This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay**. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.
483.75(e)(2)(i)-(ii)	(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless: (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151–483.154 of this part; or (B) That individual has been deemed or determined competent as provided in § 483.150(a) and (b)	Re-designated & revised	483.35(d)(1)(i)-(ii)	(d) Requirements for facility hiring and use of nursing aides — (1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless— (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of § 483.151 through § 483.154; or (B) That individual has been deemed or determined competent as provided in § 483.150(a) and (b).
483.75(e)(3)	(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.	Re-designated & revised	483.35(d)(2)	(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1) (i) and (ii) of this section.
483.75(e)(4)(i)-(iii)	(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—	Re-designated	483.35(d)(3)(i)-(iii)	(3) **Minimum** competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

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	(i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in § 483.150(a) and (b)			(i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in § 483.150(a) and (b).
483.75(e)(5)(i)-(ii)	(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless— (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	Re-designated	483.35(d)(4)(i)-(ii)	(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless— (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.
483.75(e)(6)	(6) Multi–State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.	Re-designated & revised	483.35(d)(5)	(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.
483.75(e)(7)	(7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program,	Re-designated	483.35(d)(6)	(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period

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	there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.			of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.
483.75(e)(8)(i)-(iii)	(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must— (i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; (ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and (iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	Re-designated & revised	483.35(d)(7), 483.95(g)	(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. **In-service training must comply with the requirements of § 483.95(g).** * * * * * **483.95(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 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.**
483.75(f)	(f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	Re-designated	483.35(c)	(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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483.75(g)(1)	(g) Staff qualifications. (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.	Re-designated	483.70(f)(1)	(f) Staff qualifications. (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.
483.75(g)(2)	(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	Re-designated	483.70(f)(2)	(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.
483.75(h)(1)	(h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.	Re-designated	483.70(g)(1)	(g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.
483.75(h)(2)(i)-(ii)	(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.	Re-designated	483.70(g)(2)(i)-(ii)	(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.
483.75(i)(1)	(i) Medical director. (1) The facility must designate a physician to serve as medical director.	Re-designated	483.70(h)(1)	(h) Medical director. (1) The facility must designate a physician to serve as medical director.

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483.75(i)(2)(i-ii)	(2) The medical director is responsible for— (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.	Re-designated	483.70(h)(2)(i)-(ii)	(2) The medical director is responsible for— (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.
483.75(j)(1)(i)-(iv)	(j) Laboratory services. (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. (ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.	Re-designated	483.50(a)(1)(i)-(iv)	§ 483.50 Laboratory, radiology, and other diagnostic services. (a) Laboratory services. (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. (ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter. (iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.
483.75(j)(2)	(2) The facility must—	Re-designated	483.50(a)(2)	(2) The facility must:
483.75(j)(2)(i)-(iv)	(i) Provide or obtain laboratory services only when ordered by the attending physician; (ii) Promptly notify the attending physician of the findings;	Re-designated & Revised	483.50(a)(2)(i)-(iv)	(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.**

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	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.			(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.** (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
483.75(k)	(k) Radiology and other diagnostic services.	Re-designated	483.50(b)	(b) Radiology and other diagnostic services.
483.75(k)(1)	(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in § 482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.	Re-designated	483.50(b)(1)	(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in § 482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.
483.75(k)(2)	(2) The facility must— (i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician; (ii) Promptly notify the attending physician of the findings;	Re-designated & revised	483.50(b)(2)	(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**

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	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.			**reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.** (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.
483.75(l)(1)	(l) Clinical records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—	Re-designated & revised	483.70(i)(1)	(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are—
483.75(l)(1)(i)-(iv)	(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.	Re-designated & revised	483.70(i)(1)(i)-(iv)	(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.
483.75(l)(2)	(2) Clinical records must be retained for—	Re-designated & revised	483.70(i)(4)	(4) Medical records must be retained for—
483.75(l)(2)(i)	(i) The period of time required by State law; or	Re-designated	483.70(i)(4)(i)	(i) The period of time required by State law; or
483.75(l)(2)(ii)	(ii) Five years from the date of discharge when there is no requirement in State law; or	Re-designated	483.70(i)(4)(ii)	(ii) Five years from the date of discharge when there is no requirement in State law; or
483.75(l)(2)(iii)	(iii) For a minor, three years after a resident reaches legal age under State law.	Re-designated	483.70(i)(4)(iii)	(iii) For a minor, 3 years after a resident reaches legal age under State law.
483.75(l)(3)	(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;	Re-designated & revised	483.70(i)(3)	(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use;

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483.75(l)(4)(i) -(iv)	(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by— (i) Transfer to another health care institution; (ii) Law; (iii) Third party payment contract; or (iv) The resident.	Re-designated & revised	483.70(i)(2)	**(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is—** **(i) To the individual, or their resident representative where permitted by applicable law;** **(ii) Required by law;** **(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;** **(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.**
483.75(l)(5)(i) -(v)	(5) The clinical record must contain— (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The plan of care and services provided; (iv) The results of any preadmission screening conducted by the State; and (v) Progress notes.	Re-designated & revised	483.70(i)(5)(i)-(v)	(5) The medical record must contain— (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The **comprehensive** plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations **and determinations conducted by the State**; **(v) Physician's, nurse's, and other licensed professional's progress notes; and** **(vi) Laboratory, radiology and other diagnostic services reports as required under § 483.50.**

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483.75(m)(1)	(m) Disaster and emergency preparedness. (1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	Editor's note: On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017. Click here (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html) for additional information.		
483.75(m)(2)	(2) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	Editor's note: On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017. Click here (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html) for additional information.		
483.75(n)(1)(i)-(ii)	(n) 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— (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and (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	Re-designated & revised	483.70(j)(1)(i)-(ii)	(j) 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— (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (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**

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	can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.			**community**, will be exchanged between the providers, **including but not limited to the information required under § 483.15(c)(2)(iii).**
483.75(n)(2)	(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	Re-designated	483.70(j)(2)	(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
			483.75(a) **Incudes both Phase 2 and Phase 3 requirements**	**§ 483.75 Quality assurance and performance improvement.** **(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must—** **(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;** **(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;** **(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and**

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				(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.
			483.75(b)	**(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:** **(1) Address all systems of care and management practices;** **(2) Include clinical care, quality of life, and resident choice;** **(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.** **(4) Reflect the complexities, unique care, and services that the facility provides.**
			483.75(c)	**(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:** **(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.** **(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.**

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				(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. **(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.**
			483.75(d)	**(d) Program systematic analysis and systemic action. (1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.** **(2) The facility will develop and implement policies addressing:** **(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;** **(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and** **(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.**
			483.75(e)	**(e) Program activities. (1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.**

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				(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. **(3) As a part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at § 483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.**
			483.75(f)	**(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that—** **(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.** **(2) The QAPI program is sustained during transitions in leadership and staffing;** **(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;** **(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to resident based on performance indicator data, and resident and staff input, and other information.** **(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and**

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				(6) Clear expectations are set around safety, quality, rights, choice, and respect.
483.75(o)(1)(i)-(iii)	(o) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting of— (i) The director of nursing services; (ii) A physician designated by the facility; and (iii) At least 3 other members of the facility's staff.	Re-designated & revised	483.75(g)(1)(i)-(iv) Includes Phase 1 and Phase 3 requirements.	(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; and** **(iv) The infection control and prevention officer. (Editor's note: This should read "infection preventionist").**
483.75(o)(2)(i)-(ii)	(2) The quality assessment and assurance committee— (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.	Re-designated & revised	483.75(g)(2)(i)-(iii)	(2) The quality assessment and assurance committee **reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section.** The committee must: (i) Meet at least quarterly and as needed to **coordinate and evaluate activities under the QAPI program**, such as identifying issues with respect to which quality assessment and assurance activities, **including performance improvement projects required under the QAPI program**, are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; and **(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.**

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483.75(o)(3)	(3) 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.	Re-designated & revised	483.75(h)(1)	(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.
483.75(o)(4)	(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	Re-designated	483.75(i)	(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
483.75(p)(1)	(p) Disclosure of ownership. (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.	Re-designated	483.70(k)(1)	(k) Disclosure of ownership. (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.
483.75(p)(2)(i)-(iv)	(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in— (i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter; (ii) The officers, directors, agents, or managing employees; (iii) The corporation, association, or other company responsible for the management of the facility; or (iv) The facility's administrator or director of nursing.	Re-designated	483.70(k)(2)(i)-(iv)	(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in— (i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter; (ii) The officers, directors, agents, or managing employees; (iii) The corporation, association, or other company responsible for the management of the facility; or (iv) The facility's administrator or director of nursing.
483.75(p)(3)	(3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.	Re-designated	483.70(k)(3)	(3) The notice specified in paragraph (k)(2) of this section must include the identity of each new individual or company.
483.75(q)	(q) 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 of this part.	Re-designated & revised	483.95(h)	(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.

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483.75(r)(1)-(3)	(r) Facility closure–Administrator. Any individual who is the administrator of the facility must: (1) Submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure: (i) At least 60 days prior to the date of closure; or (ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate; (2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and (3) Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.	Re-designated	483.70(l)(1)-(3)	(l) Facility closure–Administrator. Any individual who is the administrator of the facility must: (1) Submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure: (i) At least 60 days prior to the date of closure; or (ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate; (2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and (3) Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.
483.75(s)	(s) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.	Re-designated & revised	483.70(m)	(m) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section.

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			483.70(n)	**New section:** **(n) 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.** **(i) The facility must ensure that:** **(A) The agreement is explained to the resident and their representative in a form and manner that he or she understands, including in a language the resident and their representative understands, and** **(B) The resident acknowledges that he or she understands the agreement.** **(ii) The agreement must:** **(A) Be entered into by the resident voluntarily.** **(B) Provide for the selection of a neutral arbitrator agreed upon by both parties.** **(C) Provide for selection of a venue convenient to both parties.** **(iii) A resident's continuing right to remain in the facility must not be contingent upon the resident or the resident's representative signing a binding arbitration agreement.** **(iv) The agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal**

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				or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with § 483.10(k). **(v) The agreement may be signed by another individual if:** **(A) Allowed by state law;** **(B) All of the requirements in this section are met; and** **(C) That individual has no interest in the facility.** **(vi) When the facility and a resident resolve a dispute with arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years and be available for inspection upon request by CMS or its designee.**
483.75(t)	(t) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (t)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	Re-designated	483.70(o)	(t) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.

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	(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in § 418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide, based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition.			(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in § 418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide, based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24–hour room and board care, meet the resident's personal care and nursing needs in

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	(4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24–hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal,			coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to

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	mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the			someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24–hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient.

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	patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24–hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.			(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.

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483.75(u)	[Payroll Based Journal] Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. (1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping) (2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per	Re-designated	483.70(u)	[Payroll Based Journal] Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. (1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping) (2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual) (3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

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	resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual) (3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. (4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. (5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.			(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. (5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
			483.95 Includes Phase 1 Phase 2 and Phase 3 requirements.	**§ 483.95 Training requirements.** **A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to—** **(a) Communication. A facility must include effective communications as mandatory training for direct care staff.** **(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10, respectively.**

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				(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.** **(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.** **(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).** **(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at § 483.85—** **(1) An effective way to communicate that program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.** **(2) Annual training if the operating organization operates five or more facilities.** **(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.**

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				(2) Include dementia management training and resident abuse prevention training. **(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.** **(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.** **(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at § 483.40 and as determined by the facility assessment at § 483.70(e).**

List of Revisions:

- October 20, 2016: Corrected the Phase 3 implementation date from November 28, 2018 to November 28, 2019 (typo)
- October 24, 2016: Corrected typos in the opening Notes paragraph; added "Exploitation" to the list of new definitions in section 483.5 (inadvertently omitted).

APPENDIX H: REQUIREMENTS OF PARTICIPATION POLICY TRACKING LOG

Structural						Policy and Procedure						Educational Module						Training Performed						Implementation Verified					
TASK LIST						TASK LIST						TASK LIST						TASK LIST						TASK LIST					
MY TASKS	Responsible	DUE DATE	% COMPLETE	DONE	Notes	MY TASKS	Responsible	DUE DATE	% COMPLETE	DONE	NOTES	CreatE Education	START DATE	DUE DATE	% COMPLETE	DONE	NOTES	Center Compliance	START DATE	DUE DATE	% COMPLETE	DONE	NOTES	MY TASKS	START DATE	DUE DATE	% COMPLETE	DONE	NOTES
Abuse	DeLena?	12/7/2016	**0%**			**Create New P/P**	[Date]	[Date]	**0%**			**?????**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**		
P/P adverse event	[Date]	[Date]	**0%**			**Modify PRN**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**		
Exploitation	[Date]	[Date]	**0%**			**Modify P/P**	[Date]	[Date]	**25%**			**[Task]**	[Date]	[Date]	**25%**			**[Task]**	[Date]	[Date]	**25%**			**[Task]**	[Date]	[Date]	**25%**		
Missappropriation of Resident Property	[Date]	[Date]	**0%**			**Modify P/P**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**			**[Task]**	[Date]	[Date]	**0%**		
Mistreatment	[Date]	[Date]	**0%**	######		Modify PRN	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Neglect	[Date]	[Date]	**0%**	######		Modify PRN	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Person Centered Care	[Date]	[Date]	**0%**	######		Create P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Resident Representative	[Date]	[Date]	**0%**	######		Create New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Sexual Abuse	[Date]	[Date]	**0%**	######		Modify PRN	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
PASARR Modification	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
CP within 24 hours	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
CP Add New req members	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Discharge Planning Mod	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
NA and Nutrition to CP	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Active role of res in DP	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
MD delegation to anp/px	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Staff competency	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Behavioral Health Comp	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
SW New Prof Criteria	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
RPh new review expected	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Definition of Psychotropic	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Clincal Dose Reduction	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Physician extenders new authorities	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Assist with Dental reimb	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Lost dentures	[Date]	[Date]	**0%**	######		Clarify in P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Meal flexibility	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Resident food preferences	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Add Respiratory to Sp Svs	[Date]	[Date]	**0%**	######		Develop New P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Center assessment	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Binding Arbitration	[Date]	[Date]	**0%**	######		Modify PRN	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
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Infection prevention	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
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Training expectation	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Rehospitalization	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Health associated infections	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
HIT enhancement	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Trauma informed care	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Supported decision making	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
All are residents-LT and ST	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Distinct Part	[Date]	[Date]	**0%**	######		Evaluate if used	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Paid Feeding assistant	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Resident CP Rights	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Physician non credential	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Roommate choices	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Family groups	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Access Med Records	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Admission equal access	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Hospice charges	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Special Food charges	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Access to surveys (3 yrs)	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
ID Grievance Officer	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Elections	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
A/D/T criteria	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Summary of CP	[Date]	[Date]	**0%**	######		Develop program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
MD doc risk/benefit	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Facilty locked at Night	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Grievance Response	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Resident access to MR	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Temp of 71-81 degrees	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Grievance analysis	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Reporting of crimes	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Use of personal alarms	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Transfer information	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Bed hold policy	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Payment rule revised	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Transitions of care	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Return vs Readmit	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Direct care staff defn	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Cultural compentent	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Reconcile disc meds	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Baseline CP RN 365	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Advance directives	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Post DC POC	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Staff according to cnter assessment	[Date]	[Date]	**0%**	######		Create center assessment program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Bed rails	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Nutrition when refused	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Hydration changes	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Fall analysis	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
Center assessment addresses staffing	[Date]	[Date]	**0%**	######		Evaluate budget process	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Define Behavioral health	[Date]	[Date]	**0%**	######		Develop New Program	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	
BPSD (dementia)	[Date]	[Date]	**0%**	######		Evaluate existing Program	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!		[Task]	[Date]	[Date]	**0%**	#VALUE!	
Med Dir RPh reviews	[Date]	[Date]	**0%**	######		Evaluate existing P/P	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!		[Task]	[Date]	[Date]	**25%**	#VALUE!	

MY TASKS	Responsible	DUE DATE	% COMPLETE	DONE	Notes
Policy for DRR	[Date]	[Date]	0%	######	
Lab/service communication	[Date]	[Date]	0%	######	
Normal range ? Labs/xray	[Date]	[Date]	0%	######	
Suitable Nutrit staffing	[Date]	[Date]	0%	######	
Nutrition Mgr defn	[Date]	[Date]	0%	######	
Out Pt Rehab	[Date]	[Date]	0%	######	
Board aware of QAPI	[Date]	[Date]	0%	######	
Transfer agreement	[Date]	[Date]	0%	######	
QAPI Program	[Date]	[Date]	0%	######	
Compliance and ethics	[Date]	[Date]	0%	######	
Designate Center C/E	[Date]	[Date]	0%	######	
Bed height and size	[Date]	[Date]	0%	######	
Training requirements	[Date]	[Date]	0%	######	
ADL support changed	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	
[Task]	[Date]	[Date]	0%	######	

MY TASKS	Responsible	DUE DATE	% COMPLETE	DONE	NOTES
Evaluate existing P/P	[Date]	[Date]	0%	#VALUE!	
Develop New P/P	[Date]	[Date]	25%	#VALUE!	
Develop New P/P	[Date]	[Date]	0%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	25%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	0%	#VALUE!	
Evaluate existing Program	[Date]	[Date]	25%	#VALUE!	
Evaluate existing Program	[Date]	[Date]	0%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	25%	#VALUE!	
Evaluate against reg	[Date]	[Date]	0%	#VALUE!	
Corporate P/P	[Date]	[Date]	25%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	0%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	25%	#VALUE!	
Evaluate existing	[Date]	[Date]	0%	#VALUE!	
Evaluate existing P/P	[Date]	[Date]	25%	#VALUE!	
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[Task]	[Date]	[Date]	25%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	

CreatE Education	START DATE	DUE DATE	% COMPLETE	DONE	NOTES
[Task]	[Date]	[Date]	0%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	
[Task]	[Date]	[Date]	0%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	
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[Task]	[Date]	[Date]	25%	#VALUE!	

Center Compliance	START DATE	DUE DATE	% COMPLETE	DONE	NOTES
[Task]	[Date]	[Date]	0%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	
[Task]	[Date]	[Date]	0%	#VALUE!	
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[Task]	[Date]	[Date]	25%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	

MY TASKS	START DATE	DUE DATE	% COMPLETE	DONE	NOTES
[Task]	[Date]	[Date]	0%	#VALUE!	
[Task]	[Date]	[Date]	25%	#VALUE!	
[Task]	[Date]	[Date]	0%	#VALUE!	
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APPENDIX I: MEDICARE PART B BILLING INFORMATION

Medicare.gov
The Official U.S. Government Site for Medicare

What Part B covers

What's covered?

Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition.

If you're in a Medicare Advantage Plan or other Medicare plan, you may have different rules, but your plan must give you at least the same coverage as Original Medicare. Some services may only be covered in certain settings or for patients with certain conditions.

Part B covers 2 types of services

Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.

Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

You pay nothing for most preventive services if you get the services from a health care provider who accepts assignment.

Part B covers things like:

Clinical research

Ambulance services

Durable medical equipment (DME)

Mental health

- Inpatient
- Outpatient
- Partial hospitalization

Getting a second opinion before surgery

Limited outpatient prescription drugs

2 ways to find out if Medicare covers what you need

1. Talk to your doctor or other health care provider about why you need certain services or supplies, and ask if Medicare will cover them. If you need something that's usually covered and your provider thinks that Medicare won't cover it in your situation, you'll have to read and sign a notice saying that you may have to pay for the item, service, or supply.
2. Find out if Medicare covers your item, service, or supply.

Medicare coverage is based on 3 main factors

1. Federal and state laws.
2. National coverage decisions made by Medicare about whether something is covered.
3. Local coverage decisions made by companies in each state that process claims for Medicare. These companies decide whether something is medically necessary and should be covered in their area.

Medicare.gov

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

Medicare.gov
The Official U.S. Government Site for Medicare

Your Medicare Coverage

Is my test, item, or service covered?

type your test, item, or service here | Go

Durable medical equipment (DME) coverage

How often is it covered?

Medicare Part B (Medical Insurance) covers medically necessary durable medical equipment (DME) that your doctor prescribes for use in your home. Only your doctor can prescribe medical equipment for you. DME meets these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years

DME that Medicare covers includes, but isn't limited to:

- Air-fluidized beds and other support surfaces (these supplies are only rented)
- Blood sugar monitors
- Blood sugar (glucose) test strips
- Canes (however, white canes for the blind aren't covered)
- Commode chairs
- Continuous passive motion (CPM) machine
- Crutches
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

Who's eligible?

All people with Part B are covered.

Your costs in Original Medicare

If your supplier accepts assignment, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. Medicare pays for different kinds of DME in different ways. Depending on the type of equipment:

- You may need to rent the equipment.
- You may need to buy the equipment.
- You may be able to choose whether to rent or buy the equipment.

Medicare will only cover your DME if your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims submitted by them.

It's also important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment. If suppliers are enrolled in Medicare but aren't "participating," they may choose not to accept assignment. If suppliers don't accept assignment, there's no limit on the amount they can charge you.

Competitive Bidding Program

If you live in or visit certain areas, you may be affected by Medicare's Competitive Bidding Program. In most cases, Medicare will only help pay for these equipment and supplies if they're provided by contract suppliers when both of these apply:

- You have Original Medicare.
- You get competitively bid equipment and supplies in competitive bidding areas.

Contract suppliers can't charge you more than the 20% coinsurance and any unmet yearly deductible for any equipment or supplies included in the Competitive Bidding Program.

Note

To find out how much your specific test, item, or service will cost, talk to your doctor or other health care provider. The specific amount you'll owe may depend on several things, like:

- Other insurance you may have
- How much your doctor charges
- Whether your doctor accepts assignment
- The type of facility
- The location where you get your test, item, or service

Note

If you live in an area that's been declared a disaster or emergency, the usual rules for your medical care may change for a short time. Learn more about how to replace lost or damaged equipment in a disaster or emergency.

Related Resources

- Where to get covered DME items
- More information about DME
- Competitive Bidding Program

Return to search results

Medicare.gov

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

Medicare.gov
The Official U.S. Government Site for Medicare

Your Medicare Coverage

Is my test, item, or service covered?

type your test, item, or service here | Go

Enteral nutrition supplies & equipment (feeding pump)

How often is it covered?

Medicare Part B (Medical Insurance) covers enteral nutrition supplies and equipment (feeding pump) under the prosthetic device benefit.

Who's eligible?

All people with Part B are covered.

Your costs in Original Medicare

You pay 20% of the Medicare-approved amount.

Medicare will only cover your enteral infusion pump if your doctor or supplier is enrolled in Medicare. If a supplier doesn't accept assignment, Medicare doesn't limit how much the supplier can charge you. You may also have to pay the entire bill (your share and Medicare's share) at the time you get the pump.

Competitive Bidding Program

If you live in or visit certain areas, you may be affected by Medicare's Competitive Bidding Program. In most cases, Medicare will only help pay for these equipment and supplies if they're provided by contract suppliers when both of these apply:

- You have Original Medicare.
- You get competitively bid equipment and supplies in competitive bidding areas.

Contract suppliers can't charge you more than the 20% coinsurance and any unmet yearly deductible for any equipment or supplies included in the Competitive Bidding Program.

In most cases, you need to obtain your enteral nutrients from a contract supplier for Medicare to help pay. Depending on how long you've been renting your pump, you might not need to get it from a contract supplier.

If you've been renting an enteral infusion pump on a continuous basis for at least 15 months, your supplier must continue to provide you with the pump as long as it's medically necessary even if the supplier isn't a contract supplier. If your current supplier isn't a contract supplier, it isn't allowed to pick up the pump from you because Medicare is still covering it.

If you've been renting an enteral infusion pump for less than 15 months, and your current supplier isn't a Medicare contract supplier under the new program, then you'll have to change suppliers. However, your current supplier isn't allowed to pick up any equipment or supplies from you until the last day of the last rental month that began before July 1, 2013. Your current supplier and your Medicare contract supplier must work together and coordinate to make sure you have the equipment you need. For example, if you've paid for a rental pump with your

current supplier through the end of December, they must continue to provide the equipment you need through December 31 and make sure they work with your new supplier so that you don't have any interruptions in service.

Find a Medicare contract supplier.

Note

To find out how much your specific test, item, or service will cost, talk to your doctor or other health care provider. The specific amount you'll owe may depend on several things, like:

- Other insurance you may have
- How much your doctor charges
- Whether your doctor accepts assignment
- The type of facility
- The location where you get your test, item, or service

Related resources

- Where to get covered medical items
- Information about DME
- Competitive Bidding Program

Return to search results

APPENDIX J: DAILY CENSUS REPORT

Daily Census Report

Date:	

Complete every morning for the previous day's activities. Save and then email to HDG when finished.

1

	1st Floor	2nd Floor	3rd Floor	4th Floor	Total
Previous Day's Census:					0
Admissions (+):					0
Discharges (-):					0
Total Residents:	0	0	0	0	0

2 Admissions

Name	Room #	Payor	Time	From

3 Discharges

Name	Room #	Payor	Time	Discharge To

4 Change of Payment Status

Name	Room #	Old Payor	Date	New Payor

5 Bedholds

Name	Room #	Payor		Start	End

6 LOA

Name	Room #	Payor	Out	Return

7 Room Changes

Name	Old #	New #	Date	Reason

Daily Payor Mix		Budget
Private Pay		
Medicare		
Medicaid		
Insurance		
VA		
Managed Care		
LOA		
Other		
Total	0	

Month Patient Days to Date	
Actual	
Possible	
Avg. Census	**#DIV/0!**

APPENDIX K: QUARTERLY MARKETING/REFERRAL DEVELOPMENT ACTION PLAN TEMPLATE

Quarterly Marketing/Referral Development Action Plan

Facility Name:		Quarterly Timeframe:	

Quarterly Marketing Goals

#	Goal
1	
2	

Action Items

#	Action Steps (Tactics)	Person(s) Responsible	Budget Expense	Due Date	Comments
1	.				
2					

#	Action Steps (Tactics)	Person(s) Responsible	Budget Expense	Due Date	Comments
3					
4					
5.					
6.					
6.					
7.					
8					

#	Action Steps (Tactics)	Person(s) Responsible	Budget Expense	Due Date	Comments
9.					
10.					
11					
12					
13					
14					

APPENDIX L: IDEAL DISCHARGE PLANNING PROCESS

IDEAL Discharge Planning Overview, Process, and Checklist

Evidence for engaging patients and families in discharge planning

Nearly 20 percent of patients experience an adverse event within 30 days of discharge.[1,2] Research shows that three-quarters of these could have been prevented or ameliorated.[1] Common post-discharge complications include adverse drug events, hospital-acquired infections, and procedural complications.[1] Many of these complications can be attributed to discharge planning problems, such as:

- Changes or discrepancies in medications before and after discharge[3,4]
- Inadequate preparation for patient and family related to medications, danger signs, or lifestyle changes[3,4,5]
- Disconnect between clinician information-giving and patient understanding[3]
- Discontinuity between inpatient and outpatient providers[3]

Involving the patient and family in discharge planning can improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction.[6,7]

More and more, hospitals are focusing on transitions in care as a way to improve hospital quality and safety. As one indicator of this, the Centers for Medicare and Medicaid Services implemented new guidelines in 2012 that reduce payment to hospitals exceeding their expected readmission rates.

To improve quality and reduce preventable readmissions, [insert hospital name] will use the Agency for Healthcare Research and Quality's Care Transitions from Hospital to Home: IDEAL Discharge Planning tools to engage patients and families in preparing for discharge to home.

Key elements of IDEAL Discharge Planning

Include the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home:

1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

Listen to and honor the patient's and family's goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

What does this mean for clinicians?

We expect all clinicians to:

- Incorporate the IDEAL discharge elements in their work
- Make themselves available to the [identify staff] who will work closely with the patient and family
- Take part in trainings on the process

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

How do you implement IDEAL Discharge Planning?

Each part of IDEAL Discharge Planning has multiple components:

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but a process that takes place throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Discuss with the patient and family five key areas to prevent problems at home.

1. Describe what life at home will be like. Include the home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. Review medications. Use a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.
3. Highlight warning signs and problems. Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
4. Explain test results. Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should get the results and identify who they should call if they have not gotten results by that date.
5. Make followup appointments. Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Getting all the information on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. You can:

- Elicit patient and family goals at admission and note progress toward those goals each day
- Involve the patient and family in bedside shift report or bedside rounds
- Share a written list of medicines every morning
- Go over medicines at each administration: What it is for, how much to take, how to take it, and side effects
- Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.

- Provide information to the patient and family in small chunks and repeat key pieces of information throughout the hospital stay
- Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in their room to write questions or concerns
- Ask open-ended questions to elicit questions and concerns.
- Use Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to make sure the patient and family feel prepared to go home
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers

IDEAL Discharge Planning Process

The elements of the *IDEAL Discharge Planning* process are incorporated into our current discharge. The information below describes key elements of the IDEAL discharge from admission to discharge to home. Note that this process includes at least one meeting between the patient, family, and discharge planner to help the patient and family feel prepared to go home.

Initial nursing assessment

- ❑ **Identify the caregiver who will be at home along with potential back-ups.** These are the individuals who need to understand instructions for care at home. Do not assume that family in the hospital will be caregivers at home.
- ❑ **Let the patient and family know that they can use the white board in the room to write questions or concerns.**
- ❑ **Elicit the patient and family's goals for when and how they leave the hospital,** as appropriate. With input from their doctor, work with the patient and family to set realistic goals for their hospital stay.
- ❑ **Inform the patient and family about steps in progress toward discharge.** For common procedures, create a patient handout, white board, or poster that identifies the road map to get home. This road map may include things like "I can feed myself" or "I can walk 20 steps."

Daily

- ❑ **Educate the patient and family about the patient's condition at every opportunity**, such as nurse bedside shift report, rounds, vital status check, nurse calls, and other opportunities that present themselves. Use teach back.
  Who: *All clinical staff*
- ❑ **Explain medicines to the patient and family (for example, print out a list every morning) and at any time medicine is administered.** Explain what each medicine is for, describe potential side effects, and make sure the patient knows about any changes in the medicines they are taking. Use teach back.
  Who: *All clinical staff*
- ❑ **Discuss the patient, family, and clinician goals and progress toward discharge.** Once goals are set at admission, revisit these goals to make sure the patient and family understand how they are progressing toward discharge.
  Who: *All clinical staff*
- ❑ **Involve the patient and family in care practices to improve confidence in caretaking after discharge.** Examples of care practices could include changing the wound dressing, helping the patient with feeding or going to the bathroom, or assisting with rehabilitation exercises.
  Who: *All clinical staff*

Prior to discharge planning meeting

When: *1 to 2 days before discharge planning meeting. For short stays, this meeting may occur at admission.*

- ❑ **Give the patient and family Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet.**
  Who: *Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.*

- ❑ **Schedule discharge planning meeting with the patient, family, and hospital staff.**
  Who: *Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.*

Discharge planning meeting

When: *1 to 2 days before discharge, earlier for more extended stays in the hospital*

- ❑ **Use the Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet as a starting point to discuss questions, needs, and concerns going home.**
  - If the patient or family did not read or fill out the checklist, review it verbally. Make sure to ask if they have questions or concerns other than those listed. You can start the dialogue by asking, "*What will being back home look like for you?*"
  - Repeat the patient's concerns in your own words to make sure you understand.
  - Use teach back to check if the patient understands the information given.
  - If another clinician is needed to address concerns (e.g., pharmacist, doctor, or nurse), arrange for this conversation.

  Who: *Hospital to identify staff to be involved in meeting, for example the nurse, doctor, patient advocate, discharge planner, or a combination. Patient identifies if family or friends need to be involved.*

- ❑ **Offer to make followup appointments. Ask if the patient has a preferred day or time and if the patient can get to the appointment.**
  Who: *Hospital to identify staff person to do, such as a patient advocate or discharge planner.*

Day of discharge

- ❑ **Review a reconciled medication list with the patient and family. Go over the list of current medicines. Use teach back (ask them to repeat what the medicine is, when to take it, and how to take it).** Make sure that patients have an easy-to-read, printed medication list to take home.
  Who: *Hospital to identify staff person to review the medication list with patient and family. Because this involves medications, we assume it would be a clinician — nurse, doctor, or pharmacist.*

- ❑ **Give the patient and family the patient's followup appointment times** and include the provider name, time, and location of appointments in writing.
  Who: *Staff who scheduled appointment.*

- ❑ **Give the patient and family the name, position, and phone number of the person to contact if there is a problem after discharge.** Make sure the contact person is aware of the patient's condition and situation (e.g., if the primary care physician is the contact person, make sure the primary care physician has a copy of the discharge summary on the day of discharge).
  Who: *Hospital to identify staff person to write contact information, for example a nurse, patient advocate, or discharge planner.*

IDEAL Discharge Planning Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Initial Nursing Assessment	Prior to Discharge Planning Meeting	During Discharge Planning Meeting	Day of Discharge
_____Identified the caregiver at home and backups _____Told patient and family about white board _____Elicited patient and family goals for hospital stay _____Informed patient and family about steps to discharge	_____Distributed checklist and booklet to patient and family with explanation _____Scheduled discharge planning meeting Scheduled for _____/ ___ / _____at _____ [time]	_____Discussed patient questions _____Discussed family questions _____Reviewed discharge instructions as needed _____Used Teach Back _____Offered to schedule followup appointments with providers. Preferred dates / times for: PCP: Other:	**Medication** _____Reconciled medication list _____Reviewed medication list with patient and family and used teach back **Appointments and contact information** _____Scheduled followup appointments: 1) With _____ on _____ / _____ / _____at_____ [time] 2) With _____ on _____ / _____ / _____at _____ [time] _____Arranged any home care needed _____Wrote down and gave appointments to the patient and family _____Wrote down and gave contact information for followup person after discharge

IDEAL Discharge Planning Daily Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: _____

Day 1	Day 2	Day 3	Day 4
_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back	_____Educated patient and family about condition and used teach back
_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals	_____Discussed progress toward patient, family, and clinician goals
_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other	_____Explained medications to patient and family ____Morning ____Noon ____Evening ____Bedtime ____Other
_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:	_____Involved patient and family in care practices, such as:
Notes			

References

1. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med 2003;138(3):161–7.
2. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360(14):1418–28.
3. Kripalani S, Jackson AT, Schnipper JL, et al. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. J Hosp Med 2007;2(5):314–23.
4. Anthony MK, Hudson-Barr D. A patient-centered model of care for hospital discharge. Clin Nurs Res 2004;13(2):117–36.
5. Popejoy LL, Moylan K, Galambos C. A review of discharge planning research of older adults 1990–2008. West J Nurs Res 2009;31(7):923–47.
6. Bauer M, Fitzgerald L, Haesler E, et al. Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. J Clin Nurs 2009;18(18):2539–46.
7. Shepperd S, McClaran J, Phillips CO, et al. Discharge planning from hospital to home. Cochrane Database Syst Rev. 2010;20;(1):CD000313.