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CMS Updated Guidance for Nursing Home Resident Health and Safety: What You Need to Know and How to Prepare


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Disclaimer

The information shared in today’s presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

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Updated Guidance for Nursing Home Resident Health and Safety

- On July 29, 2022, CMS released Updated Guidance for Nursing Home Resident Health and Safety
- Effective Date: Surveyors will begin using this guidance to identify noncompliance on October 24, 2022. This will allow for ample time for surveyors and facilities to be trained on this new information.

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Summary of Significant Changes

Topic	Summary
Abuse and Neglect	Clarifies compliance, abuse reporting, including sample reporting templates, and provides examples of abuse that, because of the action itself, would be assigned to certain severity levels.
Admission, Transfer, and Discharge	Clarifies requirements related to facility-initiated discharges.
Mental Health/Substance Use Disorder (SUD)	Addresses rights and behavioral health services for individuals with mental health needs and SUDs.
Nurse Staffing (Payroll-Based Journal)	Uses payroll-based staffing data to trigger deeper investigations of sufficient staffing and added examples of noncompliance.
Resident Rights	Imports guidance related to visitation from memos issued related to COVID-19, and makes changes for additional clarity and technical corrections.
Potential Inaccurate Diagnosis and/or Assessment	Addresses situations where practitioners or facilities may have inaccurately diagnosed/coded a resident with schizophrenia in the resident assessment instrument.
Pharmacy	Addresses unnecessary use of non-psychotropic drugs in addition to antipsychotics, and gradual dose reduction.
Infection Control	Requires facilities have a part-time Infection Preventionist. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized Training is required and available.
Arbitration	Clarifies existing requirements for compliance when arbitration agreements are used by nursing homes to settle disputes.
Psychosocial Outcome Severity Guide	Clarifies the application of the "reasonable person concept" and severity levels for deficiencies.
State Operations Manual Chapter 5	Clarifies timeliness of state investigations, and communication to complainants to improve consistency across states.

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Psychosocial Outcome Severity Guide

- Purpose:
 - The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific F-Tag, *including how to determine the severity of the outcome when the impact on the resident may not be apparent or documented.*
 - The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in, *or may result in*, a negative psychosocial outcome.
 - This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome.** The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome.

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Psychosocial Outcome Severity Guide

- Application of the Reasonable Person Concept:
 - *To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident’s position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance). The survey team should consider the following regarding the resident’s position, which may include, but is not limited to:*
 - *The resident may consider the facility to be his/her “home,” where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.*
 - *The resident trusts and relies on facility staff to meet his/her needs.*
 - *The resident may be frail and vulnerable.*

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Psychosocial Outcome Severity Guide

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:	
483.10 Resident Rights <ul style="list-style-type: none">• F557, Respect, Dignity/Right to Have Personal Property;• F558, Reasonable Accommodation of Needs/Preferences;	483.12 Freedom from Abuse, Neglect, and Exploitation <ul style="list-style-type: none">• F600 Free from Abuse and Neglect;• F602 Free from Misappropriation/Exploitation;• F603, Free from Involuntary Seclusion;• F604, Right to be Free from Physical Restraints;• F605, Right to be Free from Chemical Restraints;• F607, Develop/Implement Abuse/Neglect, etc. Policies; F609, Reporting of Alleged Violations;• F610, Investigate/Prevent/Correct Alleged Violation;
483.21 Comprehensive Resident Centered Care Plans <ul style="list-style-type: none">• F656, Develop/Implement Comprehensive Care Plan;• F657 Care Plan Timing and Revision;	483.24 Quality of Life <ul style="list-style-type: none">• F675, Quality of Life• F679, Activities Meet Interest/Needs of Each Resident;
483.25 Quality of Care <ul style="list-style-type: none">• F699, Trauma Informed Care	483.40 Behavioral Health Services <ul style="list-style-type: none">• F740, Behavioral Health Services;• F741 Sufficient/Competent Staff – Behavioral Health Needs; F742, Treatment/Services for Mental/Psychosocial Concerns;• F743, No Pattern of Behavioral Difficulties Unless Unavoidable;• F745, Provision of Medically Related Social Services;
483.45 Pharmacy Services <ul style="list-style-type: none">• F757, Drug Regimen is Free from Unnecessary Drugs; and• F758, Free from Unnecessary Psychotropic Medications/PRN Use.	

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Abuse and Neglect

F600: Freedom from Abuse, Neglect, and Exploitation

- Resident to Resident Abuse of Any Type
 - A resident to resident altercation should be reviewed as a potential situation of abuse. *The surveyor should not assume that every resident to resident altercation results in abuse. For example, infrequent arguments or disagreements that occur during the course of normal social interactions (e.g., dinner table discussions) would not constitute abuse. The surveyor must determine whether the incident would meet the definition of abuse*

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Abuse and Neglect

F600: Freedom from Abuse, Neglect, and Exploitation


- Identification of Goods and Services Required by Residents
 - The cumulative effect of different individual failures in the provision of care and services by staff leads to an environment that promotes neglect. *Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress.* Examples of individual failures include, but are not limited to, the following:
 - *Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;*

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Resident Rights

F557: Respect, Dignity/Right to have Personal Property

- PROCEDURES §483.10(e)(2)
 - Examples of noncompliance may include, but are not limited to:
 - *Facility staff searching a resident's body or personal possessions without the resident's or, if applicable, the resident's representative's consent.*
 - *It is important for facility staff to have knowledge of signs, symptoms, and triggers of possible illegal substance use; such as changes in resident behavior, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. This may include asking residents, who appear to have used an illegal substance (e.g., cocaine, hallucinogens, heroin), whether or not they possess or have used an illegal substance.*

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Resident Rights

F557: Respect, Dignity/Right to have Personal Property


- PROCEDURES §483.10(e)(2)
 - *If the facility determines through observation that a resident may have access to illegal substances that they have brought into the facility or secured from an outside source, the facility should not act as an arm of law enforcement. Rather, in accordance with state laws, these cases may warrant a referral to local law enforcement. To protect the health and safety of residents, facilities may need to provide additional monitoring and supervision. If facility staff identify items or substances that pose risks to residents' health and safety and are in plain view, they may confiscate them. But, facility staff should not conduct searches of a resident or their personal belongings, unless the resident, or resident representative agrees to a voluntary search and understands the reason for the search. For concerns related to the identification of risk and the provision of supervision to prevent accidental overdose, investigate potential non-compliance at F689, §483.25(d) – Accidents.*

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Admission, Transfer, and Discharge

F622: Transfer & Discharge Requirements

- *The determination that a transfer or discharge is facility-initiated does not equate to noncompliance if the requirements in this regulatory section are met.*
- *NOTE: Situations in which residents sign out of the facility, or leave Against Medical Advice (AMA) should be thoroughly investigated to determine if the discharge is facility- or resident-initiated. If evidence reveals that a resident or resident representative was forced, pressured, or intimidated into leaving AMA, the discharge would be considered a facility-initiated discharge, requiring further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F623. See additional guidance on AMA discharges at F660 and guidance on Abuse, Neglect and Exploitation at F600.*

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Admission, Transfer, and Discharge

F622: Transfer & Discharge Requirements

- *In certain cases, residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge and the requirements at §§483.15(c)(1) and (c)(2)(i)-(ii) apply to ensure the discharge is not involuntary. These situations may require further investigation to ensure that discrimination based on payment source has not occurred in accordance with §483.10(a)(2) (F550). Additionally, in cases where the resident does not appear to object to the discharge, or has not appealed it, the discharge could still be a facility-initiated discharge and be thoroughly investigated to determine if resident-, or facility-initiated.*

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Admission, Transfer, and Discharge

F622: Transfer & Discharge Requirements

- **Nonpayment as Basis for Discharge**
 - *In situations where a resident's Medicare coverage may be ending, the facility must comply with the requirements at §483.10(g)(17) and (18), F582. If the resident continues to need long-term care services, the facility, under the requirements above, should offer the resident the ability to remain, which may include:*
 - *Offering the resident the option to remain in the facility by paying privately for a bed;*
 - *Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:*
 - *if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and*
 - *if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.*
 - *The resident **cannot** be discharged for nonpayment while a determination on the resident's Medicaid eligibility is pending.*

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Admission, Transfer, and Discharge

F626: Permitting Residents to Return to the Facility

- **GUIDANCE §483.15(e)**
 - *Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. **These policies apply to all residents, regardless of their payment source.** The facility policies must provide that residents who seek to return to the facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period or when state law does not provide for bed-holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident:*
 - *Still requires the services provided by the facility; and*
 - *Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.*
 - *The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements of paragraph at 42 CFR 483.15(c) as they apply to facility-initiated discharges.*

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Mental Health/Substance Use Disorder (SUD)

F740: Behavioral Health Services

- GUIDANCE §483.40
 - *The behavioral health care needs of those with a SUD or other serious mental disorder should be part of the facility assessment under §483.70(e) (F838) and the facility should determine if they have the capacity, services, and staff skills to meet the requirements as discussed in F741.*
 - *Surveyors should be aware that all residents are screened for possible serious mental disorders or intellectual disabilities and related conditions prior to admission to determine if specialized services under Preadmission Screening and Resident Review (PASARR) requirements are necessary. If a resident qualifies for specialized Level II services under PASARR, please refer to §483.20(k) (F645), as well as §483.20(e) (F644). If the resident does not qualify for specialized services under PASARR, but requires more intensive behavioral health services (e.g., individual counseling), the facility must demonstrate reasonable attempts to provide for and/or arrange for such services. This would include ensuring that the type(s) of service(s) needed is clearly identified based on the individual assessment, care plan and strategies to arrange such services.*

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Mental Health/Substance Use Disorder (SUD)

F740: Behavioral Health Services

- *Additionally, behavioral contracts are only intended to be used for residents who have the capacity to understand them. The contract cannot conflict with resident rights or other requirements of participation (i.e., requirements at §483.15 related to admission, transfer, and discharge), but may address issues such as:*
 - *Residents with mental disorder and/or SUD may be at increased risk for leaving the facility without facility knowledge (which could be considered an elopement) at various times throughout their treatment, or if going through active withdrawal. The facility should explain the resident's right to have a leave of absence and also explain the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA). The facility cannot restrict a resident's right to leave the facility, but a contract can distinguish between a leave of absence, elopement, and leaving AMA. (For concerns related to inadequate supervision resulting in elopement, see F689 - Free of Accidents Hazards/Supervision/Devices);*
 - *Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable;*

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Mental Health/Substance Use Disorder (SUD)

F740: Behavioral Health Services

- Additionally, behavioral contracts are only intended to be used for residents who have the capacity to understand them. The contract cannot conflict with resident rights or other requirements of participation (i.e., requirements at §483.15 related to admission, transfer, and discharge), but may address issues such as:*
 - Steps the facility may take if substance use is suspected, which may include:*
 - Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents;*
 - Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff (See F563 - Right to receive/deny visitors);*
 - Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition;*
 - Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others (See F557- Respect, Dignity/Right to have Personal Property); and*
- Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons (See F557- Respect, Dignity/Right to have Personal Property).*

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Mental Health/Substance Use Disorder (SUD)

F740: Behavioral Health Services

- DEFICIENCY CATEGORIZATION §483.40
 - An example of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or Safety includes, but is not limited to:
 - A resident was admitted to the facility one month ago with diagnoses of major depression, SUD, and a history of a suicide attempt. After admission, the resident continuously expressed wanting to die and often yelled and cursed at staff members. The attending physician ordered a psychological evaluation, an antidepressant, and 30 minute checks which were implemented by the facility. Record review showed that the psychological evaluation recommended the use of several non-pharmacological behavioral health interventions, which were not implemented. During additional record review and an interview with the nurse it was revealed that the resident was found hanging from his closet bar with a sheet tied around his neck, and no pulse. CPR was started and the resident was resuscitated.*
 - The facility failed to adequately meet a resident's mental health needs when it did not address non-pharmacological approaches to care.*

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Mental Health/Substance Use Disorder (SUD)

F741: Sufficient/Competent Staff-Behavioral Health Needs

- Skill and Competency of Staff**
 - The facility must identify the skills and competencies needed by staff to work effectively with residents (both with and without mental disorders, psychosocial disorders, *SUDs, a history of trauma, and/or PTSD*). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through *the facility assessment. The facility assessment must include an evaluation of the overall number of facility staff needed to ensure that a sufficient number of qualified staff are available to meet each resident's needs. Furthermore, the assessment should include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. This also includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care identified.*

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Mental Health/Substance Use Disorder (SUD)

F741: Sufficient/Competent Staff-Behavioral Health Needs

- Non-pharmacological Interventions**
 - Examples of individualized, non-pharmacological interventions to help meet behavioral health needs of *all ages* may include, but are not limited to:
 - Supporting the resident through meaningful activities that match his/her individual abilities (e.g., simplifying or segmenting tasks for a resident who has trouble following complex directions), interests, *goals*, and needs, based upon the stress management, comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns (e.g., providing an early morning activity for a farmer used to waking up early);
 - Assisting the resident outdoors in the sunshine and fresh air (e.g. in a non-smoking area for a non-smoking resident);*
 - Providing access to pets or animals for the resident who enjoys pets (e.g. a cat for a resident who used to have a cat of their own);*
 - Assisting the resident to participate in activities that support their spiritual needs;*
 - Assisting with the opportunity for meditation and associated physical activity (e.g. chair yoga);*
 - Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;*
 - Utilizing techniques such as music, art, *electronics/computer technology systems, massage, essential oils, reminiscing;*
 - Assisting residents with *SUDs* to access counseling (e.g., *individual or group counseling services, 12-step programs, and support groups*) to the fullest degree possible;
 - Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy; and*
 - Providing support with skills related to verbal de-escalation, coping skills, and stress management.*

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Mental Health/Substance Use Disorder (SUD)

F741: Sufficient/Competent Staff-Behavioral Health Needs

- DEFICIENCY CATEGORIZATION §483.40(a), (a)(1) & (a)(2)
 - An example of Severity Level 2 Non-compliance: No Actual Harm with Likelihood for More Than Minimal Harm that is Not Immediate Jeopardy includes, but is not limited to:
 - *The facility failed to have sufficient numbers of staff who had the skills and competencies to monitor a resident with SUD and who had just returned from a leave of absence (LOA). The resident had a history of substance abuse when on LOA, and had care plan interventions indicating to monitor every 15 minutes for signs and symptoms of substance use, which included changes in behavior, slowed respirations and somnolence.*
 - *Upon interview of the nurse's aide assigned to monitor this resident, the aide did not know what somnolence was, and could not state what a normal respiratory rate was. The aide also stated that he or she had never been assigned to this resident before and was unaware of what the resident's baseline behaviors were. Therefore, the aide could not state if he or she had observed any changes in the resident's behaviors. This was the only aide working the unit when the resident returned from LOA.*

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Potential Inaccurate Diagnosis and/or Assessment

F641: Accuracy of Assessments

- *Note: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.*

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Nurse Staffing (Payroll-Based Journal)

F851: Payroll Based Journal

- §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.
- §483.70(q)(1) Direct Care Staff.
- §483.70(q)(2) Submission requirements.
- §483.70(q)(3) Distinguishing employee from agency and contract staff.
- §483.70(q)(4) Data format.
- §483.70(q)(5) Submission schedule.

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Pharmacy

F758: Free from Unnecessary Psychotropic Meds/PRN Use

- **Psychotropic Medications and Antipsychotic Medications (F758 Only Guidance)**
 - *For example, if a resident is prescribed valproic acid and the medical record shows no history of seizures but there is documentation that the medication is being used to treat agitation or other expressions of distress, then the use of valproic acid should be consistent with the psychotropic medication requirements under §483.45(e). Residents who take these medications must be monitored for any adverse consequences, specifically increased confusion or over-sedation, as required by §483.45(d)(3). Concerns related to the use of the medications noted here would be investigated at F757, Unnecessary Medications, if the medication is being used for its original or approved indication and not primarily as a psychotropic medication.*
 - The regulations and guidance concerning psychotropic medications are not intended to supplant the judgment of a physician or prescribing practitioner in consultation with facility staff, the resident and his/her representatives and in accordance with appropriate standards of practice. Rather, the regulations and guidance are intended to ensure psychotropic medications are used only when the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). *Concerns related to inappropriate prescribing of psychotropic medications may require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.*

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Pharmacy

F758: Free from Unnecessary Psychotropic Meds/PRN Use

- **Psychotropic Medications and Antipsychotic Medications (F758 Only Guidance)**
- *Note: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure.*
- *For these situations, please refer to the following regulations:*
 - *§483.21(b)(3)(i), F658, to determine if the practitioner’s diagnostic practices meet professional standards.*
 - *§483.20(g), F641 to determine if the facility completed an assessment which accurately reflects the resident’s status.*

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Pharmacy

F758: Free from Unnecessary Psychotropic Meds/PRN Use

- **Gradual Dose Reduction for Psychotropic Medications**
 - *Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. Compliance with the requirement to perform a GDR may be met if, for example, within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.*

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Pharmacy

F758: Free from Unnecessary Psychotropic Meds/PRN Use

- PROCEDURES: §483.45(d) Unnecessary drugs and §§483.45(c)(3) and (e) Psychotropic Drugs Investigating Concerns Related to Medication Regimen Review, Unnecessary Medications, and Psychotropic Medications
 - Interview the resident, his or her family, and representative(s) and the IDT, as needed to gather information about use of medications and any possible side effects in the nursing home. *Evaluate if the resident may have experienced psychosocial harm related to side effects of medications. Did side effects such as sedation, lethargy, agitation, mental status changes, or behavior changes:*
 - *affect a resident's abilities to perform activities of daily living or to interact with others,*
 - *cause the resident to withdraw or decline from usual social patterns,*
 - *show the resident has decreased engagement in activities,*
 - *cause diminished ability to think or concentrate.*
 - *For a resident who is unable to communicate psychosocial outcomes related to medication side effects, the surveyor should consider how a reasonable person would experience the changes caused by medication side effects as explained in the Psychosocial Outcome Severity Guide, on the CMS Nursing Homes Survey Resources website.*

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Pharmacy

F758: Free from Unnecessary Psychotropic Meds/PRN Use

- POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION
 - Examples of some of the related requirements that may be considered when concerns have been identified include the following:
 - *42 CFR §483.80(a)(3), F881, Antibiotic Stewardship Program*
 - *Review whether the facility has developed and implemented their antibiotic stewardship program (e.g., antibiotic use protocols that utilize an infection assessment tool, monitoring of antibiotic use, feedback and education to prescribing providers).*

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Infection Control

F880: Guidance

- We expect facilities to tailor the emphasis of their IPCP for visitors and to work to prevent transmission of infection to the resident from the visitor using reasonable precautions and national standards. For example, *“screening may be* passive through the use of signs to alert *family members and* visitors with signs and symptoms of communicable diseases not to enter. *More active screening may include the completion of a screening tool or questionnaire which elicits information related to recent exposures or current symptoms. That information is reviewed by the facility staff and the visitor is either permitted to visit or is excluded.*
- The Infection Prevention and Control Program must include, *at a minimum*, the following parts:
 - A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that:
 - Covers all residents, staff, *contractors, consultants*, volunteers, visitors, others *who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions;*
 - Is based on the individual facility assessment *conducted under §483.70(e); and*
 - Follows accepted national standards.

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Infection Control

F880: Guidance

- **Water Management**
 - *Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. Water management must be based on nationally accepted standards (e.g., ASHRAE (formerly the American Society of Heating, Refrigerating, and Air Conditioning Engineers), CDC, U.S. Environmental Protection Agency or EPA) and include:*
 - *An assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter) could grow and spread; and*
 - *Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them.*
 - *Examples of an assessment include a description of the building water systems using text and flow diagrams for identification. Additionally, control measures may include visible inspections, use of disinfectant, and temperature (that may require mixing valves to prevent scalding). Monitoring such controls include testing protocols for control measures, acceptable ranges, and documenting the results of testing. Water management should also include established ways to intervene when control limits are not met.*

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Infection Control

F882: Infection Preventionist Qualifications/Role

- INTENT §483.80(b)**
 - The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections.
- GUIDANCE**
 - Responsibility for the Infection Prevention and Control Program (including the Antibiotic Stewardship Program)** The facility must designate one or more individuals as the infection preventionist (IP) who is responsible for assessing, developing, implementing, monitoring, and managing the IPCP. The IPCP includes content required in §§483.80(a)(1)-(4), (F880, Infection Prevention and Control and at F881, Antibiotic Stewardship Program (ASP)). While the IP is responsible for the IPCP, other staff play important roles in infection prevention and control as well as antibiotic stewardship. For example, staff must appropriately implement standard precautions such as hand hygiene and transmission-based precautions. Furthermore, ASP development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership and therefore, the IP should utilize and work collaboratively with these team members to also implement the ASP. While an ASP is a team effort, the IP is responsible for ensuring the program meets the requirements for ASPs (at §483.80(a)(3), F881). The IP should review and approve infection prevention and control training topics and content, as well as ensure facility staff are trained on the IPCP (for further information, see §483.95(e), F945, Infection Control Training). However, the IP is not required to perform the IPCP training, since some facilities may have designated staff development personnel.

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Infection Control

F882: Infection Preventionist Qualifications/Role

- IP Hours of Work**
 - Designated IP hours per week can vary based on the facility and its resident population. Therefore, the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment, conducted according to §483.70(e), to determine the resources it needs for its IPCP, and ensure that those resources are provided for the IPCP to be effective. Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP. A facility should consider resident census as well as resident characteristics, types of units such as respiratory care units, memory care, skilled nursing and the complexity of the healthcare services it offers as well as outbreaks and seasonality of infections such as influenza in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and **participate in required committees such as QAA.**
 - The IP must physically work onsite in the facility. He/she cannot be an off-site consultant or perform the IP work at a separate location such as a corporate office or affiliated short term acute care facility.

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Infection Control

F882: Infection Preventionist Qualifications/Role

- **Specialized Training in Infection Prevention and Control**
 - Infection prevention and control (IPC) training must be sufficient to perform the role of the IP. Specialized training in IPC may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high acuity conditions. If a facility's resident population changes, the IP should re-evaluate his/her knowledge and skills, and may need to obtain additional training for the change in the facility's scope of care.
 - An IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role. Training can occur through more than one course, but the IP must provide evidence of training through a certificate(s) of completion or equivalent documentation.

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Infection Control

F882: Infection Preventionist Qualifications/Role

- **KEY ELEMENTS OF NONCOMPLIANCE**
 - To cite deficient practice at F882, the surveyor's investigation will generally show that the facility failed to ensure that the IPCP was overseen by a qualified individual, who:
 - Meets the requirement for professional training; or
 - Adequately assesses, develops, implements, monitors, and manages the IPCP; or
 - Has the appropriate knowledge and skills to care for the IPC needs of the facility's resident population and to be responsible for the IPCP; or
 - Has time to perform IP responsibilities; or
 - Performs IP duties in the facility; or
 - Completed specialized training in IPC.

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Arbitration

F847 Entering Into Binding Arbitration Agreements

- **INTENT**

- *To ensure that long-term care facilities inform residents or their representatives of the nature and implications of any proposed binding arbitration agreement, to inform their decision on whether or not to enter into such agreements.*
- *The requirements at F847 emphasize the residents' or their representatives' right to make informed decisions and choices about important aspects of residents' health, safety and welfare. Facilities may present residents or their representatives the opportunity to utilize a binding arbitration agreement to resolve disputes at any time during a resident's stay as long as the agreement complies with the regulations at §483.70(n)(1)-(5).*

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Arbitration

F848 Arbitrator/Venue Selection and Retention of Agreements

- **INTENT**

- *To provide a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator, and that the venue is convenient to both parties. In addition, the requirement to retain a copy of the signed agreement for binding arbitration and the arbitrator's final decision enables CMS to ensure that CMS can fully evaluate quality of care complaints that are addressed in arbitration and assess the overall impact of these agreements on the safety and quality of care provided in long-term care facilities.*

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Best Practices To Prepare

- Review updated guidance documents in detail
- Review current policies and procedures and update based upon updated guidance's
- Train staff on updated guidance's and new policies

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Resources

- <https://www.cms.gov/newsroom/fact-sheets/updated-guidance-nursing-home-resident-health-and-safety>
- <https://www.cms.gov/files/document/qso-22-19-nh.pdf-0>
- <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfo/policy-and-memos-states-and-revised-long-term-care-surveyor-guidance-revisions-surveyor-guidance-phases-2-3-arbitration>
- <https://qsep.cms.gov/welcome.aspx>

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Resources

- <https://www.cms.gov/files/zip/ce-pathways.zip>

Name	Type	Compressed size	Password ...	Size	Ratio	Date modified
CMS-20052 Beneficiary Notice	Adobe Acrobat Document	764 KB	No	803 KB	5%	7/12/2022 10:43 AM
CMS-20053 Dining	Adobe Acrobat Document	803 KB	No	841 KB	5%	7/12/2022 10:43 AM
CMS-20054 Infection Prevention C...	Adobe Acrobat Document	936 KB	No	949 KB	2%	8/31/2022 8:04 AM
CMS-20055 Kitchen	Adobe Acrobat Document	738 KB	No	791 KB	5%	7/12/2022 10:43 AM
CMS-20057 Resident Council	Adobe Acrobat Document	799 KB	No	830 KB	4%	7/12/2022 10:43 AM
CMS-20058 QAPI and QAA	Adobe Acrobat Document	669 KB	No	691 KB	4%	7/12/2022 10:43 AM
CMS-20059 Abuse	Adobe Acrobat Document	819 KB	No	866 KB	6%	7/12/2022 10:43 AM
CMS-20061 Environment	Adobe Acrobat Document	759 KB	No	786 KB	4%	7/12/2022 10:43 AM
CMS-20062 Sufficient and Compet...	Adobe Acrobat Document	835 KB	No	877 KB	5%	7/12/2022 10:43 AM
CMS-20063 Personal Funds	Adobe Acrobat Document	779 KB	No	802 KB	3%	7/12/2022 10:43 AM
CMS-20067 Behavioral-Emotional	Adobe Acrobat Document	720 KB	No	746 KB	4%	7/12/2022 10:43 AM
CMS-20068 Urinary Catheter or UTI	Adobe Acrobat Document	743 KB	No	769 KB	4%	7/12/2022 10:43 AM
CMS-20070 Dental	Adobe Acrobat Document	693 KB	No	716 KB	4%	7/12/2022 10:43 AM
CMS-20076 Pain Mgt	Adobe Acrobat Document	695 KB	No	720 KB	4%	7/12/2022 10:43 AM
CMS-20082 Unnecessary Medicatio...	Adobe Acrobat Document	806 KB	No	846 KB	5%	7/12/2022 10:43 AM
CMS-20089 Medication Storage	Adobe Acrobat Document	657 KB	No	672 KB	3%	7/12/2022 10:43 AM
CMS-20091 Extended Survey	Adobe Acrobat Document	758 KB	No	785 KB	4%	7/12/2022 10:43 AM
CMS-20123 Hospitalization	Adobe Acrobat Document	706 KB	No	732 KB	4%	7/12/2022 10:43 AM
CMS-20127 Accidents	Adobe Acrobat Document	721 KB	No	756 KB	5%	7/12/2022 10:43 AM
CMS-20130 Neglect	Adobe Acrobat Document	751 KB	No	781 KB	4%	7/12/2022 10:43 AM
CMS-20132 Discharge	Adobe Acrobat Document	794 KB	No	833 KB	5%	7/12/2022 10:43 AM
CMS-20133 Dementia Care	Adobe Acrobat Document	710 KB	No	734 KB	4%	7/12/2022 10:43 AM
CMS-20140 Arbitration	Adobe Acrobat Document	796 KB	No	826 KB	4%	7/12/2022 10:43 AM

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Questions

