CAH Swing Bed Management

Conditions of Participation (CoP)

Webinar Series – Part 3
December 9, 2020

HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

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- **This information was prepared with the best of intention using CMS such as State Operations Manual, Claims Processing Manual, Medicare Benefit Policy Manual and other resources for regulations and is not intended to grant rights or impose obligations. This training may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.**

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  - Changes Effective Nov 29, 2019
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Medicare State Operations Manual

Appendix

- Contains list of all appendix (see next 2 slides)
- https://www.cms.gov/files/document/appendices-table-content.pdf

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749 pages

306 pages

Appendix W for CAHs and Swing Bed

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

- See page 236 to 252 – C-1608 to C-1626 for SB regulations
- Anita Moore from Medicare is now in charge of CAHs
- Questions regarding CoP may be asked via email it to qsog_cah@cms.hhs.gov
- When answered via email, it gives the hospital an answer in writing which can be put in your files in case the issue comes up later with a surveyor

C-1608

- **§485.645(d) SNF Services.**
- The CAH is substantially in compliance with the following SNF requirements

❑ **Resident Rights**

- §483.10(b)(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 decisions 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.

C-1608

- **DEFINITIONS** §483.10(b)(3)-(7) "Court of competent jurisdiction" means any court with the authority to hear and determine a case or suit with the matter in question.
- "Resident representative" For purposes of this subpart, the term resident representative may mean 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-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
  - 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.

C-1608

- **GUIDANCE §483.10(b)(3)-(7)**

- When reference is made to "resident" in the Guidance, it also refers to any person who may, under State law, act on the resident's behalf when the resident is unable to act for themselves. That person is referred to as the resident representative. If the resident has been formally declared incompetent by a court, the representative is whomever the court appoints (for example, a guardian or conservator).

- A competent resident may wish to delegate decision-making to specific persons, or the resident and family may have agreed among themselves on a decision-making process. To the degree permitted by State law, the facility staff must respect the delegated resident representative's decisions regarding the resident's wishes and preferences so long as the resident representative is acting within the scope of authority contemplated by the agreement authorizing the person to act as the resident's representative.

- In the case of a resident who has been formally declared incompetent by a court, a court appointed resident representative may be assigned. Facility staff must confer with the appointed resident representative.

- State laws and court orders authorizing guardians, conservators, etc., vary considerably. Many statutes and court orders limit the scope of the authority of the representative to act on behalf of the resident.

C-1608

- **GUIDANCE §483.10(b)(3)-(7) (cont')**

- Facility staff must obtain documentation that the resident's representative has been delegated the necessary authority to exercise the resident's rights and must verify that a court-appointed representative has the necessary authority for the decision-making at issue as determined by the court. For example, a court-appointed representative might have the power to make financial decisions, but not health care decisions. Additionally, the facility must make reasonable efforts to ensure that it has access to documentation of any change related to the delegation of rights, including a resident's revocation of delegated rights, to ensure that the resident's preferences, are being upheld.

- Whether a resident has or has not been judged incompetent by a court of law, if it is determined that the resident understands the risks, benefits, and alternatives to proposed health care and expresses a preference, then the resident's wishes should be considered to the degree practicable, including resident input into the care planning process. The involvement of a representative does not relieve facility staff of their duty to protect and promote the resident's interests. For example, a representative does not have the right to insist that a treatment be performed that is not medically appropriate or reject a treatment that may be subject to State law. Surveyors must confirm delegation of resident rights to a resident representative. Surveyors must also determine, through interview and record reviews, whether or not the resident's delegation of rights has been followed by facility staff.

- If a resident's representative is a same-sex spouse, he or she must be treated the same as an opposite-sex spouse with regard to exercising the resident's rights. In Obergefell v. Hodges, 576 U.S.___ (2015), the Supreme Court of the United States also ruled that all States must recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out-of-state.

C-1608

❖ C-1608 (cont')

- **§483.10(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)(iii)** The right to be informed, in advance, of changes to the plan of care.
- **§483.10(c)(6)** The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive

C-1608

- **§483.10(c) Planning and implementing care.**

- **INTENT** §483.10(c)(2)-(3) To ensure facility staff facilitates the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting.

- **GUIDANCE** §483.10(c)(2)-(3) Residents and their representative(s) must be afforded the opportunity to participate in their care planning process and to be included in decisions and changes in care, treatment, and/or interventions. This applies both to initial decisions about care and treatment, as well as the refusal of care or treatment. Facility staff must support and encourage participation in the care planning process. This may include ensuring that residents, families, or representatives understand the comprehensive care planning process, holding care planning meetings at the time of day when a resident is functioning best, providing sufficient notice in advance of the meeting, scheduling these meetings to accommodate a resident's representative (such as conducting the meeting in-person, via a conference call, or video conferencing), and planning enough time for information exchange and decision making.

C-1608

❖ **C-1608 (cont')**

- **§483.10(c) Planning and implementing care – (cont')**
- **GUIDANCE** §483.10(c)(2)-(3) **(cont')**
- A resident has the right to select or refuse specific treatments options before the care plan is instituted, based on the information provided as required under §483.10(c)(1), (4)-(5), F552. While Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not require the facility to provide specific medical interventions or treatments requested by the resident, family, and/or resident representative that the resident's physician deems inappropriate for the resident's medical condition.
- A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been declared incompetent by a court, must, to the extent practicable, be kept informed and be consulted on personal preferences.

C-1608

❑ Resident Rights (cont')

- **§483.10(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 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.

- **(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.

C-1608

❑ Resident Rights (cont')

- **GUIDANCE §483.10(d)(1)-(5)**

- The right to choose a personal physician does not mean that a resident is required to do so. It also does not mean that the physician the resident chose is obligated to provide service to the resident. If a resident or his or her representative declines to designate a personal physician or if a physician of the resident's choosing fails to fulfill their responsibilities, as specified in §483.30, F710, Physician Services, or elsewhere as required in these regulations, facility staff may choose another physician after informing the resident or the resident's representative.

- Before consulting an alternate physician, the medical director must have a discussion with the attending physician. Only after a failed attempt to work with the attending physician or mediate differences may facility staff request an alternate physician.

- Facility staff may not interfere in the process by which a resident chooses his or her physician. If a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, facility staff must assist the resident or the resident's representative in finding a replacement.

C-1608

- **Resident Rights (cont')**

- **GUIDANCE §483.10(d)(1)-(5) – (cont')**

- A resident in a distinct part of a general acute care hospital may choose his or her own physician. If the hospital requires that physicians who supervise residents in the distinct part have privileges, then the resident cannot choose a physician who lacks them.

- **Note: I wrote to CMS re: hospitalist ……**

C-1608

❑ Resident Rights (cont')

- **§483.10(e)(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(e)(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.

- **§483.10(f)(4)(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(f)(4)(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(g)(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.

C-1608

❑ Resident Rights (cont')

- **§483.10(f)(4)(iii)** The facility must provide immediate access to a resident by others who are visiting …….

- **DEFINITIONS §483.10(f)(4)(ii)-(v)**

- "Reasonable clinical and safety restrictions" include a facility's policies, procedures or practices that protect the health and security of all residents and staff. These may include but are not be limited to:

- Restrictions placed to prevent community-associated infection or communicable disease transmission to the resident.
- A resident's risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication).
- If deferral cannot occur such as the case of end-of-life, the visitor should follow respiratory hygiene/cough etiquette as well as other infection prevention and control practices such as appropriate hand hygiene

C-1608

❑ Resident Rights (cont')

- **§483.10(f)(4)(iii)** The facility must provide immediate access to a resident by others who are visiting …….
- **DEFINITIONS §483.10(f)(4)(ii)-(v) –** (cont')
- Immediate access can be denied in the following situation
  - Keeping the facility locked or secured at night with a system in place for allowing visitors approved by the resident;
  - Denying access or providing limited and supervised access to an individual if that individual is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed or has been found to be abusing, exploiting, or coercing a resident;
  - Denying access to individuals who have been found to have been committing criminal acts such as theft; or
  - Denying access to individuals who are inebriated or disruptive.

C-1608

❑ Resident Rights (cont')

- **§483.10(f)(4)(iii)** The facility must provide immediate access to a resident by others who are visiting …….

- **GUIDANCE §483.10(f)(4)(ii)-(v)** For purposes of this regulation, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State's common law equivalent. It is important to understand that there are many types of families, each of which being equally viable as a supportive, caring unit. For example, it might also include a foster family where one or more adult serves as a temporary guardian for one or more children to whom they may or may not be biologically related.

- Residents have the right to define their family. During the admissions process, facility staff should discuss this issue with the resident. If the resident is unable to express or communicate whom they identify as family, facility staff should discuss this with the resident's representative.

- Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident. With the consent of the resident, facilities must provide 24-hour access to other non-relative visitors, subject to reasonable clinical and safety restrictions.

C-1608

❑ Resident Rights (cont')

- **§483.10(f)(4)(iii)** The facility must provide immediate access to a resident by others who are visiting …….
- **GUIDANCE §483.10(f)(4)(ii)-(v) – (cont')**
- If these visitation rights infringe upon the rights of other residents, facility staff must find a location other than a resident's room for visits.
  - For example, if a resident's family visits in the late evening when the resident's roommate is asleep, then the visit should take place somewhere other than their shared room so that the roommate is not disturbed.
- Individuals who provide health, social, legal, or other services to the resident have the right of reasonable access to the resident.
- Facility staff must provide space and privacy for such visits.

C-1608

❑ Resident Rights (cont')

- **§483.10(g)(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(g)(18)**[introductory text only] 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.

C-1608

❑ Resident Rights (cont')

- **§483.10(h)** Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.
  - (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.
  - (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.
  - (3) The resident has a right to secure and confidential personal and medical records.
    - (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.
    - (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

C-1608

❑ Resident Rights (cont')

- ***NEW CHANGE***

- The CoPs had a section that said that patient had the right to choose or refuse to perform services (work) and cannot require it
  - It required documentation of the need or desire to work
  - Was it voluntary or paid for and if so, must have prevailing rate and have in plan of care
  - In a LTC maybe the resident who was a chef made special pastries on Sunday or a resident helped fold towels for physical therapy
  - Never made sense for shorter LOS programs so it was REMOVED
  - CAH tag number 361(now 1608)
  - Hospitals can elect to still do this if they want
  - If they allow residents to perform services, then must have a policy and procedure since hospitals can never require a patient to do work

C-1610

- **§485.645(d)(2) Admission, Transfer and Discharge Rights (§483.5 definition of transfer & discharge,**
- **§483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9)** of this chapter)
- **§483.5 definition of transfer & discharge:**
  - 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.
  - §483.15(c)(1) 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;

C-1610

❖ C-1610 (cont')

- (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
- (F) The facility ceases to operate.

- 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.

C-1610

- **§485.645(d)(2) Admission, Transfer and Discharge Rights (§483.5 definition of transfer & discharge – (cont')**

- **§483.15(c)(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.

- (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).
- (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 (c)(1)(i)(C) or (D) of this section.

C-1610

- **§483.15(c)(2) Documentation. (cont')**
- (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 resident's 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.

C-1610

Will update with info re: Notice of Medicare Non-Coverage (NOMNC) before sending to you all

- **§483.15(c)(4) Timing of the notice.**
- (i) Except as specified in paragraphs (c)(4)(ii) and (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.
  (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 (c)(1)(i)(C) of this section;
  - (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
  - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
  - (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
  - (E) A resident has not resided in the facility for 30 days.

C-1610

- **§483.15(c)(5) Contents of the notice**. The written notice specified in paragraph (c)(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;
- (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.

C-1610

❖ C-1610 (cont')

- **§483.15(c)(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

- **§483.15(c)(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)

- **§483.15(c)(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.

C-1612

- **§485.645(d)(3) Freedom from abuse, neglect and exploitation** (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter)

- **§483.12**(a)(1) Freedom 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.(a) The facility must—

  - (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; • §483.12(a)

  - (2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

C-1612

- **ABUSE (cont')**

- §483.12(a)(3) Not employ or otherwise engage individuals who—
  - (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

  - (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

- §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

- §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,

C-1612

- **ABUSE (cont')**

- §483.12(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 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.

  - (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.

  - (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.

C-1616

- **§485.645(d)(4) Social Services (§483.40(d) of this chapter).**
- **§483.40(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.
- ***NEW CHANGE***
  - Previously had a section that said if you had 120 beds or more you had to have a full-time social worker
  - This just confused everyone since CAH cannot have more than 25 beds and rural hospitals not more than100 beds
  - Therefor this section has been removed
  - All we had been doing anyway was providing medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident – provided by an RN designee or a SW

C-1620

- **§485.645(d)(5) Comprehensive assessment**, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).

- **§483.20(b)** Comprehensive assessments—

- (1) Resident assessment - A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences. 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

C-1620

❖ C-1620 (cont')

- (1) Resident assessment – (cont')
  - (ix) Continence
  - (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 **(does not apply to CAHs)**
  - (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 non-licensed direct care staff members on all shifts

  - **§483.20(b) # 2 i) – ii) and iii)** - regarding timeframe for the above does not apply to CAH SB.

C-1620

- **§483.21(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).
  - (1) 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. (PASARR does not apply to SB – unless they came from a NH with one)

C-1620

❖ C-1620 (cont')

Let's discuss

- **§483.21(b) Comprehensive care plans (cont')**
  - (2) 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 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.

- (2) A comprehensive care plan must be—

- (i) Developed within 7 days after completion of the comprehensive assessment. (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.

C-1620

- **§483.21(b) Comprehensive care plans (cont')**
  - (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
- (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
- (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
- (i) Meet professional standards of quality.
- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.
- (iii) Be culturally-competent and trauma-informed
- **Note:** consultant recommend that we update the care plan at the initial IDT meeting by day-3 and updated as necessary but no less that weekly

C-1620

❖ C-1620 (cont')

- **§483.21(c)(2) Discharge summary.** When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:
  - (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.
  - (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.
  - (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
  - (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.

C-1622

- **§485.645(d)(6) Specialized Rehabilitative Services** (§483.65 of this chapter).
  - **§483.65 (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—
  - (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.
  - (b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

C-1624

§485.645(d)(7) **Dental Services** (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).

NEW CHANGE

- Previously said facility must contract with a dentist to assist residents in obtaining routine and 24-hour emergency dental care
- Hospitals are addressing emergent dental need under the existing CoPs and hospitals should have P&P already
- Would recommend that the P&P include the following parts of the regulation
  - Should 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;
  - Must promptly, within x days, refer residents with lost or damaged dentures for dental services if it should not wait for post discharge
  - 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

C-1626

- **§483.25(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—
  - (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;
  - (2) Is offered sufficient fluid intake to maintain proper hydration and health.

Activity

❖ ***New Change***

- **Activity Program (the entire tag number was finally deleted))**
  - Deleted the section that said the facility provide an ongoing activity program based on the resident's comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation
  - Previously said the facility must provide an ongoing program to support the resident in their choice of activities
  - Deleted since swing bed patients are not long-term residents and only receive services for a short time
  - However, if the hospital has a patient for an extended period of time then expected to provide an activity program

Swing Bed P&Ps

- The plan is for me to update all sample P&Ps I have after the SB series is complete as time allows along with others you should have that are more specific to your CAHs
- Will send to Dianna to be shared with all
- Would highly recommend that you review and compare with what you have
- Remember that you should have a process where P&Ps should be reviewed by all staff – surveyors are known to ask staff what their P&P on XYZ states.

Next webinar (# 4) SB training is next Tuesday December 15 – *2:00 PM ET*
Title: SB CMS Survey