



Activities Related FTags: Excerpts from Advance Appendix PP (CMS.gov)

F550 Resident Rights/Exercise of 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.

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.

Exercise of Rights

All residents have rights guaranteed to them under Federal and State laws and regulations. This regulation is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.

Examples of treating residents with dignity and respect include, but are not limited to:

- Encouraging and assisting residents to dress in their own clothes, rather than hospital- type gowns, and appropriate footwear for the time of day and individual preferences;
- Promoting resident independence and dignity while dining, such as avoiding: Daily use of disposable cutlery and dishware; Bibs or clothing protectors instead of napkins (except by resident choice); Staff standing over residents while assisting them to eat; Staff interacting/conversing only with each other rather than with residents while assisting with meals;

Consider the resident's life style and personal choices identified through their assessment processes to obtain a picture of his or her individual needs and preferences. Staff and volunteers must interact with residents in a manner that takes into account the physical limitations of the resident, assures communication, and maintains respect. For example, getting down to eye level with a resident who is sitting, maintaining eye contact when speaking with a resident with limited hearing, or utilizing a hearing amplification device when needed by a resident.



F552 Right to be Informed/Make Treatment Decisions

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.

“Total health status” includes functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

F553 Right to Participate in Planning Care

The right to participate in *the development and implementation of his or her person-centered plan of care, including but not limited to:*

- (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.*

F557 Respect and Dignity/Right to have Personal Property

The resident has a right to be treated with respect and dignity, including: 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.

INTENT

All residents’ possessions, regardless of their apparent value to others, must be treated with respect.



F558 Reasonable Accommodation

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.

INTENT §483.10(e)(3)

The accommodation of resident needs and preferences is essential to creating an individualized, home-like environment.

GUIDANCE §483.10(e)(3)

Reasonable accommodation(s) of resident needs and preferences includes, but is not limited to, individualizing the physical environment of the resident's bedroom and bathroom, as well as individualizing common living areas as much as feasible. These reasonable accommodations may be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preferences.

F561 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.

The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of healthcare services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

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.



INTENT

The intent of this requirement is to ensure that each resident has the opportunity to exercise his or her autonomy regarding those things that are important in his or her life. This includes the residents' interests and preferences.

GUIDANCE

It is important for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed. Additionally, a resident's needs and choices for how he or she spends time, both inside and outside the facility, should also be supported and accommodated, to the extent possible, including making transportation arrangements.

Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans. This includes, but is not limited to, choices about the schedules that are important to the resident, such as waking, eating, bathing, and going to bed at night.

PROCEDURES

During interviews with residents or their family and/or representative(s), determine if they are given the opportunity to choose and whether facility staff accommodate his or her preferences for:

- Activities that interest them;
- Their sleep cycles;
- Their bathing times and methods;
- Their eating schedule;
- Their health care options; and
- Any other area significant to the resident.

F565 Resident and Family Group and Responses

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.

The resident has a right to participate in family groups.

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.



DEFINITIONS

“A resident or family group” is defined as a group of residents or residents’ family members that meets regularly to:

- Discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life;
- Support each other;
- Plan resident and family activities;
- Participate in educational activities; or
- For any other purpose.

GUIDANCE

This requirement does not require that residents organize a resident or family group. However, whenever residents or their families wish to organize, they must be able to do so without interference..

F 566) Work

The resident has a right to choose 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.

“Prevailing rate” is the wage paid to the majority of workers in the community surrounding the facility for the same type, quality, and quantity of work requiring comparable skills.

GUIDANCE

All work or services provided by a resident, whether voluntary or paid, must be part of his/her care plan. Any work assignment must be agreed to and negotiated by the resident or the resident’s representative. The resident also has the right to refuse to participate in these services or



assignments at any time. A resident's request to work or perform services should be discussed by the interdisciplinary team and be clinically and psychologically appropriate for the resident.

F571 Limitation or Charges to Personal Funds

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. (

(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:

(A) Nursing services as required

(B) *Food and Nutrition services as required*

(C) An activities program as required

(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

(G) *Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.*

(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 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.



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(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.

(F) 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

(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist

(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.

(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.



GUIDANCE

Residents must not be charged for universal items such as *computers, telephones, television services or other electronic devices, books, magazines* or newspaper subscriptions intended for use by *all residents*.

F573 Right to Access and Purchase Copies of Medical Records

- (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).*

GUIDANCE

An oral request is sufficient to produce *the resident's personal and medical* record for review. *The facility may charge a reasonable, cost-based fee for providing a copy of the requested records, whether in paper or electronic form. This may only include the cost of labor for copying the records, supplies for creating the paper copy or electronic media, and postage, if applicable.* Additional fee

F576 Rights to Forms of Communication and Privacy

This includes the right to retain and use a cellular phone at the resident's own expense. 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;*
- (ii) *The internet, to the extent available to the facility; and*
- (iii) *Stationery, postage, writing implements and the ability to send mail.*

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.

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.

Resident access to telephones in staff offices or at nurses' stations alone does not meet the provisions of this requirement. Examples of facility accommodations to provide reasonable access to the use of a telephone without being overheard include providing cordless telephones or having telephone jacks in residents' rooms.

The facility is responsible for providing reasonable access to the internet to the extent it is available onsite. Computers in public areas for general use must be located in a manner to protect resident privacy in email, communications, and internet use. s for locating the records or typing forms/envelopes may not be assessed.

F583 Personal Privacy and Confidentiality of records .

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.

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.

"Promptly" means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

"Right to personal privacy" includes the resident's right to *meet or communicate with whomever they want without being watched or overheard*. Private space may be created flexibly and need not be dedicated solely for visitation purposes.



Photographs or recordings of a resident and/or his or her private space without the resident's, or designated representative's written consent, is a violation of the resident's right to privacy and confidentiality. Examples include, but are not limited to, staff taking unauthorized photographs of a resident's room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area. Taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (for example, cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality.

F584 Safe Comfortable Homeline 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 A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

Adequate and comfortable lighting levels in all areas;

Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

For the maintenance of comfortable sound levels.

Adequate lighting design has these features:

Lighting with minimum glare in areas frequented by residents. Elimination of high levels of glare produced by shiny flooring and from unshielded window openings;

Even light levels in common areas and hallways, avoiding patches of low light caused by too much space between light fixtures, within limits of building design constraints;

Use of daylight as much as possible;

Extra lighting, such as table and floor lamps to provide sufficient light to assist residents with tasks such as reading;

Lighting for residents who need to find their way from bed to bathroom at night (*for example, red colored night lights preserve night vision*); and

Dimming switches in resident rooms (where possible and when desired by the resident) so that staff can tend to a resident at night with limited disturbances to them or a roommate.



F585 Grievances

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 not been furnished, *the behavior of staff and of other residents, and other concerns regarding their LTC facility stay*. 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*.

The facility must make information on how to file a grievance or complaint available to the resident.

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 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

With permission *from the resident council president or officer*, review resident council minutes.



F 602 Freedom of Misappropriation/Exploitation

INTENT

Each resident has the right to be free from misappropriation of property and exploitation.

Examples of misappropriation of resident property include, but are not limited to: A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion; and A resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in a financial crisis.

F603 Free of Involuntary Seclusion

The facility must Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

Involuntary seclusion includes, but is not limited to, the following:

A resident displays disruptive behaviors, such as yelling, screaming, distracting others (such as standing and obstructing others viewing abilities for the TV or programs) and staff remove and seclude the resident in a separate location such as in an office area or his/her room, leaving and closing the door and without providing interventions to address the behavioral symptoms;

In an attempt to isolate a resident in order to prevent him/her from leaving an area, the resident(s) is involuntarily confined to an area by staff placing furniture, carts, chairs in front of doorways or areas of egress;

F604 Right to be Free from Physical Restraints

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).

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.

Prohibits the use of physical restraints for discipline or convenience;



When a physical restraint is used, the facility must:

Use the least restrictive restraint for the least amount of time; and

Provide ongoing re-evaluation of the need for the physical restraint.

F605 Right to be Free from Chemical Restraints

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.

When a medication is indicated to treat a medical symptom, the facility must: Use the least restrictive alternative for the least amount of time;

Provide ongoing re-evaluation of the need for the medication; and

Not use the medication for discipline or convenience.

F607 Develop/Implement Abuse Neglect Policies

In addition, a facility must develop and implement policies and procedures to prohibit and prevent both abuse and neglect. This would include screening prospective residents to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. The facility's written procedures may include, but are not limited to:

- *For prospective residents, reviewing:*
- *An assessment of the individual's functional and mood/behavioral status;*
- *Medical acuity; and*
- *Special needs (e.g., mechanical ventilation care, dialysis, hospice).*

The facility can then determine whether – in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment- it can safely and competently provide the necessary care to meet the resident's needs. For example, a resident may have a prior history of distressed behaviors such as unsafe wandering, physically aggressive behaviors including sexually aggressive behaviors, or mental/psychiatric illnesses. In order to provide protections and a safe environment for the resident and other residents, the facility must determine whether it has sufficient competent and qualified staff in order to meet the needs of the



resident. If the individual is admitted, preadmission screening information may provide information that may be used as part of the initial assessment and care planning data.

F635 Admission Physician Orders for immediate care

To ensure each resident receives necessary care and services upon admission.

“Physician orders for immediate care” are those written and/or verbal orders facility staff need to provide essential care to the resident, consistent with the resident’s mental and physical status upon admission to the facility. These orders should, at a minimum, include dietary, medications

(if necessary) and routine care to maintain or improve the resident’s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan

F636 Comprehensive Assessment and Timing

Comprehensive Assessments 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) Psychological well-being.*
- (viii) Physical functioning and structural problems.*
- (ix) Continence.*
- (x) Disease diagnosis and health conditions.*
- (xi) Dental and nutritional status.*
- (xii) Skin Conditions.*



(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.

At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days

F637 Comprehensive Assessment after Significant Change

Within 14 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 purpose 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.)

A Significant Change in Status MDS is required when:

- A resident enrolls in a hospice program; or
- A resident changes hospice providers and remains in the facility; or
- A resident receiving hospice services discontinues those services; or
- A resident experiences a consistent pattern of changes, with either **two or more** areas of decline or **two or more** areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS).



F638 Quarterly Assessment at least every 3 months

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.

Facilities are required to maintain 15 months of assessment data in *each* resident's active clinical record.

F641 Accuracy of Assessments

To assure that each resident receives an accurate assessment, *reflective of the resident's status at the time of the assessment*, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

F655 Baseline Care Plans

*** Please note regulation does not state activities but critical pathway for Activities does list Baseline Careplan under documentation review.

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.*

3) The facility must provide the resident and their representative with a summary of the baseline care plan



INTENT §483.21(a)

Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

F656 Develop/ Implement Comprehensive Care Plans

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 —

(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

(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.

Care plans must be person-centered and reflect the resident's goals for admission and desired outcomes. Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.



F TAG 657 Care plan timing and revision

(A) comprehensive care plan must be—

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

(ii) Prepared by an interdisciplinary team, (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.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment. "After each assessment" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set. For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission

F658 Services Provided Meet Professional Standards

Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must) Meet professional standards of quality.

GUIDANCE

"Professional standards of quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular

clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency.

Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work,



F659 Qualified Persons

Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must be provided by qualified persons in accordance with each resident's written plan of care.

Be culturally-competent and trauma-informed. [§483.21(b)(iii) will be implemented beginning November 28, 2019 (Phase 3)]

The facility must ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required

F661 Discharged Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes, *but is not limited to, the following:*

In addition to the recapitulation of the resident's stay, the discharge summary must include a final summary of the resident's status which includes the items from the resident's most recent comprehensive assessment identified at §483.20(b)(1)(i) – (xviii) Comprehensive Assessment. This is necessary to accurately describe the current clinical status of the resident. Items required to be in the final summary of the resident's status are:

- *Identification and demographic information;*
- *Customary routine;*
- *Cognitive patterns;*
- *Communication;*
- *Vision;*
- *Mood and Behavior patterns;*
- *Psychosocial well-being;*
- *Physical functioning and structural problems;*
- *Continence;*



- *Disease diagnoses and health conditions;*
- *Dental and nutritional status*
- *Skin condition;*
- *Activity pursuit;*

F675 Quality of life

*See Full regulation at www.nccap.org

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.

INTENT

The intent of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:

Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and

Ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

F679 Activities Program

*See full Regulation at www.nccap.org

§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing 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.

INTENT §483.24(c)

To ensure that facilities implement an *ongoing resident centered* activities program that incorporates *the resident's* interests, hobbies and *cultural* preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being *and*



independence. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

F680 Qualification of the Activity Director

****See full regulation at www.nccap.org**

The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—

(i) Is licensed or registered, if applicable, by the State in which practicing; and

(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

(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.

“Recognized accrediting body” refers to those organizations that certify, register, or license therapeutic recreation specialists, activity professionals, or occupational therapists.

F686 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 in making appointments, and 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.

Assistive devices to maintain vision include, *but are not limited to*, glasses, contact lenses, magnifying *lens* or *other devices that are used by the resident*.

Assistive devices to maintain hearing include, *but are not limited to*, hearing aids, and amplifiers.



F697 Pain Management.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Developing and implementing *both non-pharmacological and pharmacological* interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both;

Non-pharmacological interventions

Research supports physical activity and exercise as a part of most treatment programs for chronic pain. Activity can be supported by conventional physical therapy and exercise approaches, or by a wide range of movement therapies. Some non-pharmacologic interventions may need to be ordered by the provider while others can be provided by facility staff during routine care. Examples of non-pharmacological interventions may include, but are not limited to:

Altering the environment for comfort (such as adjusting room temperature, tightening and smoothing linens, using pressure redistributing mattress and positioning, comfortable seating, and assistive devices);

Physical modalities, such as ice packs or cold compresses (to reduce swelling and lessen sensation), mid heat (to decrease joint stiffness and increase blood flow to an area), neutral body alignment and repositioning, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture/acupressure, chiropractic, or rehabilitation therapy;

Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility; and

Cognitive/Behavioral interventions (e.g., relaxation techniques, reminiscing, diversions, activities, music therapy, offering spiritual support and comfort, as well as teaching the resident coping techniques and education about pain).

F740 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. Effective November 28, 2017



“Highest practicable physical, mental, and psychosocial well-being” is defined as the highest possible level of functioning and well-being, limited by the individual’s recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

“Mental disorder” is a syndrome characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition*. Arlington, VA: American Psychiatric Association Publishing, 2013.).

“Substance use disorder” is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems or disability (Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA) definition found at <http://www.samhsa.gov/disorders/substance-use>).

GUIDANCE §483.40

Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident’s distress or loss of abilities.

The facility must provide necessary behavioral health care and services which include:

- *Ensuring that the necessary care and services are person-centered and reflect the resident’s goals for care, while maximizing the resident’s dignity, autonomy, privacy, socialization, independence, choice, and safety;*
- *Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.*
- *Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident’s customary routines, interests, preferences, etc. and enhance the resident’s well-being;*
- *Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;*



- *Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.*

Depression

Although people experience losses, it does not necessarily mean that they will become depressed. Depression is not a natural part of aging, however, older adults are at an increased risk. Symptoms may include fatigue, sleep and appetite disturbances, agitation, expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation. Late life depression may be harder to identify due to a resident's cognitive impairment, loss of functional ability, the complexity of multiple chronic medical problems that compound the problem, and the loss of significant relationships and roles in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

Anxiety and Anxiety Disorders

Anxiety is a common reaction to stress that involves occasional worry about circumstantial events. Anxiety disorders, however, include symptoms such as excessive fear and intense anxiety and can cause significant distress. Anxiety disorders are prevalent among older adults and may cause debilitating symptoms. The distinction between general anxiety and an anxiety disorder is subtle and can be difficult to identify. Accurate diagnosis by a professional is essential. Anxiety can be triggered by loss of function, changes in relationships, relocation, or medical illness. Importantly, anxiety may also be a symptom of other disorders, such as dementia, and care must be taken to ensure that other disorders are not inadvertently misdiagnosed as an anxiety disorder (or vice versa).

KEY ELEMENTS OF NONCOMPLIANCE §483.40

The facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being meet each resident's needs and include individualized approaches to care.

To cite deficient practice at F740, the surveyor's investigation will generally show that the facility failed to:

- *Identify, address, and/or obtain necessary services for the behavioral health care needs of residents;*
- *Develop and implement person-centered care plans that include and support the behavioral health care needs, identified in the comprehensive assessment;*
- *Develop individualized interventions related to the resident's diagnosed conditions (e.g., assuring residents have access to community substance use services);*
- *Review and revise behavioral health care plans that have not been effective and/or when the resident has a change in condition;*



- *Learn the resident's history and prior level of functioning in order to identify appropriate goals and interventions;*
- *Identify individual resident responses to stressors and utilize person-centered interventions developed by the IDT to support each resident; or*
- *Achieve expected improvements or maintain the expected stable rate of decline based on the progression of the resident's diagnosed condition.*

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:

• *The surveyor was able to determine through an interview with a certified nurse aide (CNA), that the resident often became anxious and agitated in the evenings and attempted to leave the facility on multiple occasions over the last three months. Last week, he left the facility for 30 minutes before being found by facility staff. While outside the nursing home, he fell, resulting in several abrasions and a laceration on his forehead and right knee, which required transfer to acute care. Review of the resident's record neglected to provide documentation of potential underlying causes for his anxiety and agitation. Nor did his care plan include any interventions to reduce his expressions of distress and deter elopement. This was confirmed through interviews with the social worker, director of nursing, and medical director. The attending physician also confirmed that the IDT had not discussed potential causes for the resident's anxiousness and agitation and had not developed interventions to resolve these concerns.*

The facility failed to investigate underlying causes of the resident's anxiety and agitation and failed to develop and implement individualized interventions for the resident, which led to numerous elopement episodes and injury.

An example of Severity Level 3 Non-compliance: Actual Harm that is not Immediate Jeopardy includes, but is not limited to:

• *A resident was admitted to the facility with a diagnosis of post-traumatic stress disorder, from war related trauma. The resident assessment identified that certain environmental triggers such as loud noises and being startled caused the resident distress and provoked screaming. The resident's care plan identified that his environment should not have loud noises and that staff should speak softly to the resident. Observations in the home revealed that the entry and exit doors had alarms that sounded with a loud horn each time they were opened. Additionally, staff were observed approaching the resident from behind and shaking his shoulder to get his attention. The resident was startled and screamed for fifteen minutes. The director of nursing (DON) stated that they hoped he would eventually get used to living in the home.*

The facility identified triggers that were known to cause the resident distress and developed a care plan to support the resident's behavioral health care needs. However, the facility failed to implement the care planned approaches to care.



Severity Level 2: No Actual Harm with Likelihood for More Than Minimal Harm that is Not Immediate Jeopardy

- A resident with a diagnosed anxiety disorder preferred staff to announce themselves before entering his room. His care plan identified the non-pharmacological approach of staff knocking on his door and requesting permission before entering. This had proved effective in reducing his anxiety. When interviewed, the resident indicated that facility staff usually followed this direction. He feels anxious on weekends when the workers from a temporary staffing agency provide care, because they frequently enter his room without asking permission. Although this increases his anxiety, he tries to live with it, but wished the nursing home would do something about it. During an interview, the DON mentioned that he was not aware of the resident's concern and that it was difficult to control all staff interactions with the resident. However, the DON agreed to investigate the situation and work to find a resolution.

The facility failed to ensure that all staff members, both those employed by the nursing home and those from the staffing agency, respected the privacy of each resident by announcing themselves prior to entering resident rooms. This led to increased anxiety for the resident.

F741 Sufficient / Competent Staff – Behavioral Health Needs

§483.40(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 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:

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), as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3).

Implementing non-pharmacological interventions.

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 and psychosocial disorders). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through an evidence-based process that could include the following: an analysis of Minimum Data Set (MDS) data, review of quality improvement



data, resident-specific and population needs, review of literature, applicable regulations, etc. Once identified, staff must be aware of those disease processes that are relevant to enhance psychological and emotional well-being. Competency is established by observing the staff's ability to use this knowledge through the demonstration of skill and the implementation of specific, person-centered interventions identified in the care plan to meet residents' behavioral health care needs. Additionally, competency involves staff's ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements.

***SEE NCCAP ENGAGEMENT CERTIFICATION - OPEN TO ALL HEALTHCARE PERSONALS**

Non-pharmacological Interventions

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs may include, but are not limited to:

Ensuring adequate hydration and nutrition (e.g., enhancing taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); exercise; and pain relief;

Individualizing sleep and dining routines, as well as schedules to use the bathroom, to reduce the occurrence of incontinence, taking into consideration the potential need for increased dietary fiber to prevent or reduce constipation, and avoiding, where clinically inappropriate, the use of medications that may have significant adverse consequences (e.g., laxatives and stool softeners);

Adjusting the environment to be more individually preferred and homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);

Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment);

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, and needs, based upon the 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);

Utilizing techniques such as music, art, massage, aromatherapy, reminiscing; and

Assisting residents with substance use disorders to access counseling programs (e.g., substance use disorder services) to the fullest degree possible. For additional examples of individualized non-pharmacological interventions, see §483.15(f), Activities. While there may be situations where a pharmacological intervention is indicated first, these situations do not negate the obligation of the facility to also develop and implement appropriate non-pharmacological interventions.



F742 Treatment and Services for Mental/Psychosocial Concerns

Based on the comprehensive assessment of a resident, the facility must ensure that—

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*;

GUIDANCE §483.40(b) & §483.40(b)(1)

Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (PTSD) require specialized care and services to meet their individual needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.

Background on Trauma and PTSD

A close relationship exists between mental and psychosocial adjustment difficulties, histories of trauma, and PTSD.

- *Adjustment difficulties:*

Occur within 3 months of the onset of a stressor and last no longer than 6 months after the stressor or its consequences have ended;

Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning;

May be related to a single event or involve multiple stressors and may be recurrent or continuous;

May cause a depressed mood, anxiety, and/or aggression;

May be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief exceeds what normally might be expected; and

Can occur for individuals with or without PTSD or a history of trauma.

- *History of trauma:*



Involves psychological distress, following a traumatic or stressful event, that is often variable;

May be connected to feelings of anxiety and/or fear;

Often involves expressions of anger or aggressiveness; and

Some individuals who experience trauma will develop PTSD.

- **PTSD:**

Involves the development of symptoms following exposure to one or more traumatic, life-threatening events;

Usually develops within the first 3 months after the trauma occurs, although there may be a delay in months or even years;

Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event (e.g., flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g., outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g., detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g., increased startle response or difficulty sleeping); and

May be severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture or sexual violence).

(Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013.)

Although PTSD is commonly viewed as a disorder experienced only by military veterans, it is not exclusively a consequence of combat or war zone exposure. Individuals who have been physically or sexually assaulted or who experienced a terrorist attack or natural disaster, among other things may also be affected by PTSD. Additionally, some older nursing home residents may have lived through a time of genocide and witnessed or been subjected to the intentional and systematic destruction of a racial, political, or cultural group such as that which occurred during the Holocaust in World War II.

Moving from the community into a long-term care facility, for an individual with a history of trauma or PTSD, can be a very difficult transition and cause worsening or reemergence of symptoms.

Additionally, the structured environment of the nursing home can trigger memories of traumatic events and coping with these memories may be more difficult for older adults.



F743 No Patterns of Behavioral Difficulties Unless Unavoidable

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.

GUIDANCE §483.40(b)(2)

Nursing home admission can be a stressful experience for a resident, his/her family, and/or representative. Behavioral health is an integral part of a resident's assessment process and care plan development. The assessment and care plan should include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Facility staff must:

Monitor the resident closely for expressions or indications of distress;

Assess and plan care for concerns identified in the resident's assessment;

Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;

Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;

Ensure appropriate follow-up assessment, if needed; and

Discuss potential modifications to the care plan.

F744 Treatment or Services for Dementia

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.



GUIDANCE §483.40(b)(3)

Providing care for residents living with dementia is an integral part of the person-centered environment, which is necessary to support a high quality of life with meaningful relationships and engagement. Fundamental principles of care for persons living with dementia involve an interdisciplinary approach that focuses holistically on the needs of the resident living with dementia, as well as the needs of the other residents in the nursing home. Additionally, it includes qualified staff that demonstrate the competencies and skills to support residents through the implementation of individualized approaches to care (including direct care and activities) that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

Ensuring adequate medical care, diagnosis, and supports based on diagnosis; Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; and

Utilizing individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interests, preferences, and choices to enhance the resident's wellbeing.

It is expected that a facility's approach to care for a resident living with dementia follows a systematic care process. In order to ensure that residents' individualized dementia care needs are met, the facility is expected to assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible.

F758 Free From Unnecessary Psychotropic Medication & PRN Use

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*



F810 Assistive Devices Eating Equipment /Utensils

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.*

GUIDANCE §483.60(g)

The facility must provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat or drink independently, for example, improving poor grasp by enlarging silverware handles with foam padding, aiding residents with impaired coordination or tremor by installing plate guards, or specialized cups. The facility must also provide the appropriate staff assistance to ensure that these residents can use the assistive devices when eating or drinking.

F811 Feeding assistants training/supervision/resident

(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.

§483.60(h)(2) Supervision.

- (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
- (ii) In an emergency, a feeding assistant must call a supervisory nurse for help.

§483.60(h)(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.
- (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.*



a. Minimum training course contents. A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:

- (1) Feeding techniques;
- (2) Assistance with feeding and hydration;
- (3) Communication and interpersonal skills;
- (4) Appropriate responses to resident behavior;
- (5) Safety and emergency procedures, including the Heimlich maneuver;
- (6) Infection control;
- (7) Resident rights; and
- (8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

b. Maintenance of records. A facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

F812 Food Procurement/Store/Prepare/Serve-sanitary

The facility must --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.

-Store, prepare, distribute and serve food *in accordance with professional standards for food service safety*

INTENT §483.60(i)(1)-(2) -To ensure that the facility:

Obtains food for resident consumption from sources approved or considered satisfactory by Federal, State or local authorities;



Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes; *and,*

Ensures food safety is maintained when implementing various culture change initiatives such as when serving buffet style from a portable steam table, or during a potluck.

freedom from contamination are also important when ready-to-eat or prepared food items for snacks are sent to the unit and are held for delivery, stored at the nursing station in a unit refrigerator or unit cupboards, *or stored in personal refrigerators in resident rooms.*

Special Events -Facility-sponsored special events, such as cookouts and picnics where food may not be prepared in the facility's kitchen and is served outdoors or in other locations, require the same food safety considerations.

Potluck Events – *Are generally events where families, volunteers or other non-facility staff may organize to provide enjoyment to nursing home residents and support a person-centered, homelike environment. These are different from a facility's special event.*

Regarding food brought into a nursing home prepared by others, please remember the nursing home is responsible for:

Storing visitor food in such a way to clearly distinguish it from food used by or prepared by the facility.

Ensuring safe food handling once the food is brought to the facility, including safe reheating and hot/cold holding, and handling of leftovers.

Preventing contamination of nursing home food, if nursing home equipment and facilities are used to prepare or reheat visitor food.

Clearly identifying what food has been brought in by visitors for residents and guests when served.

Should a foodborne illness occur as a result of a potluck held at the facility, the nursing home could be held responsible. For example, the facility could be held responsible if the facility failed to ensure the food was protected from contamination while being stored in the refrigerator and became contaminated from raw meat juices or failed to ensure staff involved in food service used appropriate hand hygiene and a foodborne illness resulted.

Nursing Home Gardens – Nursing homes that have their own gardens such as, vegetable, fruit or herbs may be compliant with the food procurement requirements as long as the facility has and follows policies and procedures for maintaining *and harvesting* the gardens, *including ensuring manufacturer's instructions are followed if any pesticide(s), fertilizer, or other topical or root-based plant preparations are applied.*



NOTE: Facilities must be in compliance with any State or local requirements that may exist pertaining to food grown on facility grounds for resident consumption.

Transported Foods -If residents take prepared foods with them out of the facility (e.g., bag lunches for residents attending dialysis, clinics, sporting events, or day treatment programs), the foods must be handled and prepared for them with the same safe and sanitary approaches used during primary food preparation in the facility. Appropriate food transport equipment or another approach to maintaining safe temperatures for food at special events can help *minimize the risk of* foodborne illness. waterborne illness. Ice must be made from potable water. Ice that is used to cool food items (e.g., ice in a pan used to cool milk cartons) is not to be used for consumption. Keeping the ice machine clean and sanitary will help prevent contamination of the ice. Contamination risks associated with ice and water handling practices may include, but are not limited to:

Ice chests or coolers used to store and transport ice should be cleaned regularly, especially prior to use and when contaminated or visibly soiled.

F813 Personal Food Policy

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.

GUIDANCE §483.60(i)(3)

The facility must have a policy regarding food brought to residents by family and other visitors. The policy must also include ensuring facility staff assists the resident in accessing and consuming the food, if the resident is not able to do so on his or her own. The facility also is responsible for storing food brought in by family or visitors in a way that is either separate or easily distinguishable from facility food.

The facility has a responsibility to help family and visitors understand safe food handling practices (such as safe cooling/reheating processes, hot/cold holding temperatures, preventing cross contamination, hand hygiene, etc.). If the facility is assisting family or visitors with reheating or other preparation activities, facility staff must use safe food handling practices.

F838 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 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:

§483.70(e)(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;

(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.

INTENT

The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.



DEFINITIONS §483.70(e) *“Competency” is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully.*

Although not required, facility staff are strongly encouraged to seek input from the resident/family council, residents, their representative(s), or families and incorporate that information as appropriate when formulating their assessment.

F840 Use of Outside Resources

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

F842 Resident Records/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.

F880 Infection Prevention and Control

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.

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;

The Infection Prevention and Control Program must include the following parts:

- *A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that:*



Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; Is based on the individual facility assessment; Follows accepted national standards;

F907- Space and Equipment

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 *assessment and* plan of care.

INTENT

The intent of this regulation is to ensure that dining, health services, recreation, activities and programs areas are large enough to comfortably accommodate the needs of the residents who usually occupy this space.

Dining, health services, recreation, and program areas should be large enough to comfortably accommodate the persons who usually occupy that space, including the wheelchairs, walkers, and other ambulating aids used by the many residents who require more than standard movement spaces. "**Sufficient space**" means the resident can access the area, it is not functionally off-limits, and the resident's functioning is not restricted once access to the space is gained.

Program areas where resident groups engage in activities focused on manipulative skills and hand-eye coordination should have sufficient space for storage of their supplies and "works in progress."

Program areas where residents receive physical therapy should have sufficient space and equipment to meet the needs of the resident's therapy requirement.

"**Recreation/activities area**" means any area where residents can participate in those activities identified in their plan of care.

F920 Requirement for Dining in Activities Rooms

Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities.

These rooms must-§483.90(h)(1) Be well lighted;

- §483.90(h)(2) Be well ventilated;
- §483.90(h)(3) Be adequately furnished; and
- §483.90(h)(4) Have sufficient space to accommodate all activities.