

Federal Requirements of Participation for Nursing Homes

Issued September 2016

Summary of Key Changes in the Rule - Part II

On September 28, 2016, the Centers for Medicare & Medicaid Services (CMS) issued updated federal nursing home regulations (Requirements of Participation for Long-Term Care Facilities). This is the first comprehensive revision to the regulations since they were issued in 1991. The updated rule (also referred to as the “final rule”) is being implemented in three phases: Phase 1 - November 28, 2016, Phase 2 - November 28, 2017, and Phase 3 - November 28, 2019.

This is the second of two summary sheets designed to provide an overview of key changes in regulations. This summary presents the sections on Resident Assessment (§483.20) – Training Requirements (§483.95). The purpose of the summary is to highlight what is different (new or modified) between the prior rule and the final rule. Only those requirements that go into effect in Phase 1 are included.

§483.20 RESIDENT ASSESSMENT

MODIFIED

(b)(1) Resident assessment instrument. The facility must now assess a resident's strengths, goals, life history, and preferences, in addition to the resident's needs.

MODIFIED

(1)(xvi) Discharge “potential” is changed to “planning.”

NEW

(e) Coordination

(1) The recommendations for the PASARR level II determination and the PASARR evaluation report must be incorporated into the resident's assessment, care planning, and transitions of care.

(2) When there is a significant change in status assessment, Level II residents and residents with a newly evident or possible serious mental disorder, intellectual disability or related condition must be referred for Level II review.

(k) Preadmission screening for individuals with a mental disorder and individuals with intellectual disability

MODIFIED

The term “mental illness” is replaced by “mental disorder.”

NEW

(2)(i) & (ii) This language provides exceptions to the preadmission screening for individuals with a mental disorder and individuals with intellectual disability for admission or readmission into a nursing facility under certain circumstances. It was inadvertently omitted when the regulation was initially written.

NEW

(4) The facility must notify the state mental health authority or state intellectual disability authority when there has been a significant change in the resident's physical or mental condition so that a resident review can be conducted. This language was inadvertently omitted when the regulation was initially written.

§483.21 COMPREHENSIVE PERSON-CENTERED CARE PLANNING

Care planning was formerly located under Resident Assessment and is now its own section.

(b) Comprehensive care plans

MODIFIED

(1) The facility is specifically required to implement, not just develop, the care plan, which must be person-centered and consistent with residents' rights for planning and implementing care.

NEW

(1)(iii) In addition to other elements, the care plan must describe any specialized services or specialized rehabilitative services the facility will provide as a result of PASARR recommendations.

NEW

(1)(iv) In consultation with the resident and the resident representative, the care plan must also describe:

- The resident's goals for admission and desired outcomes
- The resident's preference and potential for discharge. The facility must document if the resident wishes to return to the community and any referrals it has made to the local contact agency and/or other entities.
- Discharge plans

MODIFIED

(2)(ii) The interdisciplinary team that develops the care plan must also include:

- A CNA with responsibility for the resident
- A member of the food and nutrition services staff
- Other appropriate professionals, as well as staff, in disciplines based not only on the resident's needs, but also as requested by the resident

MODIFIED

(2)(iii) The regulation replaces "qualified persons" with the "interdisciplinary team" and clarifies that "assessment" means both the comprehensive and quarterly review assessments.

(c) Discharge planning

NEW

(1) Discharge planning process. The facility must develop and implement a discharge planning process that:

- Focuses on the resident's discharge goals; prepares the resident to actively engage in the discharge process; and reduces factors leading to preventable readmissions
- Ensures a discharge plan is developed for each resident based on the resident's discharge needs
- Addresses resident's goals of care and treatment preferences
- Involves the interdisciplinary team
- Considers caregiver/support person availability, capacity, and capability to perform required care
- Involves the resident and resident representative in creating the discharge plan
- Documents that residents have been asked about receiving information regarding returning to the community
 - If the resident is interested in returning to the community, the facility must
 - Document any referrals to local contact agencies or other entities
 - Revise the care plan and discharge plan to reflect information received from referrals
 - If discharge to the community is determined to not be feasible, the facility must document who made the determination and why
- Assists residents who are being transferred to a post-acute care setting (home health agency, long term care hospital, inpatient rehabilitation facility, another skilled nursing facility) with using data to select the provider. The facility must ensure that residents and their resident representatives receive a range of data, including quality measure and resource use data, geared to the goals and preferences of the resident
- Ensures the evaluation of the resident's discharge needs and the discharge plan are documented, included in the resident's record, and discussed with the resident or resident representative
- Regularly re-evaluates residents to identify changes requiring the plan to be revised
- Informs the resident and resident representative of the final plan

MODIFIED

(2) Discharge summary. The required contents of the discharge summary have been expanded to include:

- Diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results in the recapitulation of the resident's stay
- Reconciliation of all pre-discharge medications with the resident's post-discharge medications
- Details about where the resident plans to live, arrangements for follow-up care, and the medical/non-medical services to be provided following discharge.

§483.24 QUALITY OF LIFE

New language has been added at the beginning of this section stating that quality of life is a fundamental principle that applies to all care and services provided to residents. In addition, language about providing the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being, formerly under Quality of Care, has been moved here.

Activities of daily living

This section on activities of daily living used to be under Quality of Care.

MODIFIED

(a) The care and services to be provided must now be consistent with the resident's needs and choices as well as being based on the comprehensive assessment and care plan.

The regulation has been expanded to say that the facility must provide the necessary care and services to ensure there is no decline.

NEW

(3) For the first time, the rule explicitly states that a resident must be given basic life support, including CPR, prior to the arrival of emergency medical personnel if this is consistent with physician orders and the resident's advance directives.

MODIFIED

(b) Activities of daily living

The activities of daily living have been renamed and expanded in some instances. They include:

Hygiene – bathing, dressing, grooming, and oral care. Oral care has been added.

Mobility – transfer and ambulation, including walking. Walking has been added.

Elimination – toileting

Dining – eating, including meals and snacks

Communication – speech, language, and other functional communication systems

(c) Activities

MODIFIED

(1) The ongoing program must:

- Be based on the care plan and preferences of each resident, in addition to the resident assessment
- Support residents in their choice of activities
- Consist of facility-sponsored group activities, facility-sponsored individual activities, and independent activities
- Be designed to support the physical, mental, and psychosocial well-being of each resident as well as to meet the resident's interests
- Encourage independence and interaction in the community

MODIFIED

(2)(ii)(B) One of the two required years of experience must be in a therapeutic activities program instead of a patient activities program in a healthcare setting.

§483.25 QUALITY OF CARE

NEW

New language has been added at the beginning of the section stating that quality of care is a fundamental principle that applies to all care and services provided to residents (almost identical to the language for Quality of Life). In addition, treatment and care must now be provided in accordance with professional standards, the resident's choices, and the person-centered care plan, as well as the comprehensive assessment.

Language requiring the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident has been eliminated. "Each" resident has been replaced by "residents."

(b) Skin integrity

This section was formerly called "Pressure sores." The term "pressure ulcers" has replaced "pressure sores."

MODIFIED

(1)(i) The regulation has been amended by deleting language about entering the facility without pressure sores and adding language stating that a resident must receive care consistent with professional standards of practice to prevent pressure ulcers.

MODIFIED

(1)(ii) Treatment and services must now be consistent with professional standards of practice.

(2) Foot care

Foot care was previously located under Quality of Care - Special Needs.

MODIFIED

The regulation has been expanded to mandate that residents must receive treatment and care to maintain mobility and good foot health.

NEW

(2)(i) Care and treatment must comply with professional standards of practice and prevent complications from the resident's medical condition.

NEW

(2)(ii) The facility must assist residents in making appointments for foot care and arranging for transportation to and from the appointments.

(c) Mobility

MODIFIED

The prior rule only covered range of motion. The revised regulations refer to mobility, which encompasses range of motion, transfer, and ambulation, including walking.

NEW

(3) The facility must also ensure that a resident with limited mobility receives services, equipment, and assistance to maintain or improve mobility, unless reduced mobility is unavoidable based on the resident's clinical condition.

(e) Incontinence

MODIFIED

"Urinary Incontinence" in the previous regulations has been changed to "Incontinence" and now incorporates fecal incontinence.

NEW

(1) The facility must ensure that a resident who is continent of bladder and bowel upon admission receives services and assistance to remain continent, unless his or her clinical condition makes continence no longer possible to maintain.

NEW

(2)(ii) If a resident has an indwelling catheter upon admission or receives one after admission, the facility must assess the resident for removal of the catheter, unless the resident's clinical condition indicates that catheterization is necessary.

NEW

(3) A resident who is incontinent of bowel must receive treatment and services to restore as much normal bowel function as possible.

MODIFIED

(f) Colostomy, urostomy, or ileostomy care

Colostomy, urostomy (previously called ureterostomy) and ileostomy were formerly located under Quality of Care - Special Needs.

Care must be provided consistent with professional standards of practice, the comprehensive person-centered plan, and the residents' goals and preferences.

(g) Assisted nutrition and hydration

MODIFIED

This was formerly three separate provisions - Nutrition, Hydration, and Naso-gastric Tubes. It now includes: naso-gastric and gastrostomy tubes, percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids. Enteral fluids had previously been under Quality of Care – Special Needs.

MODIFIED

(1) Examples of acceptable parameters of nutritional status have been changed from "body weight and protein levels" to "usual body weight or desirable body weight range and electrolyte balance."

Resident preferences have been added as a factor that may prevent maintenance of the resident's acceptable parameters of nutritional status.

MODIFIED

(2) The language has been revised from "The facility must provide each resident with sufficient fluid" to "the facility must ensure that a resident is offered sufficient fluid."

MODIFIED

(3) The facility must now ensure that the resident is offered a therapeutic diet instead of ensuring that the resident receives a therapeutic diet. The rule also specifically states that the therapeutic diet must be ordered by a health care provider.

MODIFIED

(4) The term "naso-gastric tube" is replaced by "enteral methods" and later by "enteral feeding."

The standard for enteral feeding has been amended. The new language states that a resident can only be fed by enteral methods if the resident's clinical condition demonstrates that it is clinically indicated and the resident consents.

MODIFIED

(5) The language has been modified in the following ways:

- Use of the term "enteral" has replaced "naso-gastric tube" as noted in (4)
- "Normal" eating skills has been changed to "oral" eating skills
- Preventing "complications of enteral feeding" has been added and such complications are no longer limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers

(h) Parenteral fluids

MODIFIED

Parenteral fluids was previously located under Quality of Care – Special Needs.

This provision has been expanded to require that parenteral fluids be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

MODIFIED**(i) Respiratory care, including tracheostomy care and tracheal suctioning**

This requirement was formerly located under Quality of Care – Special Needs.

The revised regulation combines tracheostomy care and tracheal suctioning under respiratory care. It mandates that respiratory care be consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences, and the requirements for specialized rehabilitative services.

(j) Prostheses

This requirement was previously located under Quality of Care – Special Needs.

MODIFIED

This provision has been enhanced. The facility must ensure that a resident with a prosthesis receives care and assistance to wear and use the prosthesis. The care and assistance must be consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

NEW**(k) Pain management**

Services for pain management must be provided if required and be consistent with professional standards of practice, the resident's comprehensive person-centered care plan, and the resident's goals and preferences.

NEW**(l) Dialysis**

Services must be provided if dialysis is necessary and be consistent with professional standards of practice, the resident's comprehensive person-centered care plan, and the resident's goals and preferences.

NEW**(n) Bed rails**

This is the first time language about bed rails is included in the regulations (side rails had been discussed in the interpretive guidelines only).

Prior to installing bed or side rails, the facility must try to use alternative methods.

The facility is responsible for correctly installing, using and maintaining the bed or side rails if used. This includes:

- Assessing the resident for risk of entrapment before installing bed rails
- Obtaining informed consent from the resident or resident representative
- Checking the bed's dimensions to ensure they are appropriate for resident size and weight
- Following manufacturer's recommendations and specifications for installation and maintenance

§483.30 PHYSICIAN SERVICES

NEW

A physician, physician assistant, nurse practitioner or clinical nurse specialist must now provide orders for the resident's immediate care and needs.

NEW

(e)(2) & (e)(3) The regulations have been broadened to permit a resident's attending physician to delegate the writing of:

- Dietary orders to a qualified dietitian or other clinically qualified nutrition professional
- Therapy orders to a qualified therapist

The qualified dietitian or other clinically qualified nutrition professional and qualified therapist must be:

- Acting within the scope of practice defined by state law
- Under the supervision of the physician

§483.35 NURSING SERVICES

The final rule does not include a minimum staffing standard (such as a requirement for at least 4.1 hours of direct care nursing per resident day), nor a registered nurse on duty 24 hours a day.

Note: In Phase 2 the rule will mandate that there be sufficient staff with appropriate competencies and skill sets as determined by resident assessments and individual plans of care and taking into consideration the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. This is new language.

MODIFIED

(a)(1)(ii) Nurse aides are explicitly included as "other nursing personnel."

NEW

(3) Licensed nurses must have the specific competencies and skill sets necessary to care for residents' needs as identified through resident assessments and care plans.

NEW

(4) "Providing care" is defined for the first time. It includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans, and responding to resident's needs.

The prior regulations pertaining to proficiency of nurse aides, hiring and use of nurse aides, non-permanent employees, minimum competency, registry verification, required retraining, and part of regular in-service education have been moved into this section. They used to be located under Administration.

§483.40 BEHAVIORAL HEALTH SERVICES

NEW

Behavioral health has been added as a new section to the regulations. However, only the provisions identified below go into effect in Phase 1.

MODIFIED

(b)(1) The requirement now applies to residents diagnosed with mental disorder or psychosocial adjustment difficulty and is no longer limited just to individuals who display a mental disorder or psychosocial adjustment difficulty. Language has also been broadened to add that attaining the resident's highest practicable mental and psychosocial well-being can also be a goal of treatment and services.

MODIFIED

(b)(2) The regulation has been expanded to include residents who do not have a diagnosis of mental or psychosocial adjustment difficulty.

Note: Both (b)(1) & (b)(2) were previously located under Quality of Care – Mental and Psychosocial Functioning

(d) The requirement for medically related social services, formerly under Quality of Life – Social Services, has been moved under Behavioral Health. The language is unchanged.

§483.45 PHARMACY SERVICES

NEW

(c)(3) The rule creates a new, broader category of “psychotropic drugs” which is defined as any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include not only antipsychotics, but also:

- Anti-depressants
- Anti-anxiety medications
- Hypnotics

MODIFIED

(4) The pharmacist must now also report irregularities to the facility's medical director.

NEW

(4)(i)-(iii) Requirements related to irregularities have been significantly expanded.

- Irregularities include, but are not limited to, drugs that meet the criteria of an unnecessary drug defined at (d).
- Irregularities must be documented on a separate written report and sent to the attending physician, the medical director, and director of nursing. The report must indicate at least the resident's name, the relevant drug, and the irregularity identified by the pharmacist.
- The attending physician must document his or her review of the pharmacist's report, any change in medication to address the irregularity, or the rationale for not making changes.

NEW

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review. Policies and procedures must include time frames for the steps in the process and what the pharmacist must do when he or she identifies an irregularity that requires urgent action to protect the resident.

(d) Requirements for Unnecessary Drugs have been moved here from the Quality of Care section in the prior rule. The language is unchanged.

§483.50 LABORATORY, RADIOLOGY AND OTHER DIAGNOSTIC SERVICES

This section was previously two different sections – Laboratory Services and Radiology and Other Diagnostic Services – located under Administration.

MODIFIED

(a)(2)(i) & (b)(2)(i) The health care professionals who can order laboratory, radiology, and other diagnostic services have been revised and expanded. The rule eliminates the requirement that the physician who orders the service must be the attending physician and permits services to be ordered by physician assistants, nurse practitioners, or clinical nurse specialists in accordance with state law, including scope of practice laws.

MODIFIED

(a)(2)(ii) & (b)(2)(ii) The health care professional to be notified and what they are notified about has been changed. The facility must now notify the “ordering” physician, physician assistant, nurse practitioner, or clinical nurse specialist, rather than just the attending physician.

In addition, instead of notifying the ordering practitioner of “findings,” the facility must notify the practitioner of results that fall outside of clinical reference ranges in accordance with either facility policies or procedures for notification or the ordering practitioner’s orders.

§483.55 DENTAL SERVICES

MODIFIED

(a)(4) & (b)(2) The facility must assist a resident with transportation if requested by the resident, not just if necessary.

NEW

(b)(5) For Medicaid only, the facility must assist residents who are eligible to apply for reimbursement of dental services as an incurred medical expense under the Medicaid state plan.

§483.60 FOOD AND NUTRITION SERVICES

MODIFIED

This section was formerly Dietary Services.

Each resident's diet must now take into consideration his/her preferences.

(a) Staffing

MODIFIED

(1)(i)-(iii) A clinically qualified nutrition professional can serve in place of a qualified dietitian.

The requirements for a qualified dietitian or clinically qualified nutrition professional have been revised. To qualify a person must:

- Hold a bachelor's degree or higher in nutrition or dietetics
- Have completed at least 900 hours of supervised dietetics practice
- Be licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. If the state does not provide licensure or certification, the person must be a "registered dietitian" recognized by the Commission on Dietetic Registration or meet the first two requirements listed above.

NEW

(1)(iv) Dietitians hired or contracted with prior to November 28, 2016 have up to 5 years to meet the requirements listed in (i)-(iii) or must meet requirements under state law.

NEW

(2)(i)-(ii) The rule establishes qualifications that the director of food and nutrition services must meet. This person must:

- Be a certified dietary manager; or
- Be a certified food service manager; or
- Be nationally certified for food service management and safety by a national certifying body; or
- Have an associate's degree or higher in food service management or hospitality and meet state requirements if they exist

Individuals designated as director of food and nutrition services before November 28, 2016 have up to 5 years to meet these requirements; those designated after November 28, 2016 have up to 1 year.

MODIFIED

(2)(iii) A person qualifying to serve as the director of food and nutrition services by having an associate's degree or higher in food service management or hospitality and meeting state requirements if they exist must also receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

NEW

(b) A member of the food and nutrition services staff is required to be part of the interdisciplinary team responsible for care planning.

(c) Menus and nutritional adequacy

MODIFIED

(1) Menus must now meet the nutritional needs of residents in accordance with established national guidelines instead of meeting the dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

NEW

(4)-(7) Menus must:

- Reflect the religious, cultural, and ethnic needs of the resident population and input from residents and resident groups
- Be updated periodically
- Be reviewed by the dietitian or other clinically qualified nutrition professional for nutritional adequacy

The resident's right to make personal dietary choices is not limited by any of these requirements.

MODIFIED

(d) Food and drink

"Drink" has been added.

MODIFIED

(2) "Safe and appetizing temperature" replaces "proper temperature." Drink, as well as food, must meet this requirement.

NEW

(4) The facility must provide food that accommodates resident allergies, intolerances, and preferences.

MODIFIED

(5) "Substitutes" are replaced by "Appealing options of similar nutritive value."

Residents "who refuse food served" are now referred to as residents "who choose not to eat food that is initially served or who request a different meal choice."

NEW

(6) The facility must provide drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.

(e) Therapeutic diets

NEW

(2) The attending physician may delegate writing orders about the resident's diet, including a therapeutic diet, to a registered or licensed dietitian to the extent allowed by state law.

(f) Frequency of meals

MODIFIED

(1) The times when meals must be served have been modified so that meals can also be served at times in accordance with resident needs, preferences, requests, and the plan of care – not just at times comparable to meals in the community.

NEW

(3) The facility must provide suitable, nourishing alternative meals and snacks to residents who want to eat at non-traditional times or outside of scheduled meal service times. The requirement to offer a bedtime snack has been removed.

(g) Assistive devices**MODIFIED**

In addition to providing assistive devices, the facility must now also help residents with using them when eating meals or snacks.

(h) Paid feeding assistants**MODIFIED**

(2)(ii) Feeding assistants must still call a supervisory nurse for help when there is an emergency, but no longer have to use the resident call system.

MODIFIED

(3)(iii) Resident selection has been changed to be based on the interdisciplinary team's assessment instead of the charge nurse's assessment. The resident's care plan should also indicate that the resident is appropriate for assistance.

(i) Food safety requirements

This was formerly referred to as Sanitary Conditions.

NEW

(1)(i)-(iii) The facility can now:

- Procure food directly from local producers
- Use food grown in facility gardens
- Permit residents to eat food not procured by the facility

MODIFIED

(2) "Under sanitary conditions" is replaced with "in accordance with professional standards for professional food safety."

NEW

(3) The facility must have a policy about using and storing food brought to residents by family and other visitors.

§483.65 SPECIALIZED REHABILITATIVE SERVICES**MODIFIED****(a) Provision of services**

Respiratory therapy has been added as a specialized rehabilitative service.

MODIFIED

(2) If the facility obtains specialized rehabilitative services from an outside provider, the provider cannot be excluded from any federal or state health care program. (Note: Federal health care programs include Medicare and Medicaid. Exclusions include having been convicted of crimes such as abuse/neglect and health care fraud.)

§483.70 ADMINISTRATION

(c) Relationship to other HHS regulations

MODIFIED

Non-discrimination on the basis of sex and compliance with HIPPA regulations have been added. Consequences of violations have been revised to a possible finding of non-compliance.

Governing body

NEW

(d)(2)(iii) The administrator must now report to and be accountable to the governing body.

(i) Medical records

MODIFIED

"Clinical records" are now referred to as "medical records."

MODIFIED

(2)(i) The rule explicitly states that confidential information in records can be released to the resident representative where permitted by applicable law.

MODIFIED

(2)(iii) The regulations revise and expand the situations under which confidential information can be released to encompass treatment, payment, or health care operations if in compliance with HIPPA regulations.

NEW

(2)(iv) A new set of circumstances under which confidential information in records can be released has been added. These relate in large part to protective and health reasons and include: public health activities; reporting of abuse, neglect or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donation purposes; research purposes; coroners; medical examiners; funeral directors; and to avert a serious threat to health or safety.

MODIFIED

(5)(iv) The medical records must also include resident review evaluations and determinations.

MODIFIED

(5)(v) The rule specifies which health care professionals must document progress notes in a resident's medical record. These include physicians, nurses, and other licensed professionals.

NEW

(5)(vi) The rule adds laboratory, radiology, and other diagnostic services reports to the list of what must be contained in a resident's records.

Hospital transfers

MODIFIED

(j)(1)(i) The regulation now also addresses transfer to the hospital in emergency situations and not just planned transfers. In an emergency, a practitioner other than the resident's attending physician - consistent with facility policy and state law - can determine if a transfer to a hospital is medically appropriate.

MODIFIED

(1)(ii) Language has been changed from "less expensive setting" to "less restrictive setting" and information to be exchanged between providers has been revised to include information to determine if the resident can be reintegrated into the community.

(n) Binding arbitration

NEW

While this new requirement was to go into effective in Phase 1, an injunction issued by a U.S. District Court halts implementation of this part of the rule until the lawsuit brought by the American Health Care Association and other plaintiffs is settled.

(p) Social Worker

MODIFIED

(1) A person with a bachelor's degree in gerontology is now also eligible to be a qualified social worker. The rule specifies that these qualifications are a minimum.

§483.75 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

(g) Quality assessment and assurance (QAA)

MODIFIED

(1) Revisions clarify that the members of the QAA committee called for in the requirements are only a minimum requirement.

The number and type of individuals required to serve on the QAA committee have been amended in the following ways:

- The medical director or his or her designee is required rather than a physician designated by the facility.
- One of the three members of the facility's staff serving on the committee must be the administrator, the owner, a board member, or other individual in a leadership role.

(h) Disclosure of information & (i) Sanctions

Both these provisions go into effect in Phase 1, but they are not new requirements, and the language is unchanged.

§483.80 INFECTION CONTROL

MODIFIED

Infection control has been broadened to include infection prevention as well as control and to clarify that the program must help prevent the development and transmission of communicable diseases in addition to infection.

(a) Infection prevention and control program

NEW

The facility must establish a combined infection prevention and control program (IPCP).

NEW

(2) The IPCP must include written standards, policies, and procedures. This is the first time that written policies are mandated. These standards/policies/procedures must include certain elements. Some of the required elements are new, while others are revisions of previous requirements.

NEW

Elements that are NEW:

- Surveillance designed to identify possible communicable disease or infections before they can spread
- Reporting requirements for possible incidents of communicable disease or infections

MODIFIED

Elements that have been MODIFIED:

- Facilities had been required to use isolation to prevent the spread of infections. Now they must have policies/procedures that state what standard and transmission-based precautions are to be followed to prevent the spread of infections and identify the circumstances in which isolation should be used for a resident. A new provision says that facilities should use the least restrictive amount of isolation possible.
- Instead of prohibiting all employees with any communicable disease or infected skin lesions from direct contact with residents or their food, facility policies/procedures must indicate the circumstances under which direct employee contact will be prohibited.
- The regulations no longer refer to hand washing. Instead, staff must follow "hand hygiene procedures" that include, but are not limited to, hand-rubbing with an alcohol-based hand rub or handwashing with soap and water.

MODIFIED

(4) The IPCP must include a formal system for recording incidents identified under the facility's IPCP and corrective actions taken by the facility.

(d) Influenza and pneumococcal immunizations

This provision was formerly located under Quality of Care.

The revised regulations do not include the former provision that a second pneumococcal immunization could be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

(f) Annual Review

NEW

Facilities must review their IPCP annually and update the program as necessary.

§483.90 PHYSICAL ENVIRONMENT

(c) Space and equipment

MODIFIED

(1) Living areas have been added to the list of areas in the facility that must have sufficient space and equipment, and the facility must consider each resident's assessment, as well as his/her care plan, when determining the space and equipment needed in the facility.

MODIFIED

(2) The word "essential" has been deleted so that the facility is required to maintain all mechanical, electrical, and patient care equipment, not just "essential" equipment.

NEW

(3) Facilities must conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program. Facilities must also ensure that bed rails are compatible with the bed frame and mattress if the bed rails and mattresses are used and purchased separately from the bed frame.

Resident rooms

MODIFIED

(e)(1)(i) Facilities that have approved plans for construction or reconstruction or are certified for the first time after November 28, 2016 must accommodate no more than 2 residents instead of 4.

MODIFIED

(2)(i) The resident's bed must be a safe, as well as convenient, size and height.

(f) Bathroom facilities

These were formerly called Toilet Facilities.

MODIFIED

Facilities that have approved plans for construction or are certified for the first time after November 28, 2016 must equip each resident room with its own bathroom that has at least a commode and sink.

MODIFIED

(g) Resident call system

Resident calls no longer have to be routed to the nurse's station. The facility must have a communication system that allows residents to send a call for assistance directly to a staff person or to a centralized staff work area.

Rooms for dining and activities

MODIFIED

(h)(2) Rooms for resident dining and activities no longer have to have non-smoking areas identified.

§483.95 TRAINING REQUIREMENTS

This is a new section that includes some nurse aide training requirements from the prior rule.

NEW

(c) Abuse, neglect, and exploitation

Training must be provided that, at a minimum, covers:

- Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property
- Reporting procedures
- Dementia management and resident abuse prevention

NEW

(g) Required in-service training for nurse aides (1) & (4)

Both these provisions go into effect in Phase 1, but they are not new requirements, and the language is unchanged.

(2) In-service training must now include dementia management and resident abuse prevention.