Quick Reference Guide:

Phase 3 F-Tag Compliance

PharMerica® NADONA

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Phase 3 F-Tag Compliance

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2022 Guidance for Resident Rights; Freedom from Abuse, Neglect and Exploitation; Admission, Transfer & Discharge; and Administrative: Binding Arbitration Agreements

Regulations	F-Tag	Title	Updates to Appendix PP
483.10 Resident Rights	**F557**	Respect, Dignity, Right to Have Personal Property	• Consent for searches of a resident or personal possessions from the resident and/or resident representative • Requirement for staff knowledge of the signs, symptoms, and triggers for possible substance use; changes in behavior, drowsiness, coordination, speech, mood or consciousness • Referrals to law enforcement
	F561	Self-Determination	• Smoking policy language re-inserted: Unintentionally deleted with implementation of Phase 2 • Prohibition of smoking: Guidance on changing from a smoking to non-smoking facility
	F563	Right to Receive/ Deny Visitors	• Denying access with history of illegal substances • Visitation during outbreaks and/or visitor illness • Signs, symptoms, and triggers of substance use after visitations • Referral to law enforcement • Staff searches
	F578	Request/Refuse/ Discontinue Treatment; Formulate Adv. Directives	• This update is only a "Technical" modification • The modification updated the tag reference under the "Key Elements of Non-compliance"

	F582	Medicare/Medicaid Coverage/Liability Notice	• Revised language based on changes to Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (Form CMS-10055)
			• Clarification regarding:
			  • 2018 the ABN form was revised
			  • Previous guidance did not align with the Medicare claims
			  • Processing Manual, so revisions were made
			  • The NOMNC (Notice of Medicare Non-coverage) form had been simplified
			  • Previous guidance lacked clarity and parts were unnecessary

Regulations	F-Tag	Title	Updates to Appendix PP

483.12 Freedom from Abuse, Neglect, and Exploitation	**F600**	Abuse/Neglect	**Abuse**
			• Past noncompliance
			• Thoroughly review to determine facility took all appropriate steps
			  • Prevent potential
			  • Reporting requirements
			  • Thorough investigation
			  • Appropriate corrective action
			  • Revisions to the plan of care as needed
			• Through review, make note of the substantial compliance date
			Neglect
			• Indifference or disregard for resident care, comfort or safety, resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress
			• Noncompliance at Quality of Care does not always result in neglect
			• Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them to the resident, resulting in, or may result in, physical harm, pain, mental anguish or, emotional distress
			Abuse/Neglect
			• Abuse Template/Neglect Template: identification patterning of type and perpetrator
			• Based on (observations/interviews/record review), the facility failed to protect the resident's(s') right to be free from (Type(s) of abuse: mental abuse / verbal abuse / physical abuse / sexual abuse / deprivation of goods and services) by (Perpetrator type: staff / a resident / a visitor) …
			• Based on (observations / interview / record review), the facility failed to protect the resident's(s') right to be free from neglect….
			Neglect Key Changes (Examples)
			• Goal to have failures in systems reported and actions taken to avoid a continuation
			• Neglect (Example):
			  • Repeated lapses in care that result in the development of an avoidable Stage 3 or 4
			  • Example of expected reporting opportunity

	F602	Misappropriation/ Exploitation	• Theft of personal property, such as jewelry • Unauthorized or coerced purchases on a resident's credit card • Missing prescription medications
	F603	Involuntary Seclusion	Technical changes only to update references inside Appendix P

Regulations	F-Tag	Title	Updates to Appendix PP
	F604	Physical Restraints	• When a bed rail is considered a restraint • It keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently
	F605	Chemical Restraints	• Technical change: only to update references inside Appendix P
	F606	Not Employ Staff with Adverse Action	• Technical change: revised intent to match the regulation text
	F607	Abuse Policies	• Policy must include coordination with QAPI • Outline how information is shared with the committee to oversee facility processes in determining when systemic actions are necessary • Will be used for citations related to the failure to develop and implement written policies and procedures related to posting of conspicuous notice of employee rights, and prohibiting and preventing retaliation
	F608	Reporting of Suspected Crimes	Has been deleted and should no longer be referenced. The prior requirement has now been divided into (2) specific tags: **F607** • Referenced for citation with failure to develop and implement written policies and procedures related to posting of conspicuous notice of employee rights, and prohibiting and preventing retaliation **F609** • Referenced for citation with failure to ensure the reporting of suspected crimes and notifying covered individuals of their reporting responsibilities
	F609	Reporting of Suspected Crimes	• Reporting of suspected crimes and reporting alleged violations is now under the same regulatory referenced category • There is revised standardized language for surveyors to use when citing, specifically, the failure of reporting of suspected crimes • Based on (observation / interview / record review), the facility failed to develop and / or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act....

Regulations	F-Tag	Title	Updates to Appendix PP

	F609	Reporting of Suspected Crimes (Cont.)	• Policies and procedures should address:
			  • Orientation to staff on reporting requirements and ensuring covered individuals are notified/educated at least annually of their responsibility in a language they understand
			  • Identifying and removing barriers to reporting promoting a culture of transparency
			  • Working with law enforcement annually to learn which crimes are reported
			  • Providing periodic drills across all shifts / levels to assure covered individuals understand the reporting requirements
			• Surveyors are required to confirm both the policy and the procedure for reporting
			• Failure to report, even in the presence of a policy, is failure to implement
			• If or when situations arise in which the covered entity has not complied with reporting reasonable suspicion of a crime or there is not a way for the surveyor to validate, consult with the State Agency Supervisor for potential reporting
			• There are no changes in regulation related to the reporting of alleged violations of abuse, neglect, and exploitation
			  • CMS did add examples of each type
			  • Additionally, interpretive guidance for resident to resident supports what must be reported and, in some instances, describes what would not need to be reported
			
			Key Changes
			• Injuries of unknown source (when ALL the following are met):
			  • The source of the injury was not observed by any person; and
			  • The source of the injury could not be explained by the residents; and
			  • The injury is suspicious because of:
			  • The extent of the injury
			  • The location of the injury (not generally vulnerable to trauma)
			  • The number of injuries observed at one particular time, or
			  • The incidence of injuries over time

		Reporting Alleged Violations	

<table>
<tr><th>Regulations</th><th>F-Tag</th><th>Title</th><th>Updates to Appendix PP</th></tr>
<tr><td></td><td>F609</td><td>Reporting of Suspected Crimes (Cont.)

Reporting Alleged Violations (Cont.)

Clarification of the Initial and Investigation Reports</td><td>Key Changes (Cont.)
• Injuries of unknown source (examples of unobserved or unexplained):
  • Skin tears on places other than the arms or legs
  • Symmetrical skin tears on both arms
  • Patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object
  • Bilateral bruising of the inner thighs, and warp around bruises that encircle the legs, arms or torso
  • Facial injuries including facial fractures, black eye(s), bruising or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth

<table><tr><th>INITIAL REPORT</th><th>INVESTIGATION REPORT</th></tr><tr><td>Basic facility information
Allegation type
Date facility aware
Alleged victim and perpetrator
Witness(es)
Details regarding allegation
Outcome on alleged victim
Notifications made (i.e., Police)
Steps immediately taken to protect
Who is submitting</td><td>Additional outcomes
Resident Representative
Reporting to other agencies
Steps taken to investigate
Resident record
Summary of all documents
Conclusion
Corrective actions
Who investigated
Who is submitting</td></tr></table></td></tr>
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Regulations	F-Tag	Title	Updates to Appendix PP

483.15 Admission, Transfer, and Discharge	**F622**	Transfer and Discharge Requirements	**Discharge from short-term rehabilitation:**
			• Not based only on payment source
			• Facility vs resident initiated
			
			Guidance clarified for situations involving:
			• Medicare ends/resident still needs care
			• Offered options for payment (assistance with Medicaid application or private pay)
			  • Explained that, if denied, will be responsible to pay
			  • If eligible and no beds (facility is only Medicare certified), will be discharged to facility with available beds
			  • Cannot be discharged for nonpayment while Medicaid application is pending
			
			Emergency Transfers:
			  • When residents transfer to acute care, they are generally expected to return
			  • If discharge initiates while in the hospital, this must be based on current conditions when resident seeks return
			  • Document the danger that permitting resident to return would pose
			• There is a resident right to appeal and return while this is pending unless the return would endanger the health or safety of the resident or other individuals in the facility
			• New deficiency categorization examples added:
			• Example that reflects how a discharge to another skilled nursing facility, when completed in violation of Federal regulation, can create actual (psychosocial and physical) and potential harm

	F623	Notice Requirements before Transfer and Discharge	• For facility-initiated transfers or discharges of a resident, *prior to the transfer or discharge,* the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing
			• Clarified exemptions to the 30 notices:
			  • The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;
			  • The resident's health improves sufficiently to allow a more immediate transfer or discharge;
			  • An immediate transfer or discharge is required by the resident's urgent medical needs; or
			  • A resident has not resided in the facility for 30 days

Regulations	F-Tag	Title	Updates to Appendix PP

	F626	Permitting Residents to Return to the Facility	• Clarified requirement to permit residents to return after hospitalization or therapeutic leave, regardless of payment source
			• A deficiency categorization example was added to reflect actual harm
			• Language was provided in the investigative procedures section to advise surveyors to investigate situations when a facility does not permit a resident to return:
			  • Due to lack of bed
			  • Inability to meet needs

	F622, F623, F626	Against Medical Advice Discharges	• Language was added to address against medical advice discharges • These situations may be facility initiated • Guidance directs surveyors to thoroughly investigate to ensure compliance • Investigations should review to determine if force, pressure or intimidation is/was evident
483.70 Administration: Binding Arbitration Agreements	**F847**	Binding Arbitration Agreement	**There are 5 key components for a facility to comply:** • Cannot require to sign as a condition of admission • Must explain the agreement in a form and manner that is understood • The agreement must state there is a right to rescind within 30 days after signing • Agreement must state it is not required for admission or to receive care • The agreement may not contain language to prohibit or discourage communication with federal, state or officials, including the State Long-Term Care Ombudsman
	F848	Arbitrator/Venue Selection and Retention of Agreements	**There are 2 key components:** • Must provide the selection of a neutral arbitrator agreed upon by the facility and resident and/or resident representative and the selection of a venue that is convenient to both parties • A copy must be retained of the signed agreement for binding arbitration for 5 years after a resolved dispute

Regulations	F-Tag	Title	Updates to Appendix PP
	F851	Mandatory Submission of Staffing Information Based on Payroll Data in Uniform Format (key changes)	• Requirement for facilities that surveyors must survey to • Surveyors will be able to obtain PBJ data prior to the recertification survey **Revised Guidance at F851** • Surveyors can obtain PBJ data from the Certification and Survey • Provider Enhanced Reports (CASPER) • This will allow surveyors to determine facility submission • The failure of the facility to submit will be reflected on the CASPER report and result in a deficiency citation

Reference: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf

2022 Guidance for Quality of Life and Quality of Care

Regulations	F-Tag	Title	Updates to Appendix PP
§483.24 Quality of Life	**F675**	Quality of Life	• Updated Quality of Life definition from Institute of Medicine (IOM). • Noncompliance, which reflects a pervasive disregard for one or more residents' quality of life, must be carefully considered for the impact to the resident(s) affected. For concerns which may rise to the level of Immediate Jeopardy, refer to Appendix Q.
	F676	ADLs Maintaining Abilities	No Change
	F677	ADL Care/ Dependent Residents	No Change
	F678	CPR	No Change
	F679	Activities Meet Interest & Needs of Resident	• Opportunities for each resident to have a meaningful life may be created by supporting his/her domains of well-being as identified by the Eden Alternative philosophy of care: • Domains of Care: Identity; Connectedness; Security; Autonomy; Meaning; Growth; Joy
	F680	Qualification of Activity Professional	No Change
§483.25 Quality of Care	**F684**	Quality of Care	No Change
	F685	TX & Devices to Maintain Hearing & Vision	No Change

	F686	TX & Services to Prevent/Heal Pressure Ulcers	• Update: to determine if PI or PU = based on staging.
			• Update: definition of Pressure Ulcer/Injury (PU/PI)
			• Update: PU/PI treatment/services to prevent infection and prevent additional PU/PI from developing.
			  • PU/PI risk assessment timing: on admission, weekly x 4 weeks after admission, quarterly and as needed.
			  • Investigative protocol and deficiency categorization.

Regulations	F-Tag	Title	Updates to Appendix PP
	F687	Foot Care	• Update: Ensure foot care is provided by trained staff and within their scope of practice. • Update: Staff must follow proper infection prevention practices for foot care equipment/devices and clean and dirty equipment must be kept separated
	F688	Increase/Prevent Decrease in ROM/Mobility	No Change

	F689	Free of Accident/ Hazards/Supervision/ Devices	• **Update: Electronic Cigarettes**
			  • Because these devices are not without risk and have accidents associated with them, facilities have a responsibility to oversee their use and provide supervision to maintain an accident-free environment.
			  • Facilities that decide, in accordance with state and local laws, to allow e-cigarette use should develop and implement policies for safe use of e-cigarettes, along with policies for traditional cigarettes. Policies should include where e-cigarettes can be used and how to handle the devices, batteries, and refill cartridges.
			• **Update: Added staff training and interventions**
			  • For residents with mental and psychosocial disorders and substance use disorder (SUD).
			• **Update: Wandering**
			  • A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.

Regulations	F-Tag	Title	Updates to Appendix PP

	F689	Free of Accident/ Hazards/Supervision/ Devices (Cont.)	• **Update: Residents with SUD and Leaving the Facility**
			  • Assess the risk for leaving the facility without notification and/or overdose and care plan interventions should be implemented to ensure the safety of all residents.
			  • A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts.
			  • A resident who leaves the facility prior to his or her planned discharge, but with facility knowledge of the departure and despite facility efforts to explain the risks of leaving, would be leaving against medical advice (AMA). Documentation in the medical record should show that facility staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA. Documentation should also identify the time the facility became aware of the resident leaving the facility.
			
			• **Update: Residents with SUD**
			  • Ensure comprehensive care plan explains risk, interventions, referral services, etc.
			  • Facility staff should be prepared to initiate emergency services (CPR, administer an opioid reversal agent) in the event of an overdose.

	F690	B&B Incontinent/Catheter UTI	• **Update**
			  • Focus on restoring bowel incontinence
			  • Removing a urinary catheter as soon as possible when the resident's condition demonstrates the catheter is no longer needed.

Regulations	F-Tag	Title	Updates to Appendix PP
	F691	Colostomy/Urostomy/ Ileostomy Care	• This tag is currently missing from the final Appendix PP. This may be either an accident or intentional. Unsure as of now.
	F692	Nutrition/Hydration	No Change
	F693	Tube Feeding/Restore Eating	No Change

	F694	Parental Fluids/IV Fluids	• Added the definition of an IV.
			• Use of appropriate antiseptic (e.g., chlorhexidine, povidone iodine, an iodophor, or 70 percent alcohol, which is recommended in CDC guidelines) to scrub IV ports, needleless connectors, and hubs prior to access or use.
			• Frequency of assessment of IV catheter to assess the insertion site for signs and symptoms of infection or inflammation (i.e., at least daily or with each use). Frequency may depend upon such factors as the:
			  • Ability of resident to report symptoms of pain, redness, etc.
			  • Type of infusion: is it an irritant or vesicant?
			  • Location of IV catheter: is it inserted in an area of flexion?
			  • Facility policy based on long-term care pharmacy IV policies and procedures
			• Assessment of continued need for the catheter if not being used for IV fluids or medications.

	F695	Respiratory, Tracheostomy Care & Suctioning	No Change
	F696	Prosthesis	No Change

Regulations	F-Tag	Title	Updates to Appendix PP

	F697	Pain Management	• Added the definition of Medication Assisted Treatment (MAT) and Opioid Use Disorder (OUD)
			  • MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders (from the Substance Abuse and Mental Health Services Administration (SAMHSA)).
			  • Opioid Use Disorder is a problematic pattern of opioid use leading to clinically significant impairment or distress. Additional criteria used to assess and diagnose OUD can be found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
			• Added language regarding use of opioids within the current opioid crisis and to align with the efforts of other government agencies
			• Recommend use of CDC resources on use of opioids for chronic pain
			• Facilities should assess residents for history of past addiction and related treatment and employ strategies to address pain for residents with history of opioid use disorder
			• Guidance describes side effects of opioids and addresses prevention of opioid overdoses by administering naloxone
			• Language regarding the use of opioids:
			  • Use the lowest possible effective dose for the shortest amount of time.
			  • Monitor for effectiveness and any adverse effects.
			  • In residents with dementia, immediate release forms of opioids are generally preferred over long-acting to reduce overdose risk.
			  • Avoid combining opioids and benzodiazepines due to risk of fatal respiratory depression, falls and hip fractures, cognitive impairment/confusion, daytime fatigue, and delirium.
			  • If combo is clinically indicated, make sure monitoring for adverse consequences is documented.
			  • If used in end of life, palliative, or hospice care, must be consistent with accepted standards of practice.
			  • Consider an OUD or addiction history when treating pain in a resident with an addiction history.

Regulations	F-Tag	Title	Updates to Appendix PP

	F697	Pain Management (Cont.)	• Resources provided:
			  • https://jamanetwork.con/journals/jamanetworkopen/fullarticle/2685628
			  • https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids
			  • https://geriatricpain.org
			  • https://www.cdc.gov/drugoverdose/prescribing/duideline.html
			• Added the following under an assessment of pain; may necessitate gathering the following information, as applicable to the resident:
			• New Bullet – History of addiction, past and/or ongoing, and related treatment for OUD
			• Added to Bullet: Current medical conditions and medications, including medication assisted treatment for OUD
			• Added the following under monitoring, reassessment, and care plan revision:
			  • Additionally, a facility should evaluate whether there is a time or day pattern to a resident's reports or signs of increased pain to ensure that the problem is not due to drug diversion
			  • Side effects to monitor for:
			  • Tolerance, meaning more medication may be needed to achieve the same level of pain relief
			  • Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed
			  • Increased sensitivity to pain
			  • Constipation
			  • Nausea, vomiting, and dry mouth
			  • Sleepiness, dizziness, and/or confusion
			  • Depression
			  • Itching and sweating

Regulations	F-Tag	Title	Updates to Appendix PP

	F697	Pain Management (Cont.)	• **Naloxone – Use in Opioid Overdose Death**
			  • Naloxone Administration
			  • If the person overdosing does not respond within 2-3 minutes after administering a dose of naloxone, administer a second dose of naloxone.
			  • Naloxone can be given as an intranasal spray and IM, SQ, or IV injection.
			  • The goal should be to restore adequate spontaneous breathing, but not necessarily complete arousal.
			  • Withdrawal triggered by naloxone may include agitation or confusion.
			  • The safety profile of naloxone is remarkably high.
			  • Provide training on assembly and administration of Naloxone kits that include a syringe and naloxone ampules or vials.
			  • The nasal spray is prefilled, needle-free and requires no assembly.
			  • The auto-injector is injected into the outer thigh to deliver naloxone to the muscle or under the skin.
			  • Both the nasal spray and auto-injector are packaged in a carton containing 2 doses to allow for repeat dosing if needed.
			  • Fentanyl and fentanyl analogs have higher potency than heroin and may require more doses of naloxone.

	F698	Dialysis	No Change

Regulations	F-Tag	Title	Updates to Appendix PP

	F699	Trauma Informed Care	• **New:**
			  • Focuses on developing care approaches to ensure that facilities deliver care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent and account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.
			  • Definitions related to trauma and culture.
			  • Staff training on trauma and cultural competency.
			  • Resident assessments and care planning to address past trauma and cultural preferences.
			
			• **Non-Compliance**
			  • Failure to do one of the following:
			  • Identify cultural preferences of residents who are trauma survivors.
			  • Identify a resident's past history of trauma, and/or triggers which may cause re-traumatization.
			  • Consistently use approaches that are culturally competent and/or are trauma informed.

	F700	Bedrails	• After a facility has first attempted to use appropriate alternatives to bed rails and determined that these alternatives do not meet the resident's needs, the facility must assess the resident for the risks of entrapment and review possible risks and benefits of bed rails prior to installation or use. • Resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. • Alternatives must be attempted and may include roll guards, foam bumpers, lowering the bed, and using concave mattresses that can help reduce rolling off the bed.

2022 Guidance for Quality of Life, Physician Services, Pharmacy Services, Infection Control, and Nurse Aide Training

Regulations	F-Tag	Title	Updates to Appendix PP
§483.24 Quality of Life	**F675**	Quality of Life	• Technical corrections made to address grammar and update references. • Removed language that suggested surveyors automatically cite F675 at an Immediate Jeopardy level (IJ). • Added language that directed surveyors to carefully consider the impact to the resident(s) affected by a pervasive disregard for Quality of Life. • Referred surveyors to Appendix Q for any concerns that may rise to the IJ level.

§483.30 Physician Services	**F712**	Physician Visits – Frequency, Timeliness/ Alternate NPPS	• Table 1 on page 446 & 447 was changed for easier use.
			  • Previously, column 2 contained both columns 2 & 3. Divided to provide user ease, but content unchanged.
			  • Column 4 had orders added to each row for clarity.
			  • Column 6, line 2 added language permitting state laws to impact ability to sign Certs and Recerts.
			Level 2 non-compliance example was updated
			  • "The facility failed to ensure the physician personally conducted an initial comprehensive visit within the first 30 days after admission, for a resident under a Medicare Part A stay."
			Skilled Nursing Facility (SNF)
			  • Physician is required to personally conduct the initial visit and cannot delegate that task to a non-physician clinician.
			Nursing Facility (NF)
			  • In this setting, the physician is allowed to delegate the initial visit to a non-physician clinician.

Regulations	F-Tag	Title	Updates to Appendix PP
§ 483.45 Pharmacy Services	**F755**	Pharmacy Services/ Procedures/ Pharmacist/ Records	Clarified language related to the disposal of fentanyl patches: • Dispositioning this drug product must include a step to ensure residual drug is irretrievable – ensure patches are not disposed of in common areas or resident room trash cans or sharps containers. • The Food and Drug Administration instructions to fold used patch and flush down toilet are not always appropriate for nursing homes. • EPA does not currently ban flushing of pharmaceuticals (unless considered hazardous; fentanyl patches are not classified as hazardous), but state and local laws may restrict flushing. • May use drug disposal systems if they can show the system minimizes accidental exposure and diversion. • Destruction of fentanyl patches should ALWAYS be recorded in writing, attested to, and witnessed by at least 2 qualified and designated facility personnel.

	F757	Unnecessary Medications	• Guidance for psychotropic medication use has been expanded to include other medications which affect brain activity.
			• Gradual Dose Reductions (GDRs) must occur in modest increments over an adequate period of time.
			• Psychosocial harm evaluation.
			  • Requires evaluation of resident's side effects of medication, including sedation, lethargy, agitation, mental status changes, or behavior changes that:
			  ▪ Affect resident abilities to perform activities of daily living or interact with others
			  ▪ Cause resident to withdraw or decline usual social patterns
			  ▪ Show resident has decreased engagement in activities, and/or
			  • Cause diminished ability to think or concentrate

Regulations	F-Tag	Title	Updates to Appendix PP

	F 758	Psychotropic Drugs	Misdiagnosis Related to Antipsychotics
			• Guidance added for situations where prescribers have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (new diagnosis of schizophrenia), thereby excluding the resident from the long-stay antipsychotic quality measure.
			• Documentation must be present to confirm diagnosed condition.
			• If surveyors determine there is a potential misdiagnosis, they should consider investigating:
			  • If the facility completed an assessment which accurately reflects the resident's status (§483.20(g); F641)
			  • If the practitioner's diagnosing practices meet professional standards (483.21(b)(3)(i); F658)
			• F 881 with F757 &F758 Implications
			  • F881 Requirement: System to monitor antibiotic use and resistance, for example:
			  • -Medical record reviews
			  • -Laboratory tests
			  • -Prescription documentation
			  • -Outcome metrics
			• F757/F758 Implications:
			  • Note added that directs the survey team to consider whether a facility is compliant with F881. If the team has found evidence of unnecessary antibiotic use, the unnecessary antibiotic use could indicate that a facility is not implementing part or all of its antibiotic stewardship program, which entails using protocols that utilize an infection assessment tool, monitoring of antibiotic use, or feedback and education to prescribing providers.

§ 483.80 Infection Control	**F880**	Infection Prevention & Control	• Water Management
			  • Must demonstrate how it protects the residents by minimizing the risk of Legionella and other waterborne (opportunistic) pathogens.
			  • One way to do this is with a documented water management plan (n*ot the emergency water supply*).
			  • Must use nationally accepted standards such as ASHRAE, CDC, EPA to minimize this risk.
			  • CDC website has a resource: "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings - A PRACTICAL GUIDE TO IMPLEMENTING INDUSTRY STANDARDS" (https://www.cdc.gov/legionella/wmp/toolkit/index.html)

Regulations	F-Tag	Title	Updates to Appendix PP

§ 483.80 Infection Control	**F880**	Infection Prevention & Control (Cont.)	• Surveyors are to determine through interview or documentation:
			  • Assessment of the building water system
			  • Identification of where waterborne pathogens could grow and spread
			  • If there are measures (control measures) in place to prevent the growth of waterborne pathogens
			  • How the facility will monitor them
			  • Have there been interventions established if the control limits have not been met
			  • Were there any cases of legionellosis diagnosed since the last survey?
			  • If there was a case identified, did the facility implement adequate prevention and control measures? What actions were taken?

	F881	Antibiotic Stewardship	• Feedback to the provider
			  • Feedback to the provider regarding antibiotic resistance data, their antibiotic use, and their compliance with facility antibiotic use protocols is now recommended instead of required.
			  • This is recommended to improve prescribing practices and resident outcomes.
			  • It no longer is a component of compliance.
			• ASP Sampling and Tag Clarification
			  • If a surveyor is concerned with the Antibiotic Stewardship program (ASP):
			  ▪ Include 1 resident on an antibiotic in the sample.
			  ▪ Determine if resident(s) are being prescribed antibiotics inappropriately.
			  ▪ Determine if there is any negative outcome/adverse event.
			  • If unnecessary antibiotics are found, cite F757.
			  • If Antibiotic Stewardship Plan (ASP) is not evident or is not being implemented, F881 should be cited.

	F882	Infection Preventionist	• This tag states that the IP is responsible for assessing, developing, implementing, monitoring, and managing the Infection Prevention & Control Program (IPCP). • This, however, is a team effort comprised of the medical director, consulting pharmacist, administrative and clinical leadership, and other nursing home staff. • Ultimately, the IP is responsible to ensure that the program meets the regulatory requirements. • At least one IP needs to be designated for this role

Regulations	F-Tag	Title	Updates to Appendix PP

	F882	Infection Preventionist (Cont.)	• Who can be an IP?
			  ▪ IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or another related field.
			  ▪ Must provide documentation of the IP's primary professional training:
			  ▪ A professionally-trained nurse must have earned a certificate/diploma or degree in nursing.
			  ▪ A medical technologist must have documentation of an associate's degree or higher in medical technology or clinical lab science.
			  ▪ A microbiologist or epidemiologist must have documentation of a bachelor's degree (or higher) in microbiology or epidemiology.
			  ▪ Physicians, pharmacists, and physician's assistants can also be an IP with supporting documentation.
			• Additional qualifications
			  ▪ The IP must be qualified by education, training, experience, or certification.
			• The IP must:
			  ▪ Work part time at the facility
			  ▪ Physically work onsite in the facility
			  ▪ Cannot be an off-site consultant
			• Cannot perform the IP work at a separate location such as a corporate office or affiliated short-term acute care facility
			• No set number of hours
			  ▪ Determined by the facility assessment
			  ▪ Census and resident population should be taken into consideration
			  ▪ Have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA.
			• Surveyors will determine through interviews if the IP has adequate time to perform the role and where the work is performed.
			• Be a member of the QAA committee and report on the IPCP on a regular basis.

Regulations	F-Tag	Title	Updates to Appendix PP

	F882	Infection Preventionist (Cont.)	• Specialized training beyond initial professional training.
			  • CMS recommends specialized training include the following topics:
			  ▪ Infection prevention and control program overview
			  ▪ The infection preventionist's role
			  ▪ Infection surveillance
			  ▪ Outbreaks
			  ▪ Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment)
			  ▪ Principles of transmission-based precautions
			  ▪ Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing)
			  ▪ Water management
			  ▪ Linen management
			  ▪ Preventing respiratory infections (e.g., influenza, pneumonia)
			  ▪ Tuberculosis prevention
			  ▪ Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions)
			  ▪ Quality assurance and performance improvement
			  ▪ Antibiotic stewardship
			  ▪ Care transitions
			  • Facility must provide evidence of completion of the specialized training

Regulations	F-Tag	Title	Updates to Appendix PP
	F883	Immunizations (Influenza & Pneumococcal)	• Updated the language on the Advisory Committee on Immunizations Practices (ACIP) in regard to recommendations on the use of PCV13. • It is no longer routinely recommended for all adults 65 or older. • Shared clinical decision-making for PCV13 use is recommended for these individuals who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and who have not previously received PCV13. • Facilities must follow the ACIP recommendations for immunizations. • Surveyors should review medical records to ensure ACIP updated recommendations are being followed. • See Survey Task Form (Clinical Pathway for Infection Prevention) www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforlawsAndRegulations/Nursing-Homes Select Survey Resources with Staff Vaccine Documents 10/4/2022.

§483.95 Training Requirements	**F945**	Infection Control Training	• Training
			  ◦ Formal training
			  ◦ Documented and tracked (maintain all training material and attendance records):
			  ▪ Learning objectives
			  ▪ Performance standards
			  ▪ Evaluation criteria
			  ▪ Addresses potential risks to residents, staff, and volunteers if procedures are not followed
			  ▪ There should be a process in place to track staff participation in and understanding of the required training (competencies)
			• Who needs this training?
			  ◦ All facility staff
			  ◦ Staff under contract
			  ◦ Volunteers
			• Minimum training areas (must be included)
			• Facility surveillance to identify possible communicable disease or infections before they can spread
			• When required, incidents of communicable disease/infection in the facility should be reported, and to whom

Regulations	F-Tag	Title	Updates to Appendix PP

§483.95 Training Requirements	**F945**	Infection Control Training (Cont.)	• How and when to use precautions
			  • Standard
			  ▪ Hand Hygiene
			  ▪ Environmental cleaning and disinfection practices
			  • Transmission-based
			  ▪ Type
			  ▪ Duration
			• Occupational health policies, including those related to staff self-reporting of illness or exposure to potentially infectious materials and enforcement of work restrictions
			• Proper infection prevention and control practices when performing resident care activities as it pertains to particular staff roles, responsibilities, and situations
			• Training program to be based on changes to:
			  • The facility assessment
			  • The resident population
			  • The physical environment
			  • National infection prevention and control standards
			  • Community risk levels
			  • Staff turnover
			  • Current outbreaks (Monkeypox, Covid, etc.)
			• Citation at F945
			  • May be issued if surveyors observe staff with poor infection control practices that could indicate staff did not receive training about the identified concern.
			  • Issue may be identified through interviews with residents/resident representatives.
			  • Surveyors to review training program materials if content:
			  ▪ Meets professional standards
			• Addresses the facility's policies and procedures

	F947	Training Requirements for nurse aides	• Mandates that all facilities:
			  • Develop
			  • Implement
			  • Permanently maintain an inservice training program for nurse aides

Regulations	F-Tag	Title	Updates to Appendix PP

	F947	Training Requirements for nurse aides (Cont.)	• The program must be appropriate and effective as determined:
			  • By nurse aide performance reviews (address weaknesses)
			  • The facility assessment
			• When able, each nurse aide should be evaluated based on individual performance.
			• Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.
			• Include dementia management training and resident abuse prevention training.
			• Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.
			• The care of the cognitively impaired.
			• Under Procedures & Probes: (page 827)
			  • See list of questions that the surveyor will explore to determine if training is an issue.
			  • Example:
			  ▪ Were nurse aides observed working with residents in a manner that indicates a training need?
			  ▪ Did interviews with residents and/or resident representatives indicate any areas where training was needed?
			  ▪ What type of training do the nurse aides report receiving about the concern identified by the surveyor?

Regulations	F-Tag	Title	Updates to Appendix PP

§483.60 Food and Nutrition Services	**F-812**	Food Procurement, Store/Prepare/Service-Sanitary (Cont.)	• Critical Steps: Food & Nutrition Services
			  • Step 1:
			  • Resident record reviews and interviews
			  • Validate diet order, preferences, food satisfaction survey, care plan, MDS, modified diet, and adaptive equipment needs
			  • Direct observations of food storage, food preparation, PPE use, food distribution, temperatures and infection control practices (ensure residents/staff hand hygiene before/after meals)
			  • Step 2:
			  • Review your current training
			  • Review staff competencies and training (conduct frequent observation of staff)
			  • Step 3:
			  • Create a Performance Improvement Project (PIP) and review in the Quality Assurance Performance Improvement Committee.
			  • Conduct a gap analysis and create a plan for implementation.
			  • Ensure compliance and utilize the survey pathway tools located in the Appendix PP.

2022 Guidance for QAPI, Compliance and Ethics Program, Physical Environment, and Nursing Services

Regulation	F-Tag	Title	Updates to Appendix PP

§483.35 Nursing Services	**F 725**	Sufficient Nursing Staff	• Instructs surveyors to access the PBJ Staffing Data Report and use it to identify sufficient nursing staff concerns
			• Surveyors will investigate using the Sufficient and Competent Staffing Critical Element Pathway and updated probes
			  • Deficiency cite would be due to failure of the following:
			  ▪ Ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each **resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care.**
			  ▪ Ensure licensed nurse coverage 24 hours a day, except when waived.
			  ▪ Ensure a licensed nurse is designated to serve as a charge nurse on each tour of duty, except when waived.
			  • **Severity Level 1 does not apply for this regulatory requirement.**

	F726	Competent Nurse Staff	No changes

	F 727	RN 8 Hours/7 Days/Week, Full-Time Director of Nursing (DON)	• Updated Language from SOM Appendix PP
			  • "Charge Nurse" is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison as well as direct resident care.
			  • Nurse staffing in nursing homes has a substantial impact on the quality of care and outcomes that residents experience. A registered nurse (RN) is typically responsible for overseeing the care provided to nursing home residents by other staff such as licensed nurses.
			  • Practical Nurses (LPN) or Certified Nurse Aides (CNA). The RN is generally responsible for more advanced care activities such as resident assessments, consulting with physicians, and administering intravenous fluids or medications.
			• Instructs surveyors to access the PBJ Staffing Data Report and use it to determine whether facilities have an RN onsite each day.
			  • Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week. However, per facility assessment requirements at F838, §483.70(e), facilities are expected to identify when they may require the services of an RN for more than 8 hours a day based on the acuity level of the resident population.
			  • If it is determined the services of an RN are required for more than 8 hours a day, surveyors are to refer to the guidance at F725 related to sufficient nurse staffing for further investigation.
			  • Facilities may choose to have differing tours of duty (e.g., 8 hour or 12-hour shifts) for their licensed nursing staff. Regardless of the approach, the facility is responsible for ensuring the 8 hours worked by the **RN are consecutive within each 24-hour period.**

Regulations	F-Tag	Title	Updates to Appendix PP
	F 727	RN 8 Hours/7 Days/Week, Full-Time Director of Nursing (DON) (Cont.)	• **Note:** Due to the way the report is structured, CMS training documents carry over previous guidance that facilities that report the absence for an RN for 4 or more days in a quarter will be cited at F727. **However, this is not included in the Draft Appendix PP guidance, and CMS notes that it expects the surveyors will consider issuing a citation "when a minimum of one day is identified to not meet the nurse staffing requirements for both a Registered Nurse and licensed nursing staff."**

	F 729	Nurse Aide Registry Verification, Retraining	• Updates the survey procedure to instruct surveyors to review at least 5 nurse aide personnel files if concerns are identified with nurse aide services at F725 and F726 (Competent Nurse Staff), including any specific staff members with whom concerns were identified.
			  • Review the nurse aide personnel folder to determine if the facility received registry verification that the individual has met competency evaluation requirements before the employee's start date unless an exception applies as noted in §483.35(d)(4).
			  • Review the nurse aide personnel folder to determine if the facility verified information from every state registry that the facility believes will include information concerning that individual before the employee's start date. **If records reveal a nurse aide has not provided nursing related services for monetary compensation over a 24-month period, did the individual complete a new training and competency evaluation program?**

§483.35 Nursing Services (Cont.)	**F 732**	Posted Nurse Staffing Information	• Adds new survey procedures and probes, requiring surveyors to use observations and record reviews to ensure compliance.
			  • The facility posts the following information on a daily basis at the beginning of each shift:
			  ▪ Facility name
			  ▪ The current date
			  ▪ The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides
			  ▪ Resident census
			  • The data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors
			  • The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard
			  • The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater
			• Also added a new key element of noncompliance: failure to make daily staffing available to the public upon request.

Regulations	F-Tag	Title	Updates to Appendix PP

		Management of Nursing Services Suggestions	• Audit, Audit, Audit.
			  • Audit personnel files
			  • Audit competencies
			  • Recommend you review your PBJ data each pay period, which is easier than quarterly
			• Be sure you have a system to complete competencies not only annually and with new hires, but also with any performance concerns. Always do some spot audits for return demonstrations to assure competency in the particular process or task.
			• Enlist the assistance of the Administrator and/or others to review personnel files after hire as well as annually. Have a checklist of everything needed in the file and a second person checking the file. HR should not audit HR.
			• Be sure PBJ data is reviewed to assure no errors in times/hours are present. This could be done as a collaborative effort by Business Office, Administrator, HR, and DON.
			• Validate the Posting of Staffing Hours is being completed and updated each shift when indicated, 7 days a week. This could be a task of the Charge Nurse on each shift.

§483.85 Compliance and Ethics Program	**F895**.	Compliance and Ethics, Committee Definition	Compliance and Ethics Program:
			  • The operating organization of each facility must have a compliance and ethics program that has been reasonably designed, implemented, maintained, and enforced, so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care.
			  • It is important for the facility to consider their facility assessment developed according to §483.70(e) in identifying risk areas, developing and maintaining their compliance and ethics program, and determining resources needed for the program.
			  • The operating organization must have written standards, policies, and procedures for its compliance and ethics program, which include at a minimum:
			  • Designation of an appropriate compliance and ethics program contact to whom an individual can report suspected violations
			  • An alternate method of reporting suspected violations anonymously without fear of retribution
			  • Disciplinary standards that describe the consequences for committing violations for the entire staff
			  • The operating organization must assign specific individuals within the high-level personnel of the organization with the overall responsibility of overseeing adherence to the compliance and ethics program's standards, policies, and procedures.
			  • High-level personnel means individuals who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization. The individuals considered "high-level personnel" will differ according to each operating organization's structure. Some examples include, but are not limited to:

Regulations	F-Tag	Title	Updates to Appendix PP

	F895	Compliance and Ethics, Committee Definition (Cont.)	• Director
			• Executive officers including:
			  • Chief executive officer (CEO)
			  • Members of the board of directors
			  • Individual in charge of a major business or functional unit of the operating organization
			  • Individual with a substantial ownership interest in the operating organization, as defined in section 1124(a)(3) of the Act
			Specific individual(s) designated with oversight responsibility must have:
			• Sufficient Resources and Authority
			• Delegation of Substantial Discretionary Authority
			• Effectively Communicating Program Standards, Policies, and Procedures
			• Reasonable Steps to Achieve Program Compliance
			
			Compliance and Ethics Risk Areas
			• Common risk areas are mostly associated with the delivery of healthcare to nursing facility residents, including sufficient staffing, comprehensive care plans, medication management, infection prevention, appropriate use of psychotropic medications, and resident abuse, neglect, and safety.
			• Additional risk areas include, but are not limited to:
			• Resident rights
			• Fraud prevention
			• Billing and cost reporting
			• Employee screening
			• Resident assessment accuracy
			• Creation and retention of records
			• Falsification and modification of documentation
			• Conflicts of interest
			• Kickbacks
			• Inducements
			• Self-referrals
			Annual review
			• As an operating organization becomes aware of changes in laws and/or requirements, it should modify its program to ensure it is current with requirements.
			• The operating organization's performance in prior years should also be used to improve its program.
			• As an operating organization revises its program, it should ensure that those changes are communicated to its entire staff.

Regulations	F-Tag	Title	Updates to Appendix PP
§483.85 Compliance and Ethics Program	**F895.**	Compliance and Ethics, Committee Definition (Cont.)	• Designated Compliance Officer • **Operating organizations that operate 5 or more facilities** must designate a compliance officer for whom the compliance and ethics program is a major responsibility. • The operating organization should ensure that the assigned compliance officer has sufficient time and other resources to fulfill all his or her responsibilities under the operating organization's compliance and ethics program. • The compliance officer should be able to communicate with the governing body without being subject to any coercion or intimidation. This is to ensure that the compliance officer is not unduly influenced by other managers or executive officers, such as the general counsel, chief financial officer, or chief operating officer. • Designated Compliance Liaison: • A designated compliance liaison must be located at each of the operating organization's facilities. At a minimum, the facility-based liaison should be responsible for assisting the compliance officer with his or her duties under the operating organization's program at their individual facilities. (*This is required for an organization with 5 or more facilities)* • **Respond to Detected Violations: Such steps may include a corrective action plan, the return of overpayments, a report to the government, and/or a referral to criminal and/or civil law enforcement authorities. The steps will differ depending upon the size of the operating organization, the position of the individual reporting the violation, and the type of violation.** • Probes used by surveyors: • Does the operating organization have written standards, policies, and procedures for the compliance and ethics program that are reasonably capable of reducing the possibility of criminal, civil, and administrative violations under the Act? • Interview high-level personnel designated to oversee the organization's compliance and ethics program about their involvement in the program. Determine how the facility uses monitoring and auditing systems to detect criminal, civil, and administrative violations by staff, if they are aware of the potential violation under investigation, and what was their response. • Ask staff if they are aware of the facility's compliance and ethics program. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. Is there is a method for staff to anonymously report suspected violations? Are they confident in reporting compliance matters without fear of retaliation? Is training conducted?

Regulations	F-Tag	Title	Updates to Appendix PP

		Management of Compliance & Ethics	• Consider the key members of your committee. Examples Include:
			  • CEO
			  • Pharmacist
			  • Physician
			  • Attorney
			  • Medical Director
			  • Owner
			  • Board Member(s)
			  • Accountant
			  • Administrator
			  • DON
			  • Pastor
			  • Hospice
			  • Medical Director
			• Designate a Director or leader of the committee.
			• Use the Guidelines in the SOM Appendix PP to write your committee's Policies and Procedures.
			• Follow the Guidelines as listed for areas of focus.
			• Take meeting minutes and attendance at each meeting.
			• Review the facility assessment annually for focus changes.
			• Use the probes used by surveyors to review the processes required for Compliance and Ethics to assure compliance (listed above).

§483.90 (Physical Environment)	**F919**	Resident Call System	• Requires that residents be able to access the communication system from the bedside, the toilet, or bathing facilities and either directly call a staff member or call a centralized staff work area.
			  • The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from §483.90(g).
			  • Each resident's bedside and toilet and bathing facilities:
			  • The call system **must** be accessible to residents while in their bed or other sleeping accommodations within the resident's room
			  • The call system **must** be accessible to the resident at each toilet and bath or shower facility
			  • The call system **should** be accessible to a resident lying on the floor
			• In addition, CMS is making new recommendations, **but not requirements,** for resident rooms under §483.90. Currently, bedrooms in facilities that receive approval of construction or reconstruction plans by state and local authorities or are newly certified **after Nov. 28, 2016,** must accommodate no more than two residents, while older facilities can have up to four residents per room. **However, CMS is now "urging providers to consider making changes to their physical environment to allow for a maximum of double occupancy in each room," says the agency. "Additionally, we encourage facilities to explore ways in which they can allow for more single occupancy rooms for residents."**

Regulations	F-Tag	Title	Updates to Appendix PP

	F919	Resident Call System (Cont.)	• Survey probes for investigation:
			  • Is there a functioning communication system from rooms, at the bedside, toilets, and bathing facilities in which resident calls are received and answered by staff?
			  • Is the call system accessible **if the resident were lying on the floor?**
			  • If a resident has disabilities that make use of the facility's communication system inaccessible, are alternatives, auxiliary aids, or services available to meet this requirement and to meet the resident's needs as identified in the resident's assessment or plan of care?
			  • Residents and their representatives should be interviewed about whether calls are being answered
			  • Has the call system needed repair recently? If yes, ask:
			  • What did the facility do if the call system was not working?
			  • How many times was the call system non-functional/not operating?
			  • Were any needed repairs made in a timely manner?
			  • How long was the call system non-functional/not operating?
			  • Does the facility have a process to routinely ensure the call system for residents is operational?
			  • During a loss of power, will the resident call system be operational or is an alternate means of communicating with the staff put into place?

		Management of Resident Call System	• Audits of the call system as described in the probes (see above).
			• Consider how a resident will use call light if on floor:
			  • Do you purchase pendants?
			  • Whistles?
			  • Bells?
			  • Floor buzzer?
			  • Get a longer cord?
			  • Clip everyone's call light to their clothing so call light pulls out of wall if they fall to floor?
			  • What if they are walking in room and fall on the floor?
			  • How will they reach call light?
			  • What about residents who cannot use their call light due to dementia?
			  • What care is planned?
			• It is a surveyor probe to check for ability to use call light if on floor even though the current guidance says "Should" and not "must."

Regulations	F-Tag	Title	Updates to Appendix PP

§483.75 Quality Assurance and Performance Improvement QAPI	**F865**	QAPI Program/Plan, Disclosure/Good Faith Attempt
		QAPI Program/Plan, Disclosure/Good Faith Attempt
			• Overview of new requirements for the QAPI plan and program to ensure that nursing homes (including multi-unit chains) implement a comprehensive QAPI program that addresses all the care and unique services that a facility provides. Changes include the following:
			  • Adds definitions for governing body, indicators, QAPI, and QA.
			  • Details minimum program requirements, including the need to:
			  • Address all care and management systems.
			  • Include clinical care, quality of life, and resident choice concerns.
			  • Use the best available evidence to define measure indicators of quality and facility goals that reflect care processes and facility operations that are demonstrated to predict desired outcomes for residents.
			  • Reflect the complexities, unique care, and services that the facility provides.
			  • Defines governorship and leadership requirements for the program.
			  • Provides examples of when disclosure of information may be needed for surveyors to determine compliance.
			  • Instructs surveyors to use the QAPI and QAA review facility task plus the Appendix PP guidance to investigate concerns and determine compliance.
			  • Updates the facility elements of noncompliance.
			• QAPI Program Updated Language
			  • QAPI is a type of quality management program which takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. An interdisciplinary approach encompasses all managerial, and clinical, services, which includes care and services provided by outside (contracted or arranged) providers and suppliers.
			  • The purpose of a QAPI program is to ensure continuous evaluation of facility systems with the objectives of:
			  • Ensuring care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards where available
			  • Preventing deviation from care processes, to the extent possible
			  • Identifying issues and concerns with facility systems as well as opportunities for improvement
			  • Developing and implementing plans to correct and/or improve identified areas
			  • Program and Documentation: Each facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

Regulations	F-Tag	Title	Updates to Appendix PP

§483.75 Quality Assurance and Performance Improvement QAPI	**F865**	QAPI Program/Plan, Disclosure/Good Faith Attempt QAPI Program/Plan, Disclosure/Good Faith Attempt (Cont.)	• The facility must maintain and be able to provide documentation and evidence of its ongoing QAPI program, which meets the requirements of §483.75. Demonstration of compliance includes, but is not limited to:
			  • Evidence of systems and reports demonstrating identification, reporting, investigation, analysis, and prevention of adverse events
			  • Data collection and analysis at regular intervals
			  • Documentation demonstrating development, implementation, and evaluation of corrective actions or performance improvement activities
			• Program Design and Scope: Each facility must have a QAPI program that is ongoing, comprehensive, and capable of addressing the full range of care and services it provides. At a minimum, the program must:
			  • Address all systems of care and management practices
			  • Include clinical care, quality of life, and resident choice
			  • Utilize the best available evidence to define measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents
			  • Reflect the complexities, unique care and services that the facility provides
			• Effective QAPI programs address systems of care and management practices. Systems of care (or care delivery systems) are the processes in place to achieve an expected clinical outcome.
			• Nursing homes have many systems of care which intersect and involve multiple disciplines and departments. For example, the system for prevention of pressure ulcers also involves the system for ensuring adequate nutrition as well as the systems for identification of changes in condition and infection prevention.
			• In order to ensure all aspects of these systems of care occur consistently, accurately, timely, and with the intended outcome, an effective program includes methods for monitoring the systems.
			• In addition to systems of care, the facility should monitor important management practices such as resident finances and personal funds, admission and discharge practices, and other services that impact quality of life and resident rights.
			• The QAPI program should address quality of life and resident choice by identifying the unique needs and preferences of the varying demographics of residents residing in the facility (e.g., young and/or culturally diverse residents) and seeking ongoing input and feedback from their residents.
			• The governing body and/or executive leadership (or organized group or an individual who assumes full legal authority and responsibility for operation of the facility) must ensure the QAPI Program:
			  • Is defined, implemented, and ongoing
			  • Addresses identified priorities
			  • Is sustained through transitions in leadership and staffing

Regulations	F-Tag	Title	Updates to Appendix PP
§483.75 Quality Assurance and Performance Improvement QAPI	**F865**	QAPI Program/Plan, Disclosure/Good Faith Attempt QAPI Program/Plan, Disclosure/Good Faith Attempt (Cont.)	• Has adequate resources, including staff time, equipment, and technical training as needed • Uses performance indicator data, resident and staff input, and other information to identify and prioritize problems and opportunities • Implements corrective actions to address gaps in systems and evaluates actions for effectiveness • Establishes clear expectations around safety, quality, rights, choice, and respect • To the extent a facility's QAPI/QAA information is necessary to demonstrate the facility's compliance with the requirements of 42 CFR § 483.75, a facility is required under 42 CFR § 483.75(h) to disclose this information to the state agency and/or CMS. • Failure to do so can end in a deficiency under F865.
	F866	QAPI/QAA Data Collection and Monitoring	• Relocates the Requirements From this Tag into F867 (QAPI/QAA Improvement Activities)
	F867	QAPI/QAA Improvement Activities	• Adds requirements that address how a facility obtains feedback, collects data, monitors adverse events, identifies areas for improvement, prioritizes improvement activities, implements corrective and preventive actions, and conducts performance improvement projects. This includes the following: • Updates multiple definitions, including adverse event, high-risk areas, incidence, indicator, medical error, near miss, prevalence, systematic, and systemic. • Addresses the role of feedback as a data source. • Requires that the facility: • Collect and monitor data reflecting its performance. • Address how data will be identified as well as the frequency and methodology for collecting and using data from all departments. • Establish priorities for performance improvement activities that focus on resident safety, health outcomes, autonomy, choice, and quality of care as well as high-risk, high-volume, and/or problem-prone areas. • Have policies and procedures in place for developing, monitoring, and evaluating performance indicators, including how and with what frequency that will be done. • Have systems in place and implement actions to improve performance, including implementing corrective actions, measuring the success of these actions, and tracking their performance. This should include changes at the systems level to prevent quality of care, quality of life, or safety problems. • Develop and implement policies and procedures addressing the use of systematic approaches to assist in determining underlying causes of problems that impact larger systems (e.g., root cause analysis, reverse tracker methodology, or healthcare failure and effects analysis). • Track medical errors and adverse resident events, analyze the cause of identified errors or events, implement corrective actions, including the education of staff, residents, resident representatives, and family members, and monitor to ensure that the desired outcome has occurred and is maintained.

Regulations	F-Tag	Title	Updates to Appendix PP
	F867	QAPI/QAA Improvement Activities (Cont.)	• Conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. • **Instructs surveyors to use the QAPI and QAA review facility task plus the Appendix PP guidance to investigate concerns and determine compliance.** • Updated Language • Feedback • Data Collection Systems and Monitoring • Performance Indicators • Systemic Analysis and Action • Establishing Priorities • Medical Errors and Adverse Events • Performance Improvement Projects • Performance Improvement Projects (PIPs): The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified as a result of the facility assessment required at §483.70(e). • While the number and frequency of improvement projects may vary, each facility must conduct at least 1 improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. • QAA Committee and the Governing Body: Functioning under the facility's governing body, the QAA committee is responsible for reporting its activities, including the implementation of the QAPI program, to the governing body or designated person(s) functioning as the governing body. • *Note: Small facilities might not have a governing body; there may only be an administrator who is already a required member of the QAA committee, and therefore, already apprised of QAPI activities.* • **Surveyors should refer to the following when investigating concerns and citing noncompliance related to QAPI:** • F865: For concerns related to whether a facility has implemented and maintains a comprehensive QAPI program and plan, disclosure of records, and governance and leadership. • F867: For concerns related to how the facility obtains feedback, collects data, monitors adverse events, identifies areas for improvement, prioritizes improvement activities, implements corrective and preventive actions, and conducts performance improvement projects. • F868: For concerns related to the composition of the QAA committee, frequency of meetings, and reporting to the governing body.

Regulations	F-Tag	Title	Updates to Appendix PP

		Managing QAPI/QAA	• Administrator sets the stage for changing culture to one of quality, focus, and support.
			• ***Subcommittees are a must for continued review of concerns and audit results to the larger QA+A Committee and should involve all leadership on at least 1 subcommittee as well as other line staff members.
			• Policies and procedures need to delineate the QAPI process and adhere to them.
			• Do not study all things all the time. Once sustained, slowly reduce the timeframe to assure continued correction but it does not have to be monthly for all areas.
			• Use a checklist to ensure all areas needing review based on priority are covered.
			  • ****Instituting an ad hoc QAPI meeting to occur at the time of a serious or potentially serious event is a MUST.
			• FYI: Surveyors have indicated (*off the record*) they will look for 2 documents regarding QAPI to see if complete:
			  • A full agenda for each meeting with pertinent topics.
			  • A full attendance sheet to affirm those expected to be attending are signed in.

Training	**F726-F729**	Nursing Services	• Ensure the licensed nurses and other nursing personnel have the knowledge, competencies, and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan.
	F865 – F867	QAPI	• Institute effective systems to obtain and use feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high-risk, high-volume, or problem-prone, and opportunities for improvement. Provide education to all staff, visitors, residents, and resident representatives on the QAPI process.
	F940	General)	• Requires that facilities develop, implement, and maintain effective training programs for all new and existing staff (including contract workers and volunteers) as well as determine the amount and types of training necessary based on the facility assessment.
	F946	Compliance and Ethics Training	• Requires that each facility's operating organization (the individual or entity that operates the facility) provide a training program or another practical way to effectively communicate the standards, policies, and procedures of the compliance and ethics program to all staff. Facilities should track staff participation in the required trainings, and annual staff training must be conducted by operating organizations that operate 5 or more facilities
	F947	Nurse Aide Training	• Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. §483.95(g) • Include dementia management training and resident abuse prevention training. §483.95(g) • Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.

2022 Guidance for Behavioral Health Services and Food and Nutrition Services

Regulation	F-Tag	Title	Updates to Appendix PP

483.40 Behavioral Health Services	**F-740**	Behavioral Health Services	• Definitions Updated:
			  • "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. *Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.*
			  • "Substance use disorder" *("SUD")* is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, *and failure to meet major responsibilities at work, school, or home.*
			• Four Takeaways:
			  • Identify SUD population on your facility assessment (staffing ratios, training/competencies, services provided/offered to support).
			  • Review activities to meet the needs of individuals with SUD.
			  • Ensure documentation identifies SUD (MDS, care plan, interventions, assessment, behavior contracts. *Behavioral contracts should not punish or deprive the resident of goods/services (see abuse/neglect/exploitation.
			  • Ensure identified interventions are implemented (counseling services, increased monitoring, etc.)
			• Actions the Facility May Take if Substance Use is Suspected, Which May Include:
			  • Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use as well as all residents.
			  • Restricted or supervised visitation if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff (See F563 - Right to receive/deny visitors).
			  • Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition.
			  • Voluntary inspections if there is reasonable suspicion of possession of illegal drugs, weapons, or other unauthorized items which could endanger the resident or others (See F557- Respect, Dignity/Right to have Personal Property).
			  • Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia, or weapons. (See F557- Respect, Dignity/Right to have Personal Property).

Regulations	F-Tag	Title	Updates to Appendix PP

	F-741	Sufficient Competent Staff-Behavioral Health Needs	• Updated definitions:
			  • Mental disorder – See above
			  • Substance use disorder – See above
			  • Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening physical, social, emotional, or spiritual well-being.
			  • Post-traumatic stress disorder (PTSD) occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD.
			
			• The skills and competencies needed to care for residents should be identified through the facility assessment.
			  • The facility assessment must include an evaluation of the overall number of facility staff needed to ensure that a sufficient number of qualified staff are available to meet each resident's needs.
			  • The assessment should include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice.
			  • This also includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care identified.
			• Added examples of non-pharmacological interventions:
			  • Assisting the resident outdoors in the sunshine and fresh air (e.g. in a non-smoking area for a non-smoking resident)
			  • Providing access to pets or animals for the resident who enjoys pets (e.g. a cat for a resident who used to have a cat of their own)
			  • Assisting the resident to participate in activities that support their spiritual needs
			  • Assisting with the opportunity for meditation and associated physical activity (e.g. chair yoga)

Regulations	F-Tag	Title	Updates to Appendix PP

	F-741	Sufficient Competent Staff-Behavioral Health Needs (Cont.)	• Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him
			• Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing
			• Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible
			• Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem-solving therapy
			• Providing support with skills related to verbal de-escalation, coping skills, and stress management
			• Critical steps to take:
			  • Step 1:
			  • Determine your resident population. Who do you serve?
			  • Review resident assessments (PASARR, MDS, care plans, other…)
			  • Review your facility assessment and update as needed (to include population served, staffing needed and competencies to support the population)
			  • Step 2:
			  • Review your current programming
			  • Review your psychosocial-wellness programming, even if you are not a center who specializes in behavioral health
			  • Review the activity calendar and 1:1 activities to ensure activities meet the needs of all residents
			  • Request feedback from resident council, HOA meetings, and the resident council president
			  • Review staff competencies and training (specific diagnoses, cultural/ethnic factors to consider, interventions, crisis mitigation) and conduct frequent observation of staff

Regulations	F-Tag	Title	Updates to Appendix PP

	F-741	Sufficient Competent Staff-Behavioral Health Needs (Cont.)	• Step 3:
			  • Create a Performance Improvement Project (PIP) and review in the Quality Assurance
			  • Performance Improvement Committee.
			  • Conduct a gap analysis and create a plan for implementation
			  • Ensure compliance and utilize the survey pathway tools.

§483.60 Food and Nutrition Services	**F-812**	Food Procurement, Store/Prepare/Service-Sanitary	• Food and nutrition services states that the facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
			• **Food Procurement, Store/Prepare/Service - Sanitary Definition Updates**
			  • Food Distribution means the processes involved in getting food to the resident. This may include holding foods hot on the steam table or under refrigeration for cold temperature control, dispensing food portions for individual residents, family style and dining room service, or delivering meals to residents' rooms or dining areas, etc. When meals are assembled in the kitchen and then delivered to residents' rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart.
			  • Food Service means the processes involved in actively serving food to the resident. When actively serving residents in a dining room or outside a resident's room where trained staff are serving food/beverage choices directly from a mobile food cart or steam table, there is no need for food to be covered. However, food should be covered when traveling a distance (e.g., down a hallway, to a different unit or floor).
			• **Foodborne Illness and Critical Control Points (CCP) Evaluation**
			  • Effective food safety systems involve identifying hazards at specific points during food handling and preparation, and identifying how the hazards can be prevented, reduced, or eliminated. It is important to focus attention on the risks that are associated with foodborne illness by identifying critical control points (CCPs) in the food preparation processes that, if not controlled, might result in food safety hazards. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices

Regulations	F-Tag	Title	Updates to Appendix PP

§483.60 Food and Nutrition Services	**F-812**	Food Procurement, Store/Prepare/Service-Sanitary (Cont.)	• Web sites for additional information regarding safe food handling to minimize the potential for foodborne illness include:
			  • National Food Safety Information Network's Gateway to Government Food Safety Information at http://www.FoodSafety.gov
			  • United States Food & Drug Administration Food Code Web site at https://www.fda.gov/food/fda-food-code/food-code-2017
			
			• Sanitary Hairnets
			  • Hair Restraints/Jewelry/Nail Polish: According to the current standards of practice such as the Food Code of the FDA, food service staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.
			  • According to the Food Code, food service staff must wear hairnets when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.
			
			• Glove Use
			  • Glove Use: According to the Food Code, gloves are necessary when directly touching ready-to-eat food.
			  • Additionally, per infection control guidance, gloves are necessary when serving residents who are on transmission-based precautions (See F880 for additional information on transmission-based precautions).
			  • However, staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine, unless touching ready-to-eat food

Regulations	F-Tag	Title	Updates to Appendix PP

§483.60 Food and Nutrition Services	**F-812**	Food Procurement, Store/Prepare/Service-Sanitary (Cont.)	• Critical Steps: Food & Nutrition Services
			  • Step 1:
			  • Resident record reviews and interviews
			  • Validate diet order, preferences, food satisfaction survey, care plan, MDS, modified diet, and adaptive equipment needs
			  • Direct observations of food storage, food preparation, PPE use, food distribution, temperatures and infection control practices (ensure residents/staff hand hygiene before/after meals)
			  • Step 2:
			  • Review your current training
			  • Review staff competencies and training (conduct frequent observation of staff)
			  • Step 3:
			  • Create a Performance Improvement Project (PIP) and review in the Quality Assurance Performance Improvement Committee.
			  • Conduct a gap analysis and create a plan for implementation.
			  • Ensure compliance and utilize the survey pathway tools located in the Appendix PP.