CMS Manual System

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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 107 **Date: April 4, 2014**

SUBJECT: State Operations Manual (SOM) Appendix PP LTCF revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

I. SUMMARY OF CHANGES: Revisions have been made to Appendix PP-Guidance to Surveyors for Long Term Care Facilities to reflect the current ICF/IID nomenclature.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 4, 2014
IMPLEMENTATION DATE: April 4, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix PP/Table of Contents
R	Appendix PP /F150/§483.5 Definitions
R	Appendix PP/F169/§483.10(h) Work
R	Appendix PP/F203/§483.12(a)(4) Notice Before Transfer
R	Appendix PP/F284/§483.20(l)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.
R	Appendix PP/F285/§483.20(e) Coordination
R	Appendix PP/F319/§483.25(f)(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem; and
R	Appendix PP/F355/§483.30(c) Nursing Waivers
R	Appendix PP/F406/§483.45(a) Provision of Services
R	Appendix PP/F407/§483.45(b) Qualifications
R	Appendix PP/F498/§483.75(f) Proficiency of Nurse Aides

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

State Operations Manual
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(Rev.107, Issued: 04-04-14)

Transmittals for Appendix PP

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F150

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.5 Definitions

(a) Facility defined. For purposes of this subpart "facility" means, a skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of §§1819 or 1919(a), (b), (c), and (d) of the Social Security Act, the Act. "Facility" may include a distinct part of an institution specified in §440.40 of this chapter, but does not include an institution for the *intellectually disabled* or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution. For Medicare, a SNF (see §1819(a)(1)), and for Medicaid, a NF (see §1919(a)(1)) may not be an institution for mental diseases as defined in §435.1009.

Interpretive Guidelines §483.5

The following are the statutory definitions at §§1819(a) and 1919(a) of the Act for a SNF and a NF:

"Skilled nursing facility" is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(1)) with one or more hospitals having agreements in effect under §1866; and meets the requirements for a SNF described in subsections (b), (c), and (d) of this section.

"Nursing facility" is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(1)) with one or more hospitals having agreements in effect under §1866; and meets the requirements for a NF described in subsections (b), (c), and (d) of this section.

If a provider does not meet one of these definitions, it cannot be certified for participation in the Medicare and/or Medicaid programs.

NOTE: If the survey team finds substandard care in §§483.13, 483.15, or 483.25, follow the instructions for partial extended or extended surveys.

F169

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.10(h) Work

The resident has the right to--

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when--

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care

Interpretive Guidelines §483.10(h)(1)-(2)

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

All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident's desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated.

Procedures §483.10(h)(1)-(2)

Are residents engaged in what may be paid or volunteer work (e.g., doing housekeeping, doing laundry, preparing meals)? Pay special attention to the possible work activities of residents with *intellectual disabilities* or mental illness. If you observe such a situation, determine if the resident is in fact performing work and, if so, is this work, whether voluntary or paid, described in the plan of care?

F203

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.12(a)(4) Notice Before Transfer

Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

§483.12(a)(5) Timing of the notice.

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) The safety of the individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

§483.12(a)(6) Contents of the notice

The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Procedures §483.12(a)(4)-(6)

If the team determines that there are concerns about the facility's transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including:

- Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge);
- Reason for transfer/discharge;
- The effective date of the transfer or discharge;
- The location to which the resident was transferred or discharged;
- Right of appeal;
- How to notify the ombudsman (name, address, and telephone number); and

- How to notify the appropriate protection and advocacy agency for residents with mental illness or *intellectual disabilities* (mailing address and telephone numbers).

- Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.

F284

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.20(l)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Interpretive Guidelines §483.20(l)(3):

A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with *intellectual disabilities*. Resident protection concerning transfer and discharge are found at §483.12. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community.

Probes §483.20(l):

- Does the discharge summary have information pertinent to continuing care for the resident?

- Is there evidence of a discharge assessment that identifies the resident's needs and is used to develop the discharge plan?

- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)?

- Do discharge plans address necessary post-discharge care?

- Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?

- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?

- Does the discharge summary have information identifying if the resident triggered the CAA for return to community referral?

F285

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.20(e) Coordination

A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

Interpretive Guidelines §483.20(e)

With respect to the responsibilities under the Pre-Admission Screening and Resident Review (PASRR) program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.

§483.20(m) Preadmission Screening for Mentally Ill Individuals and Individuals With *Intellectual Disabilities.*

§483.20(m)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for *intellectual disabilities*.

(ii) *Intellectual Disability*, as defined in paragraph (m)(2)(ii) of this section, unless the State *intellectual disability* or developmental disability authority has determined prior to admission--

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for *intellectual disabilities*.

§483.20(m)(2) Definitions. For purposes of this section:

(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at 483.102(b)(1).

(ii) An individual is considered to be "*intellectually disabled*" if the individual is *intellectually disabled* as defined in 483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

Intent §483.20(m):

To ensure that individuals with mental illness and *intellectual disabilities* receive the care and services they need in the most appropriate setting.

"Specialized services" are those services the State is required to provide or arrange for that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to NF services--they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF.

The statute mandates preadmission screening for all individuals with mental illness (MI) or *intellectual disabilities* (*ID*) who apply to NFs, regardless of the applicant's source of payment, except as provided below. (See §1919(b)(3)(F).) Residents readmitted and individuals who initially apply to a nursing facility directly following a discharge from an acute care stay are exempt if:

- They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and
- They require care at the nursing facility for the same condition for which they were hospitalized.

The State is responsible for providing specialized services to residents with MI/*ID* residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition. Therefore, if a facility has residents with MI/*ID*, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

If the resident's PAS report indicates that he or she needs specialized services but the resident is not receiving them, notify the Medicaid agency. NF services ordinarily are not of the intensity to meet the needs of residents with MI or *ID*.

Probes §483.20(m):

If sampled residents have MI or *ID*, did the State Mental Health or *Intellectual Disabilities* Authority determine:

- Whether the residents needed the services of a NF?
- Whether the residents need specialized services for their *ID* or MI?

F319

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.25(f)(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem; and

Intent §483.25(f)

The intent of this regulation is that the resident receives care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.

Interpretive Guidelines §483.25(f)

"Mental and psychosocial adjustment difficulties" refer to problems residents have in adapting to changes in life's circumstances. The former focuses on internal thought processes; the latter, on the external manifestations of these thought patterns.

Mental and psychosocial adjustment difficulties are characterized primarily by an overwhelming sense of loss of one's capabilities; of family and friends; of the ability to continue to pursue activities and hobbies; and of one's possessions. This sense of loss is perceived as global and uncontrollable and is supported by thinking patterns that focus on helplessness and hopelessness; that all learning and essentially all meaningful living ceases once one enters a nursing home. A resident with a mental adjustment disorder will have a sad or anxious mood, or a behavioral symptom such as aggression.

The "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM/IV)," specifies that adjustment disorders develop within 3 months of a stressor (e.g., moving to another room) and are evidenced by significant functional impairment. Bereavement with the death of a loved one is not associated with adjustment disorders developed within 3 months of a stressor.

Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include:

- Impaired verbal communication;

- Social isolation (e.g., loss or failure to have relationships);

- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);

- Spiritual distress (disturbances in one's belief system);

- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and

- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Appropriate treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for self-governance; systematic orientation programs; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services. (See §483.45(a).)

Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty are: (This list is not all inclusive.)

- Metabolic diseases (e.g., abnormalities of serum glucose, potassium, calcium, and blood urea nitrogen, hepatic dysfunction);

- Endocrine diseases (e.g., hypothyroidism, hyperthyroidism, diabetes, hypoparathyroidism, hyperparathyroidism, Cushing's disease, Addison's disease);

- Central nervous system diseases (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease, vascular disease);

- Miscellaneous diseases (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure);

- Over-medication with anti-hypertensive drugs; and

- Presence of restraints.

Probes: §483.25(f)(1)

For sampled residents selected for a comprehensive or focused review, determine, as appropriate, for those residents exhibiting difficulties in mental and psychosocial adjustment:

- Is there a complete accurate assessment of resident's usual and customary routines?
- What evidence is there that the facility makes accommodations for the resident's usual and customary routines?

- What programs/activities has the resident received to improve and maintain maximum mental and psychosocial functioning?

- Has the resident's mental and psychosocial functioning been maintained or improved (e.g., fewer symptoms of distress)? Have treatment plans and objectives been re-evaluated?

- Has the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treat her/his condition, if necessary?

- Identify if resident triggers CAAs for activities, mood state, psychosocial well-being, and psychotropic drug use. Consider whether the CAA process was used to assess the causal factors for decline, potential for decline or lack of improvement.

- How are mental and psychosocial adjustment difficulties addressed in the care plan?

See §483.45(a), F406 for health rehabilitative services for mental illness and *intellectual disabilities*

Psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

F355 – Nursing Waivers

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.30(c) Nursing facilities

Waiver of requirement to provide licensed nurses on a 24-hour basis.

To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if--

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;
(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and *intellectually disabled*; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

Intent §483.30(c)

To give the facility flexibility, in limited circumstances, when the facility cannot meet nurse staffing requirements.

Interpretive Guidelines §483.30(c)

The facility may request a waiver of the RN requirement, and/or the 24-hour licensed nurse requirement. If the facility is Medicaid-certified only, the State has the authority to grant the waiver. If the facility is dually-participating, CMS has the delegated authority to grant the waiver. (See guidelines for §483.30(d).)

A survey of Nursing Services must be conducted if a waiver has been granted or requested.

Probes: §483.30(c)

Before granting a continuation of this waiver, or during the annual review, at a minimum, determine:

- Is a continuing effort being made to obtain licensed nurses?
- How does the facility ensure that residents' needs are being met?
- Are all nursing policies and procedures followed on each shift during times when licensed services are waived?
- Is there a qualified person to assess, evaluate, plan and implement resident care?
- Is care being carried out according to professional practice standards on each shift?
- Can the survey team ensure the State that the absence of licensed nurses will NOT endanger the health or safety of residents?
- Are there trends in the facility, which might be indicators of decreased quality of care as a result of insufficient staffing to meet resident needs (e.g., increases in incident reports, the infection rate, hospitalizations)?
- Are there increases in loss of function, pressure sores, tube feedings, catheters, weight loss, mental status?
- Is there evidence that preventive measures (e.g., turning, ambulating are taken to avoid poor quality of care outcomes and avoidable sudden changes in health status?
- Is there evidence that sudden changes in resident health status and emergency needs are being properly identified and managed by appropriate facility staff and in a timely manner?
- If the facility has a waiver of the requirement to provide licensed nurses on a 24-hour basis, have they notified the ombudsman, residents, surrogates or legal representatives, and members of their immediate families of the waiver, and are there services residents need that are not provided because licensed nurses are not available?
- Is there an increase in hospitalizations because licensed personnel are not available to provide appropriate services?
- Does the facility meet all applicable requirements to continue to receive a waiver?
- Does the staff indicate that an RN or physician is available to respond immediately to telephone calls when licensed nurses are not available?

§483.30(d) SNFs

Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

§483.30(d)(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that --

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
(iii) The facility either--

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or;

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and *intellectually disabled*; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

Interpretive Guidelines §483.30(d)

CMS is delegated the waiver authority for SNFs, including dually-participating facilities (SNF/NFs). The Medicare waiver authority is far more limited than is the States' authority under Medicaid since a State may waive any element of the nurse staffing requirement, whereas the Secretary may waive only the RN requirement. The requirements that a registered nurse provide services for 8 hours a day, 7 days a week

(more than 40 hours a week), and that there be an RN designated as director of nursing on a full-time basis, may be waived by the Secretary in the following circumstances:

- The facility is located in a rural area with an inadequate supply of SNF services to meet area needs. Rural is defined as "all areas not delineated as `urban` by the Bureau of Census, based on the most recent census;

- The facility has one full-time registered nurse regularly working 40 hours a week. This may be the same individual, or part-time individuals. This nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires; **and either**;

- The facility has only residents whose physicians have noted, in writing, do not need RN or physician care for a 48 hour period. This does not relieve the facility from responsibility for providing for emergency availability of a physician, when necessary, nor does it relieve the facility from being responsible for meeting all needs of the residents during those 48 hours;

OR

- A physician or RN will spend the necessary time at the facility to provide care residents need during the days that an RN is not on duty. This requirement refers to clinical care of the residents that need skilled nursing services.

- If a waiver of this requirement has been granted, conduct a survey of nursing services during each certification survey. Dually-participating facilities must meet the waiver provisions of the SNF.

Probes: §483.30(d)

If the SNF has a waiver of the more than 40 hours a week RN requirement:

- Is there an RN on duty 40 hours a week?

- If more than one RN provides the 40 hour per week coverage, how is information exchanged that maintains continuity of resident care?

- Does each clinical record have documentation by the physician that the resident does not need services of a physician or an RN for a 48 hour period each week.

- Are there any emergency or routine services that should be, but are not, provided to residents during the days that a registered nurse is not on duty?

- If specific skilled care is necessary for a resident during the time that an RN is not on duty, does an RN or physician provide that service on an "as needed" basis?

- Did the facility notify residents (or their legal guardians) and their immediate families about the waiver and the ombudsman?

See also probes at §483.30(c).

If the SNF requests continuation of the waiver to provide the services of a registered nurse for more than 40 hours a week, the survey team is to provide the Secretary with information needed to grant this continuation.

- Does the SNF meet all requirements necessary for continuation of the waiver?

Procedures §483.30(a)-(d)

If the facility has an approved nurse staffing waiver, it is **not** considered a deficiency. The facility does not need to submit a POC.

The following procedure should be used to document that a facility has a waiver of nurse staffing requirements.

When a facility does not meet the nurse staffing requirements, cite the appropriate tag. If the facility does have a waiver, reference the tag number based on the type of facility. The type of facility (SNF, NF, or SNF/NF) determines what type of waiver is granted:

- For SNFs and SNF/NFs which may be waived from the requirement to provide more than 40 hours of registered nurse services a week, and for NFs which have been granted a waiver from the 56 hour registered nurse requirement, cite F354;

    - For NFs that have a waiver of the 24-hour licensed nursing requirement, cite F353, or

    - Both facility types could be waived for the requirement to designate a registered nurse as the director of nursing on a full-time basis. Cite F355.

When the Form CMS-2567 is entered into OSCAR, code the waived tag as a "W." Enter the tag number, leave the correction date blank, and enter a "W" in the CP field. This will indicate that this is not a deficiency--that the requirement has been waived.

F406

(Rev.107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.45(a) Provision of Services

If specialized rehabilitative services such as, but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and *intellectual disabilities*, are required in the resident's comprehensive plan of care, the facility must--

(1) Provide the required services; or

(2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

Intent: §483.45(a)(1)(2)

The intent of this regulation is to assure that residents receive necessary specialized rehabilitative services as determined by the comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psycho-social well-being.

"**Specialized rehabilitative services**" are differentiated from restorative services which are provided by nursing staff. Specialized rehabilitative services are provided by or coordinated by qualified personnel.

Specialized rehabilitative services are considered a facility service and are, thus, included within the scope of facility services. They must be provided by or coordinated by qualified personnel. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.

A facility is not obligated to provide specialized rehabilitative services if it does not have residents who require these services. If a resident develops a need for these services after admission, the facility must either provide the services, or, where appropriate, obtain the services from an outside resource.

For a resident with MI or *ID* to have his or her specialized needs met, the individual must receive all services necessary to assist the individual in maintaining or achieving as much independence and self-determination as possible. They are:

"**Specialized services for MI or *ID***" refers to those services to be **provided by the State** which can only be delivered by personnel or programs other than those of the NF (e.g., outside the NF setting), because the overall level of NF services is not as intense as necessary to meet the individual's needs.
The Preadmission Screening and Annual Resident Review (PASARR) report indicates specialized services required by the resident. The State is required to list those services in the report, as well as provide or arrange for the provision of the services. If the State determines that the resident does not require specialized services, the facility is responsible to provide all services necessary to meet the resident's mental health or *intellectual disability* needs.

"**Mental health rehabilitative services for MI and *ID***" refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff who come into contact with the resident who is mentally ill or who has *intellectual disabilities*. These services are necessary regardless of whether or not they are required to be subject to the PASARR process and whether or not they require additional services to be provided or arranged for by the State as specialized services.

The facility should provide interventions which complement, reinforce and are consistent with any specialized services (as defined by the resident's PASARR) the individual is receiving or is required to receive by the State. The individual's plan of care should specify how the facility will integrate relevant activities throughout all hours of the individual's day at the NF to achieve this consistency and enhancement of PASARR goals. The surveyor should see competent interaction by staff at all times, in both formal and informal settings in accordance with the individual's needs.

Mental health rehabilitative services for MI and *ID* may include, but are not limited to:

- Consistent implementation during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors;
- Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;

- Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal);

- Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management, and maintenance of the living environment;

- Crisis intervention service;

- Individual, group, and family psychotherapy;
- Development of appropriate personal support networks; and
- Formal behavior modification programs.

Procedures: §483.45(a)(1)(2)

For sampled residents, whose comprehensive assessment indicates physical, psychosocial, and/or communications rehabilitation potential (Refer to appropriate sections of the MDS, as applicable), observe for unmet needs for rehabilitative services. Determine the extent of follow through with comprehensive care plan using probes outlined below. Verify from the chart that resident is receiving frequency and type of therapy as outlined in the care plan.

Probes: §483.45(a)(1)(2)

1. For physical therapy
    a. What did the facility do to improve the resident's muscle strength? The resident's balance?
    b. What did the facility do to determine if as assistive device would enable the resident to reach or maintain his/her highest practicable level of physical function?
    c. If the resident has an assistive device, is he/she encouraged to use it on a regular basis?
    d. What did the facility do to increase the amount of physical activity the resident could do (for example, the number of repetitions of an exercise, the distance walked)?
    e. What did the facility do to prevent or minimize contractures, which could lead to decreased mobility and increased risk of pressure ulcer occurrence?
2. For occupational therapy
    a. What did the facility do to decrease the amount of assistance needed to perform a task?
    b. What did the facility do to decrease behavioral symptoms?

c. What did the facility do to improve gross and fine motor coordination?

d. What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration?

e. What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards?

3. For speech-language pathology.

a. What did the facility do to improve auditory comprehension such as understanding common, functional words, concepts of time and place, and conversation?

b. What did the facility do to improve speech production?

c. What did the facility do to improve the expressive behavior such as the ability to name common, functional items?

d. What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received and audiologic evaluation? For example, did the facility instruct the resident how to effectively and independently use environmental controls to compensate for hearing loss such as eye contact, preferential seating, use of the better ear?

e. For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?

4. For health rehabilitative services for MI and *ID*

a. What did the facility do to decrease incidents of inappropriate behaviors, for individuals with *ID*, or behavioral symptoms for persons with MI? To increase appropriate behavior?

b. What did the facility do to identify and treat the underlying factors behind tendencies toward isolation and withdrawal?

c. What did the facility do to develop and maintain necessary daily living skills?

d. How has the facility modified the training strategies it uses with its residents to account for the special learning needs of its residents with MI or *ID*?

e. Questions to ask individuals with MI or *ID*:

(1) Who do you talk to when you have a problem or need something?

(2) What do you do when you feel happy? Feel sad? Can't sleep at night?

(3) In what activities are you involved, and how often?

F407

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§483.45(b) Qualifications

Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Intent: §485.45(b)

The intent of this regulation is to assure that the rehabilitative services are medically necessary as prescribed by a physician and provided by qualified personnel to maximize potential outcomes.

Specialized rehabilitative services are provided for individual's under a physician's order by a qualified professional. Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional. Once a resident has met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative sides will follow to maintain functional and physical status.

Interpretive Guidelines: §483.45(b)

"**Qualified personnel**" means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws.

Health rehabilitative services for MI and *ID* must be implemented consistently by all staff unless the nature of the services is such that they are designated or required to be implemented only by licensed or credentialed personnel.

Procedures: §483.45(b)

Determine if there are any problems in quality of care related to maintaining or improving functional abilities. Determine if these problems are attributable in part to the qualifications of specialized rehabilitative services staff.

Determine from the care plan and record that rehabilitative services are provided under the written order of a physician and by qualified personnel. If a problem in a resident's rehabilitative care is identified that is related to the qualifications of the care providers, it may be necessary to validate the care providers qualification.

Probes: §483.45(b)

If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with MI or *ID*, how has the facility arranged for the necessary direct or staff training services to be provided?

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§483.75(f) Proficiency of Nurse Aides

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Interpretive Guidelines: §483.75(f)

"Competency in skills and techniques necessary to care for residents' needs" includes competencies in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services and resident rights.

Procedures: §483.75(f)

During the Resident Review, observe nurse aides.

Probes: §483.75(f)

Do nurse aides show competency in skills necessary to:

- Maintain or improve the resident's independent functioning, e.g.:
    - Performing range of motion exercises,

    - Assisting the resident to transfer from the bed to a wheelchair,
    - Reinforcing appropriate developmental behavior for persons with *ID*, or
    - Psychotherapeutic behavior for persons with MI;
- Observe and describe resident behavior and status and report to charge nurse;
- Follow instructions; and
- Carry out appropriate infection control precautions and safety procedures.