**CMS Requirements of Participation – Phase 3 Checklist**

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| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| **Resident Rights**  §483.10  F557  (Respect, Dignity / Right to Have Personal Property) | Clarifies how facilities should manage incidents involving mental health and substance use disorders, including the need to consent for staff searches of resident’s body or personal possessions; referrals to law enforcement; and staff training requirements on the signs, symptoms, and triggers of potential substance abuse | ***P/P***  Residents Rights to include the right to search with consent  ***P/P*** Search of Resident/  Possessions |
| F561  (Self-Determination) | Including guidance inadvertently deleted on facility smoking/nonsmoking policies & transition from smoking to nonsmoking facility | ***P/P*** Smoking re-vised to include E-Cig  Vaping Device  Grandfathering of smokers when facility becomes non-smoking |
| F563  (Right to Receive / Deny Visitors) | Clarifies visitation rules during communicable disease outbreaks (i.e., the need to adhere to the core principles of infection prevention while enabling maximum visitation), as well as guidance on denying access or providing unsupervised visits | ***P/P***  Visitation to  Include search of packages,  Supervised, or restricted visitation |
| F582  (Medicaid/Medicare Coverage / Liability Notice) | Revises guidance for two Medicare beneficiary notices, specifically the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN; for CMS-10055) and the Notice of Medicare Non-Coverage (NOMNC; form CMS-10123), consistent with existing Medicare Claims Processing Manual / instructions | New forms available on CMS |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| **Abuse and Neglect**  §483.12  F600  (Free from Abuse and Neglect) | **Resident-to-Resident Abuse:**  Clarifies that not every resident-to-resident altercation is a case of abuse.  **Sexual Abuse**: Ensure that residents that want to engage in sexual activity must have the capacity to do so. Facilities should have/develop PP to ensure residents needs for physical intimacy are addressed as well resident’s capacity to consent to sexual activity, any time that the facility has reason to suspect that the resident may lack the capacity to consent.  **Neglect:**  Adds language to better define neglect as “the failure of the facility, it’s employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress” | ***P/P***  Abuse  Revisions made  ***P/P*** Sexual versus Non- Sexual Relations |
| F600 | **Psychosocial Outcome Severity Guide**:  This revised guide helps surveyors consider the impact of a facility’s noncompliance on the **resident’s psychosocial outcome,** and how to apply these principles to cases of abuse at F600 to categorize a deficiency at the appropriate severity level. |  |
| F604  (Right to be Free from Physical Restraints) | Clarifies that “a bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to their physical or cognitive inability to lower the bed rail independently.” | ***P/P***  Siderail Usage  ***P/P***  Restraints |
| F607  (Develop/ Implement Abuse / Neglect, etc. Policy) | **QAPI:** Added new guidance that providers must include QAPI coordination in policies and procedures for prohibiting abuse and neglect and that these policies and that these procedures should direct staff how to share information with the Quality Assessment and Assurance (QAA) committee so that the QAA committee can effectively oversee facility processes and determine the need for additional systemic actions. | ***P/P***  Abuse revised to include need to coordinate with QAPI and QAA  Committee |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| F609  (Reporting of Alleged Violations) | **Moved Citations:**  **Deleted F608** and the investigative protocol related to the failure to ensure that suspected crimes are reported and that covered individuals are notified about their reporting responsibilities.  **Reporting of suspected crimes:**  Updates what the facility’s policies and procedures should address with examples (e.g., orientating new staff to the reporting requirements and assuring that covered individuals are annually notified of their responsibilities in a language they understand).  **Reporting of alleged violations:**  Clarifies reporting requirements with additional guidance on what needs to be reported and what does not, including examples of each type of alleged violation, for staff-to-resident abuse; resident-to-resident altercations, including three new categories: mental/verbal conflict, sexual contact, and physical altercations; injuries of unknown source; neglect; and misappropriation of resident property and exploitation.  **Contents of facility reports on alleged violation:**  Updates the guidance for what facilities must include in the initial report and the investigation report for each alleged violation. This includes sample reports for each type: **SOM Exhibit 358 – Sample form for Facility Reported Incidents and SOM Exhibit 359 – Follow-Up Investigation Report.** | ***P/P***  Abuse revised  ***P/P***  Accident and Incident reporting will refer to new forms when  finalized |
| **Admission Transfer and Discharge Rights**  §483.15  F622  (Transfer and Discharge Requirements) | Clarifies specific situations, illustrating both psychosocial and physical harm, for transfers and discharges, including the facility’s responsibility: | ***P/P***  Transfer/  Discharge revised to include psychosocial/  physical harm |
| F623  (Notice Requirements Before Transfer/Discharge) | Provides guidance on giving residents a notice of transfer or discharge prior to the transfer or discharge, including a clarification that the notice should have the specific transfer or discharge location (e.g., the new provider’s name or the residential address) – | ***P/P***  Transfer /Discharge  And 30 -day Discharge Notice |
| F626  (Permitting Residents to Return to the Facility) | Clarifies that facility policies on bed-hold and permitting residents to return after hospitalization or therapeutic leave apply to all residents, regardless of payment source. | ***P/P***  Bed Hold |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| **Quality of Care**  §483.25  (Quality of Care)  F686  (Treatment/Services to Prevent/Heal Pressure Ulcers) | Changes the requirements for when pressure ulcer risk assessments should occur upon admission, weekly for the first four weeks, and then quarterly, or when a change in condition occurs. | ***P/P***  Pressure Injury Prevention/  Management  Revised: 4-week risk assessment for new admit//sig change |
| F687  (Foot Care) | Clarifies the need to follow proper infection prevention and control practices for foot care equipment. | ***P/P***  Infection Prevention to address items used by Podiatrist for foot care |
| F689  (Free of Accident Hazards/Supervision/ Devices) | **The use of electronic cigarettes (e-cigarettes):**  including the need for facilities to oversee use and to address them in smoking policies, e.g., how staff will supervise use of e-cigs, how batteries and refill cartridges will be managed, and how the facility will keep residents safe, including protecting residents who want to avoid exposure to second-hand aerosol.  **Safety for residents with substance use disorder:**  including documentation requirements if the resident leaves the facility and the facility knows about the departure. Also requires the facility to assess the residents’ risk for using illicit substances in the facility, to train staff on the signs and symptoms of possible substance use, and to train staff to be prepared to address related emergencies (e.g., know how to administer opioid reversal agents like naloxone, initiate CPR as appropriate, and contact emergency services timely). | ***P/P***  Smoking revised  ***P/P***  Substance Use Disorder |
| F690  (Bowel/Bladder Incontinence, Catheter, Urinary Tract Infection | Clarifies that this tag is specific to bowel incontinence only and that bowel management issues, such as constipation or impaction are addressed under F684 Quality of Care | *No changes* |
| F694  (Parenteral / IV Fluids) | Adds new guidance on the frequency of assessment for parental and IV fluids, indicating that an exact assessment timeframe is not specified but providing factors that could impact what frequency of assessment is needed. Adds information on proper infection control practices when accessing or using a resident’s IV (e.g., the use of appropriate antiseptic to scrub IV ports, needleless connectors, and hubs prior to access or use), as well as requiring facility policies and procedures to address documentation of why an IV catheter continues to be needed when it is no longer being used for IC fluid or medication. | ***P/P***  IV Therapy  revised |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| F695  (Respiratory/Tracheostomy Care and Suctioning) | Clarifies that the mechanical ventilation guidance in this F-tag only applies to facilities that offer this service. | *No changes* |
| F697  (Pain Management) | Updates the guidance to address the use of opioids to meet residents’ pain needs in light of the ongoing national opioid crisis, adding definitions for medication-assisted treatment and opioid use disorder; providing strategies and resources for the use of opioids for pain management; instructing facilities to assess residents for a history of addiction or past or ongoing treatment for opioid use disorder and to evaluate for potential drug diversion if a resident reports or has signs of increased pain; and describing opioid side effects and the need for facilities to have a written policy addressing opioid overdoses. | ***P/P***  Pain Management Revised  **P/P**  Opioid Usage  **P/P** Recognition and Treatment of Opioid Overdose |
| F699  (Trauma Informed Care) | Adds new guidance to ensure that facilities deliver care and services that not only meet professional standards, but also use culturally competent approaches that account for resident experiences and preferences and meet the needs of trauma survivors by minimizing triggers and/or re-traumatization (i.e., culturally competent, trauma informed care). Key components of the new guidance include the following:  Definitions of key terms, including culture, cultural competency, trauma, and trauma-informed care.  Examples include of trauma survivors (e.g., Military veteran, history of homelessness or imprisonment, abuse survivor, etc.).  The requirements for the facility to identify triggers that may prompt the resident to recall the previous traumatic events and particularly triggers that may cause re-traumatization.  Care planning to address past trauma, including the need for the facility to collaborate with the resident, their family, and friends as appropriate, and additional healthcare professionals (e.g., psychologists or other mental health professionals), as well as the need for trigger-specific interventions, including examples of what those include. | ***P/P***  Trauma Informed Care  Revised to include new definitions and terms |
| F656  (Develop/Implement Comprehensive Care Plan) | Ensure that a resident’s comprehensive care plan includes approaches to address the resident’s cultural preferences and reflects trauma-informed care when appropriate. Care planning to address a resident’s history of trauma should show evidence that the facility collaborated as needed to understand the resident’s trauma experience, including developing trigger-specific interventions. | ***P/P***  Care Planning to include Trauma Care |
| F700  (Bedrails) | Facilities must have process for assessing whether beds and their rails are appropriate for the residents using them | ***P/P***  Side Rail Usage  ***P/P***  Restraints |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure**  **or Other Action** |
| **Physician Services**  §483.30 | Table F712 Physician Visits – Frequency, timeliness,  Alternate Non-Physician practitioners (NPPs) with Physicians | ***P/P***  Physician Services |
| **Nursing Services**  §483.35  F725  (Sufficient Nursing Staff)  F727  (RN 8 Hours/7 Days/Week, Full-Time Director of Nursing | Surveyors will request access to PBJ Staffing Data Report, which contains information about overall direct care staffing levels, including nurse staffing, and use it to identify sufficient nursing staff concerns.  Surveyors will request/ use the PBJ Staffing Data Report to determine whether facilities have an RN onsite each day. | ***PP***  Staffing and Emergency Staffing  Include in **Facility Assessment**  Obtain Validation report of PBJ |
| F729  (Nurse Aide Registry Verification, Retraining) | Surveyors will review at least five nurse aide personnel files if concerns are identified with nurse aide services at F725 and F726 | Develop a system to identify when Certifications expire |
| F732 (Posted Nurse Staffing Information) | Requires surveyors to use observations and review to ensure compliance posting staffing clearly and visibly. | **P/P**  Staff Posting |
| Behavioral Health Services  §483.40  F740 | **Updates the definitions of mental disorder and substance use disorder**  Ties the behavioral health care needs of residents with a substance use disorder or other serious mental disorder to the facility assessment. | **P/P**  Substance use Disorder  **Facility Assessment** revised to include SUD |
| F741  (Sufficient / Competent Staff – Behavioral Health Needs)  F742-Treatment and services for residents with a history of trauma and/or post-traumatic stress disorder (PTSD) | Adds residents with a history of trauma and/or PTSD to the requirement that facilities ensure that they have sufficient staff members who posses the basic competencies and skill sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. residents with mental or psychosocial.  Updates the definition for mental disorder and adds definitions for substance use disorder, trauma, and PTSD.  Adds surveyor guidance related to how residents with a substance use disorder or other serious mental disorder must be part of the facility assessment.  Adds examples of nonpharmacological interventions for residents diagnosed with mental health and/or substance use disorders. | ***Lesson Plan***  Trauma Informed Care  **P/P**  Trauma Informed Care |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure**  **or Other Action** |
| **Pharmacy Services**  §483.45  F755  (Pharmacy Services / Procedures / Pharmacist / Records) | Revises guidance about the disposal of fentanyl transdermal patches. | ***P/P***  Medication Administration to include disposal of Fentanyl Patch |
| F757  (Drug Regimen is Free from Unnecessary Drugs)  &  F758  (Free from Unnecessary Psychotropic Medications / PRN Use) | Updates the key elements of noncompliance for both sections to direct surveyors to consider whether a facility is compliant with F881 (Antibiotic Stewardship Program) if there is evidence of unnecessary antibiotic use. | ***P/P***  AB Stewardship eliminate verbiage “feedback to prescriber” |
| F758  (Free From Unnecessary Psychotropic Medications / PRN Use) | Revises the definitions for dose, duplicate theory, and excessive dose.  Adds information about using a facility’s QAPI program to potentially tract the facility’s use of certain classes of medications, such as antipsychotics, through reports from the long-term care pharmacist to identify trends and reduce adverse events.  Clarifies that the “use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented.” Psychotropic medication requirements apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety, and anti-hypnotic) listed in §435.45(c)(3) without exception because the risks associated with psychotropic medications are present regardless of the indication for use (e.g., nausea, insomnia, itching).  Clarifies that other medications not classified as anti-psychotic anti-depressant, anti-anxiety or hypnotic medications can also affect brain activity and should not substitute for psychotropic medication.  Updates the language for gradual dose reductions to indicate that reduction should occur in modest increments over a period of time that is adequate to minimize withdrawal symptoms and to monitor for symptom recurrence.  Adds language to address the potential misdiagnosis of residents with a condition for which antipsychotics are an approved use, such as a new diagnosis of schizophrenia.  Directs surveyors to evaluate if a resident experienced psychosocial harm related to medication side effects of medications, as well as to look at whether side effects such as sedation, lethargy, agitation, mental status changes, or behavior changes affected the resident’s abilities to perform activities of daily living (ADLs), to maintain usual social patterns, and/or to think or concentrate | ***P/P***  Psychotropic  Medication  Revised  Add to  **QAPI Plan** |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| **Food and Nutrition Services**  §483.60  F812  (Food Procurement, Store/Prepare/Serve – Sanitary) | Addresses concerns related to culture change in nursing homes, particularly dining practices.  Reorganizes and updates key guidance, including:  Separates food distribution and food service operations in the guidance.  Clarifies the definitions of food distribution and food service.  Provides details on staff hair nets and glove use. | ***P/P***  Food Service  ***P/P***  Cultural Menu Selection |
| **Administration**  §483.70  F847  (Enter into Binding Arbitration Agreements) | Updates requirements that a facility must comply with if it chooses to ask a resident or their representative to enter into an agreement for binding arbitration. This includes prohibiting facilities from requiring that residents sign a binding arbitration agreement as a condition of admission or as a requirement to receiving continued care at the facility. | **Admissions Agreement Update** |
| F851  (Payroll Based Journal) | Updates the guidance to make failure to submit the required staffing information based upon a payroll data in a uniform format a key element of noncompliance. The facility’s failure to submit PBJ data as required will be reflected on its CASPER report and will result in a deficiency citation. | **Validation Report for PBJ** |
| **Quality Assurance and Performance Improvement (QAPI)**  §483.75  F865  (QAPI Program/Plan, Disclosure/Good Faith Attempt) | Adds 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:  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.  Updates the facility elements of noncompliance. | ***P/P***  QAPI revised |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| F867  (QAPI/QAA Improvement Activities) | Add 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:  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 precent 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.  -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. | ***P/P***  QAPI revised |
| F868  (QAA Committee) | Identifies the infection preventionist as a required active member of the facility’s QAA committee who must report on the infection prevention and control program (e.g., facility processes and outcome surveillance, occupational communicable diseases, or the antibiotic stewardship program), as well as on infections identified under the program (e.g., healthcare-associated infections). | ***P/P***  Infection Preventionist/  Job Description |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure or Other Action** |
| **Infection Control**  §483.80  F880  (Infection Prevention and Control) | Adds guidance that facilities must demonstrate measures (e.g., a documented water management program) to minimize the risk of Legionella and other opportunistic waterborne pathogen outbreaks in building water systems. | ***P/P***  Legionella |
| F881  (Antibiotic Stewardship Program) | Removes the provision of feedback to prescribing practitioners regarding antibiotic resistance data, their antibiotic use, and their compliance with facility antibiotic use protocols as a required element for compliance. | ***P/P***  AB Stewardship eliminate verbiage “feedback to prescriber” |
| F882  (Infection Preventionist Qualifications / Role) | Requires that facilities designate one or more people as the infection preventionist who is responsible for meeting the regulatory requirements of the infection prevention and control program.  While there is no specified number of hours that the IP must work, they are required to work at least part-time onsite at the facility.  Sets professional training requirements for the infection preventionist | ***P/P***  Infection Preventionist/  **Job Description** |
| **Compliance and Ethics Program**  §483.85  F895 | New program requirements, including a new intent statement and definitions; requirements for all facilities and additional requirements for operating organizations with five or more facilities; and training requirements. | ***P/P***  Compliance and Ethics |
| **Physical Environment**  §483.90  F919  (Resident Call System) | **Updates F919 to require 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. \* NYS ALREADY REQUIRES THIS**  **CMS is making recommendations – 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 newly certified after November 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.” And encourage facilities to explore ways in which they can allow for more single occupancy rooms for residents.”** | *NYS Already Requires* |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure**  **or Other Action** |
| **Training Requirements**  §483.95  F940  (Training Requirements, General) | Adds **new training guidance**.  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 upon facility assessment. | ***P/P***  Staff Training  Revise/Update **Orientation** and **Mandatory Inservice** Training List and  Refer to **Facility Assessment** |
| F941  (**Communication Training)** | Requires that facilities provide mandatory training for direct care staff. | ***P/P***  Staff Training |
| F942  (**Resident’s Rights Training**) | Specifies that facilities must develop and implement an ongoing education program related to resident rights and facility responsibilities, supporting current scope and standards of practice, and ensuring that all facility staff understand and foster the rights of each nursing home resident. | ***P/P***  Staff Training |
| F944  (**QAPI Training)** | Requires that facilities conduct mandatory training for all staff on the facility’s QAPI program, including the goals and various elements of the program, the staff’s role in the program, and how to communicate concerns, problems, or opportunities for improvement to the QAA committee. Training should be updated as needed, and staff participation in training should be tracked. | ***P/P***  Staff Training  ***P/P***  QAPI |
| F945  (**Infection Control Training**) | Mandates that facilities develop, implement, and permanently maintain an effective training program for all staff. Training should address the standards, policies, and procedures for the infection prevention and control program, and training needs may change due to changes to the facility’s population, community infection risk, national standards, and evaluation criteria, and address potential risks to residents, staff, and volunteers if procedures are not followed. Facilities should track staff participation in and retention of training. | ***P/P***  Staff Training |
| F946  **(Compliance and Ethics Training)** | Requires that each facility’s operating organization (the individual 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 operative five or more facilities. | ***P/P***  Staff Training |
| **Topic** | **Regulatory Guidance** | **Policies & Procedure**  **or Other Action** |
| F947  (Required Inservice Training for Nurse Aides) | Mandates that all facilities develop, implement, and permanently maintain an Inservice training program for nurse aides. The program must be appropriate and effective as determined by nurse aide performance reviews and the facility assessment, and when able, each nurse aide should be evaluated based on individual performance. | ***P/P***  Staff Training |
| F949  (**Behavioral Health Training)** | Specifies that facilities must develop, implement, and maintain behavioral health training for all staff. The training, which must be appropriate and effective as determined by staff need and the facility assessment, should include competencies and skills necessary to provide the following:  -Person centered care that reflects the residents’ goals for care  -Interpersonal communication that promotes mental and psychosocial well-being.  -Meaningful activities that promote engagement and positive relationships.  -An environment or atmosphere that promotes mental and psychosocial well-being  -Individualized, nonpharmacological approaches to care  -Care tailored to the individual needs of residents diagnosed with a mental, psychosocial, or **substance use disorder; a history of trauma and/or post-traumatic stress disorder; or other behavioral condition**  -Care specific to the individual needs of residents diagnosed with dementia. | ***P/P***  Staff Training |