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SHINING A LIGHT ON REGULATORY DOCUMENTATION REQUIREMENTS

1

TRAINING OBJECTIVES

- Review what required documentation components must be present in the medical record.
- Understanding the Medicare rules for physician certification and recertification.
- Discuss how to identify areas for improvement
- Discuss way to improve compliance

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FEDERAL REGULATIONS

INFECTION CONTROL

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F883 INFECTION CONTROL

- **INFECTION CONTROL**
  - ***§483.80(d)***
  - **Influenza and Pneumococcal Immunizations**

F883

4

F883 INFECTION CONTROL

- Influenza
  - Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period
  - The resident or the resident's representative has the opportunity to refuse immunization.

5

F883 INFECTION CONTROL

- Pneumococcal disease
  - Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized.
  - Facilities should follow the CDC and ACIP recommendations for vaccines.

6

F883 INFECTION CONTROL

- The resident's medical record includes documentation that indicates, at a minimum, the following:
  - That the resident or resident's representative was provided education regarding the benefits and potential side effects of immunization; and
  - That the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal

7

F887 COVID-19 IMMUNIZATION

- *Effective June 14, 2021*
- COVID-19 immunization
  - The facility must develop policies and procedures that ensure the following:
    - When the vaccine is available to the facility, each resident and staff member is offered the vaccine unless the immunization is medically contraindicated, or the resident/staff member has already been immunized.

8

F887 COVID-19 IMMUNIZATION

- Before offering an immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.
- In situations where vaccination requires multiple doses, the resident, or representative is provided with current information regarding additional doses, including any changes in benefits, risk, or potential side effects, before requesting consent

9

F887 COVID-19 IMMUNIZATION

- The resident's medical record includes documentation that indicates, at a minimum the following:
  - That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
  - Each does of COVID-19 vaccine administered to the resident, or
  - If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal

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FEDERAL REGULATIONS

RESIDENT RIGHTS

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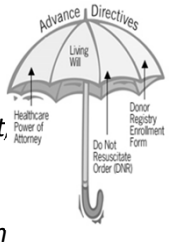
F578 ADVANCED DIRECTIVES

- RESIDENT RIGHTS
  - *§483.10(c)(6)*
  - *The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive*



F578

12

F578 ADVANCED DIRECTIVES

- ADVANCE DIRECTIVES
  - The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives)
    - These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

13

F578 ADVANCED DIRECTIVES

- GUIDANCE:
  - The facility must establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advanced directive.
  - The facility management is responsible for ensuring that staff follow the policies and procedures

14

F578 ADVANCED DIRECTIVES

- Policies and Procedures must include:
  - Determining on admission whether the resident has an advance directive and, if not, determining whether the resident wishes to formulate an advance directive.

15

F578 ADVANCED DIRECTIVES

- Facility staff should periodically assess the resident for decision-making capacity and invoke health care agent or representative if the resident is determined not to have decision-making capacity
- Identify the primary decision-maker (assessing the resident's decision-making capacity and identifying or arranging for an appropriate representative for the resident assessed as unable to make relevant health care decisions)

16

F578 ADVANCED DIRECTIVES

- Define and clarify medical issues and present the information regarding relevant health care issues to the resident or his or her representative, as appropriate
- Identify, clarify, and periodically review, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions

17

F578 ADVANCED DIRECTIVES

- Identify situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition
- Establishing mechanisms for documenting and communicating the resident's choices to the interdisciplinary team and to staff responsible for the resident's care

18

F578 ADVANCED DIRECTIVES

- If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents must be obtained and maintained in the same section of the resident's medical record readily retrievable by any facility staff

19

F578 ADVANCED DIRECTIVES

- Facility staff must document in the resident's medical record these discussions and any advance directive(s) that the resident executes

20

F554 SELF ADMINISTRATION

- **RESIDENT RIGHTS**
  - ***§483.10(c)(7)***
  - ***The Right to Self-Administer Medications***

Self Administration of Medications

F554

21

F554 RESIDENT RIGHTS

- SELF ADMINISTER MEDICATIONS
  - The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate
  - If a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team to determine that it is safe before the resident exercises that right

22

F554 RESIDENT RIGHTS

- The IDT should at a minimum consider the following:
  - The medications appropriate and safe for self-administration
  - The resident's physical capacity to swallow without difficulty and to open medication bottles
  - The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for

23

F554 SELF ADMINISTRATION

- The resident's capability to follow directions and tell time to know when medications need to be taken
- The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff

24

F554 SELF ADMINISTRATION

- ❑ The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs
- ❑ The resident's ability to ensure that medication is stored safely and securely

25

F554 SELF ADMINISTRATION

- ❑ Appropriate notation of these determinations must be documented in the resident's medical record and care plan
- ❑ The decision that a resident has the ability to self-administer medication is subject to periodic assessment by the IDT, based on changes in the resident's medical and decision-making status

26

F559 ROOMMATE/ROOM CHANGE

- ➢ **RESIDENT RIGHTS**
  - ❑ ***§483.10(e)(4), §483.10(e)(5), §483.10(e)(6)***
  - ❑ ***The right to share a room with spouse***
  - ❑ ***The right to share a room with roommate of choice***
  - ❑ ***The right to receive written notice***

F559

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F559 ROOMMATE/ROOM CHANGE

- The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed

28

F559 ROOMMATE/ROOM CHANGE

- When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required
- A resident receiving a new roommate should be given as much advance notice as possible.

29

F580 NOTICE OF CHANGE

- **RESIDENT RIGHTS**
  - ***§483.10(g)(14)***
  - ***Notification of Changes***

F580

30

F582 NOTICE OF CHANGE

- The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident's representative when there is-
  - An accident involving the resident which results in injury and has the potential for requiring physician intervention;

31

F582 NOTICE OF CHANGE

- A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications
- A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or the commence a new form of treatment);

32

F582 NOTICE OF CHANGE

- A decision to transfer or discharge the resident from the facility.

33

F582 COVERAGE NOTICE

- **RESIDENT RIGHTS**
  - ***§483.10(g)(17)***
  - ***§483.10(g)(18)***
  - ***Medicaid/Medicare Coverage/Liability Notice***

F582

34

F582 RESIDENT RIGHTS

- The Facility Must—
  - Inform each resident before, or at the time of admission and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

35

F582 COVERAGE NOTICE

- Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible
- Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change

36

F582 COVERAGE NOTICE

- Beneficiary Notices
  - **Notice of Medicare Non-Coverage (NOMNC)**
    - The NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending.

37

F582 COVERAGE NOTICE

- The NOMNC is not given if:
  - The beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit
  - The beneficiary initiates the discharge from the SNF
  - The beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage

38

F582 RESIDENT RIGHTS

- **Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)**
  - SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare.

39

F582 COVERAGE NOTICE

- **A SNFABN must be given to a beneficiary for the following triggering events**
  - Initiation - In the situation in which **a SNF believes Medicare will not pay for extended care items or services that a physician has ordered**, the SNF must provide a SNFABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary

40

F582 COVERAGE NOTICE

- Reduction - In the situation in which **a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services**, **or for any items or services at the current level and/or frequency of care that a physician has ordered**, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary

41

F582 COVERAGE NOTICE

- Termination - In the situation in which **a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care**, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services

42

F604 RESPECT AND DIGNITY

- **RESIDENT RIGHTS**
  - ***§483.10(e)***
  - ***Respect and Dignity***

F604

43

F604 RESPECT AND DIGNITY

- The resident has a right to be treated with respect and dignity, including:
  - The right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

44

F604 RESPECT AND DIGNITY

- When a physical restraint is used, the facility must:
  - Use the least restrictive restrain for the least amount of time; and
  - Provide ongoing re-evaluation of the need for the physical restraint

45

F604 RESPECT AND DIGNITY

- If a resident is identified with a physical restraint, the facility must be able to provide evidence that ensures:
  - The medical symptom that require the use of physical restraint has been identified;
  - An order is in place for the use of the specific restraint;

46

F604 RESIDENT RIGHTS

- Interventions, including less restrictive alternatives were attempted to treat the medical symptoms but were ineffective;
- The resident/representative was informed of potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use;

47

F604 RESPECT AND DIGNITY

- The length of time the restrain is anticipated to be used to treat the medical symptom, who may apply the restrain, where and how the restrain is to be applied and used, time and frequency of the restraint should be release, and who may determine when the medical symptom has resolved

48

F604 RESPECT AND DIGNITY

- The type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of monitoring;
- The identification of how the resident may request staff assistance and how needs will be met during use of the restraint

49

F604 RESPECT AND DIGNITY

- The development and implementation of interventions to prevent and address any risks related to the use of the restraint

50

F605 RESPECT AND DIGNITY

- **RESIDENT RIGHTS**
  - ***§483.10(e)(1)***
  - ***Respect and Dignity***

F605

51

F605 RESPECT AND DIGNITY

- The resident has a right to be treated with respect and dignity, including:
  - The right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

52

F605 RESPECT AND DIGNITY

- The indication for use for any medication ordered for a resident must be identified and documented in the medical record
- The clinical record must reflect whether staff and practitioner have identified and addressed the underlying cause(s) of distressed behavior

53

F604 RESIDENT RIGHTS

- The clinical record must reflect the following:
  - Whether there is an adequate indication for use for the medication;
  - Whether an excessive dose and/or duration of the medication was administered to the resident;

54

F605 RESPECT AND DIGNITY

- Whether there is adequate monitoring for the effectiveness of the medication in treating the specific condition and for any adverse consequences resulting from the medication;
- Whether a resident who uses a psychotropic drug is receiving gradual dose reduction and behavioral interventions;

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F605 RESPECT AND DIGNITY

- Whether a resident who receives a psychotropic drug pursuant to a PRN (as needed) order is not administered the medication unless the medication is necessary to treat a diagnosed specific symptom

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FEDERAL REGULATIONS

RESIDENT ASSESSMENTS

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F635 RESIDENT ASSESSMENTS

- **RESIDENT ASSESSMENTS**
  - ***§483.20(a)***
  - ***Admission orders***

F635

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F635 ADMISSION ORDERS

- At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.
- These orders should, at a minimum, include dietary, medications (if necessary), and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan

59

F636 COMPREHENSIVE ASSESSMENT

- **RESIDENT ASSESSMENTS**
  - ***§483.20(b)***
  - ***Comprehensive Assessments***
  - ***§483.20(b)(1)***
  - ***Resident Assessment Instrument***

F636

60

F636 COMPREHENSIVE ASSESSMENT

- The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
- The facility must make a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS

61

F636 COMPREHENSIVE ASSESSMENT

- The assessment must include at least the following:
  - Identification and demographic information
  - Customary routine
  - Cognitive patterns
  - Communication
  - Vision

62

F636 COMPREHENSIVE ASSESSMENT

- The assessment must include at least the following:
  - Mood and behavior patterns
  - Psychological well-being
  - Physical functioning and structural problems
  - Continence
  - Disease diagnosis and health conditions

63

F636 COMPREHENSIVE ASSESSMENT

- The assessment must include at least the following:
  - Dental and nutritional status
  - Skin conditions
  - Activity pursuits
  - Medications
  - Special treatments and procedures

64

F636 COMPREHENSIVE ASSESSMENT

- The assessment must include at least the following:
  - Discharge planning
  - Documentation of summary information regarding the additional assessment performed on the care area triggered by the completion of the Minimum Data Set (MDS)

65

F636 COMPREHENSIVE ASSESSMENT

- The assessment must include at least the following:
  - Documentation of the participation of the assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed care staff members on all shifts

66

F636 COMPREHENSIVE ASSESSMENT

- When required, a facility must conduct a comprehensive assessment of a resident in accordance with specified timeframes
  - Within 14 calendar days after admission
  - Not less than once every 12 months

67

F637 SIGNIFICANT CHANGE

- **RESIDENT ASSESSMENTS**
  - ***§483.20(b)(2)(ii)***
  - ***Comprehensive Assessment: Significant Change***

F637

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F637 SIGNIFICANT CHANGE

- Within 14-days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition

69

F638 QUARTERLY ASSESSMENT

- **RESIDENT ASSESSMENTS**
  - ***§483.20(c)***
  - ***Quarterly Review Assessment***

F638

70

F638 COMPREHENSIVE ASSESSMENT

- A facility must assess the resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months
  - At least every 92-days

71

F639 QUARTERLY ASSESSMENT

- **RESIDENT ASSESSMENTS**
  - ***§483.20(c)***
  - ***Quarterly Review Assessment***

F639

72

F639 COMPREHENSIVE ASSESSMENT

- A facility must maintain all resident assessments completed within the previous 15-months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive care plan.

73

F644 PASARR

- **RESIDENT ASSESSMENTS**
  - ***§483.20(a)***
  - ***Coordination of PASRR and Assessments***

F644

74

F644 PASARR

- A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

75

F644 PASARR

- ❑ Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care
- ❑ Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment

76

F644 PASARR

- ➢ PASARR
  - ❑ The level I PAASRR screen must be completed by the Level I PASARR Screener prior to all new admissions to a NF, and within two business days of the request.
  - ❑ A Level II evaluation must be finalized within seven business days of a completed Level II request if the Level I PASARR screen indicates a diagnosis, or suspicion of, SMI, ID, or both

77

F644 PASARR

- ➢ Exceptions to the timeframe are as follows:
  - ❑ Within seven calendar days after the delirium clears, in cases of delirium
  - ❑ Within seven calendar days of admission for emergency admission requiring protective services.

78

F644 PASARR

- By calendar day 40, when an individual is admitted to an NF under the hospital discharge exemption, and is expected to stay in the NF longer than 30 calendar days.
  - The NF must notify the AHCA-designated Level I screener on the 25th day of the individual's stay

79

F644 PASARR

- Prior to returning to the NF, when an individual with SMI, ID, or both, is transferred to the hospital form the NF, and the hospital stay is longer than 90 consecutive days.
- If the individual is not admitted to an NF within 30 calendar days of the Level II evaluation, another Level II evaluation must be completed.

80

F644 PASARR

- Nursing facilities must maintain copies of all PASRR screenings, evaluations, re-evaluations, and determinations in the individual's file for the duration of his or her stay in the facility and for a period of five years after the individual has been discharged or transferred to another facility

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FEDERAL REGULATIONS

PHYSICIAN SERVICES

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F711 PHYSICIAN SERVICES

- **PHYSICIAN SERVICES**
  - ***§483.30(b)***
  - ***Physician Visits***

F711

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F711 PHYSICIAN SERVICES

- The physician must
  - Review the resident's total program of care, including medications and treatments, at each visit
  - Write, sign, and date progress notes at each visit
  - Sign and date all orders with the exception of influenza and pneumococcal vaccines

84

F711 PHYSICIAN SERVICES

- During required visits, the physician must document a review of the resident's total program of care, including the resident's current condition, progress and problems in maintaining or improving their physical, mental and psychosocial well-being and decisions about the continued appropriateness of the resident's current medical regimen

85

F711 PHYSICIAN SERVICES

- In cases where facilities have created the option for a resident's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable

86

F712 PHYSICIAN SERVICES

- **PHYSICIAN SERVICES**
  - ***§483.30(c)***
  - ***Frequency of physician visits***

F712

87

F712 PHYSICIAN SERVICES

- FREQUENCY OF PHYSICIAN VISITS
  - The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter
  - A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required
  - All required physician visits must be made by the physician personally

88

F712 PHYSICIAN SERVICES

- The physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement
- The timing of physician visits is based on the admission date of the resident
- Although the physician may not delegate the responsibility for conducting the initial visit in a SNF, NPPs may perform other medically necessary visits prior to and after the physician's initial visit, as allowed by State law

89

F712 PHYSICIAN SERVICES

- After the initial physician visit in SNFs, where States allow their use, an NPP may make every other required visit
- NPs, CNSs, and PAs who are not employed by the facility and who are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under the scope of practice for the State

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F712 PHYSICIAN SERVICES

	Initial Comprehensive Visit	Admission Orders	Other Required Visits & Orders	Other Medically Necessary Visits and Orders	Certifications/ Recertifications
SNFs					
PA, NP & CNS employed by the facility	**May not perform**	**May not provide**	**May perform alternate visits & sign**	**May perform & sign**	**May not sign**
PA, NP & CNS not a facility employee	**May not perform**	**May not provide**	**May perform alternate visits & sign**	**May perform & sign**	**May sign as permitted under state laws**
NFs					
PA, NP & CNS employed by the facility	May not perform	May not provide	May not perform or sign	May perform & sign	Not applicable
PA, NP & CNS not a facility employee	May not perform	May not provide	May perform or sign	May perform & sign	Not applicable

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MEDICARE BENEFIT POLICY MANUAL

MEDICARE GENERAL INFORMATION, ELIGIBILITY AND ENTITLEMENT

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CHAPTER 4: MEDICARE CERTS

- Physician certification and recertification of services
  - Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished

93

CHAPTER 4: MEDICARE CERTS

- ❑ The skilled nursing facility is responsible for obtaining the required certification and recertification statements and for retaining them in file for verifications, if needed, by the A/B MAC (A)

94

CHAPTER 4: MEDICARE CERTS

- ❑ There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met

95

CHAPTER 4: MEDICARE CERTS

- ➢ A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician

96

CHAPTER 4: MEDICARE CERTS

- The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF

97

CHAPTER 4: MEDICARE CERTS

- The recertification statement must contain
  - Adequate written record of the reasons for the continued need for extended care services
  - The estimated period of time required for the patient to remain in the facility
  - Any plans, where appropriate, for home care

98

CHAPTER 4: MEDICARE CERTS

- Timing of the Medicare Certification/ Recertification
  - Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable
  - The first recertification must be made no later than the 14th day of inpatient extended care services

99

CHAPTER 4: MEDICARE CERTS

- A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories
- Subsequent recertifications must be made at intervals not exceeding 30 days.
- Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility

100

CHAPTER 4: MEDICARE CERTS

- Delays in physician signatures
  - Delayed certifications and recertifications will be honored where there has been an isolated oversight or lapse
  - In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay

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FEDERAL REGULATIONS

COMPREHENSIVE RESIDENT CENTERED CARE PLANS

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F655 CARE PLANS

- **COMPREHENSIVE RESIDENT CENTERED CARE PLANS**
  - ***§483.21***
  - ***Comprehensive Person-Centered Care Planning***
  - ***§483.21(a)***
  - ***Baseline Care Plans***

F655

103

F655 CARE PLANS

- The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care
- The baseline care plan must
  - Be developed within 48 hours of a resident's admission

104

F655 CARE PLANS

- Include the minimum healthcare information necessary to properly care for a resident including, but not limited to –
  - Initial goals based on admission orders
  - Physician orders
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendation, if applicable

105

F655 CARE PLANS

- The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
  - ❑ The initial goals of the resident
  - ❑ A summary of the resident's medications and dietary instructions

106

F655 CARE PLANS

- ❑ Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
- ❑ Any updated information based on the details of the comprehensive care plan, as necessary

107

F655 CARE PLANS

- The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan
- If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/ representative can understand

108

F655 CARE PLANS

- The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable

109

F656 COMPREHENSIVE CARE PLANS

- **COMPREHENSIVE RESIDENT CENTERED CARE PLANS**
  - ***§483.21(b)***
  - ***Comprehensive Care Plans***
  - ***§483.21(b)(1)***
  - ***Comprehensive Person-Centered Care Plan***
  - ***§483.10(c)(3)***
  - ***Measurable Objectives***

F656

110

F656 CARE PLANS

- The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

111

F656 CARE PLANS

- The comprehensive care plan must describe the following –
  - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required
  - Any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment

112

F656 CARE PLANS

- The comprehensive care plan must describe the following –
  - Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.
    - If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record

113

F656 CARE PLANS

- The comprehensive care plan must describe the following –
  - In consultation with the resident and the resident's representative(s)
    - The resident's goals for admission and desired outcomes
    - The resident's preference and potential for future discharge.

114

F656 CARE PLANS

- The comprehensive care plan must describe the following –
  - In consultation with the resident and the resident's representative(s)
    - Discharge plans in the comprehensive care plan, as appropriate

115

F656 CARE PLANS

  - The services provided or arranged by the facility, as outlined by the comprehensive care plan, must
    - Be culturally-competent and trauma–informed

116

F656 CARE PLANS

- If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident

117

F656 CARE PLANS

- Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record

118

F657 COMPREHENSIVE CARE PLANS

- **COMPREHENSIVE RESIDENT CENTERED CARE PLANS**
  - ***§483.21(b)(2)***
  - ***Comprehensive Care Plans***

F657

119

F657 COMPREHENSIVE CARE PLANS

- A comprehensive care plan must be-
  - Developed within 7-days after completion of the comprehensive assessment

120

F657 COMPREHENSIVE CARE PLANS

- A comprehensive care plan must be-
  - Prepared by an interdisciplinary team, that includes but is not limited to –
    - The attending physician
    - A registered nurse with responsibility for the resident
    - A nurse aide with responsibility for the resident

121

F657 COMPREHENSIVE CARE PLANS

- A comprehensive care plan must be-
  - Prepared by an interdisciplinary team, that includes but is not limited to –
    - A member of the food and nutrition service staff
    - To the extent practicable, the participation of the resident and representative(s).

122

F657 COMPREHENSIVE CARE PLANS

- A comprehensive care plan must be-
  - Prepared by an interdisciplinary team, that includes but is not limited to –
    - Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident
  - Reviewed and revised by the interdisciplinary team after each assessment

123

F657 COMPREHENSIVE CARE PLANS

- If the participation of the resident and their representative is determined not practicable for the development of the resident's care plan an explanation must be included in the resident's medical record.

124

F660 DISCHARGE PLANNING

- **DISCHARGE PLANNING PROCESS**
  - ***§483.21(c)(1)***
  - ***Discharge Planning Process***

F660

125

F660 DISCHARGE PLANNING

- The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

126

F660 DISCHARGE PLANNING

- The facility's discharge planning process must –
  - Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident
  - Include regular re-evaluation of residents to identify changes that require modification of the discharge plan

127

F660 DISCHARGE PLANNING

- The facility's discharge planning process must –
  - Involve the interdisciplinary team
  - Consider caregiver/support person availability and the resident's or caregiver/support person's capacity and capability to perform required care, as part of the identification of discharge needs.

128

F660 DISCHARGE PLANNING

- The facility's discharge planning process must –
  - Involve the resident and representative in the development of the discharge plan and inform them of the final plan.
  - Address the resident's goals of care and treatment preference

129

F660 DISCHARGE PLANNING

- Discharge planning must include procedures for:
  - Documentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose;
  - Documentation of the response to referrals; and

130

F660 DISCHARGE PLANNING

- For residents for whom discharge to the community has been determined to not be feasible, the medical record must contain information about who made that decision and the rationale for that decision.

131

F660 DISCHARGE PLANNING PROCESS

- If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:

132

F660 DISCHARGE PLANNING

- ❑ Discuss with the resident/representative and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location
- ❑ Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed.

133

F660 DISCHARGE PLANNING

- ❑ Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;
- ❑ Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary.

134

F661 DISCHARGE SUMMARY

➢**DISCHARGE SUMMARY**

- ❑ ***§483.21(c)(2)***
- ❑ ***Discharge Summary***

F661

135

F661 DISCHARGE SUMMARY

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

136

F661 DISCHARGE SUMMARY

- A recapitulation of the resident's stay that includes, but is not limited to
  - Diagnoses,
  - Course of illness/treatment or therapy
  - Pertinent lab
  - Radiology
  - Consultation results

137

F661 DISCHARGE SUMMARY

- A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative

138

F661 DISCHARGE SUMMARY

RESIDENTS STATUS

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood/Behavior patterns
- Psychosocial well being
- Physical functioning and structural problems
- Continence
- Diagnoses and health conditions
- Dental and nutritional status
- Skin conditions
- Activity pursuits
- Medications
- Special treatments and procedures

139

F661 DISCHARGE SUMMARY

- ❑ Discharge planning
- ❑ Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and
- ❑ Documentation of participation in assessment. This refers to documentation of who participated in the assessment process

140

F661 DISCHARGE SUMMARY

- ❑ Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter)
- ❑ A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment

141

F661 DISCHARGE SUMMARY

- In addition, the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility:
  - ❑ Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident

142

F661 DISCHARGE SUMMARY

- ❑ Resident representative information, if applicable, including contact information
- ❑ Advance directive information
- ❑ All special instructions or precautions for ongoing care, as appropriate
- ❑ Comprehensive care plan goals; and
- ❑ All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care

143

F661 DISCHARGE SUMMARY

- ❑ The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident's care after discharge
- ❑ The discharge summary may be furnished in either hard copy or electronic format

144

F661 DISCHARGE SUMMARY

- For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative

145

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FEDERAL REGULATIONS

QUALITY OF LIFE

146

F676 QUALITY OF LIFE

➢**QUALITY OF LIFE**

- ***§483.24(a)***
- ***Activities of Daily Living***

F676

147

F676 QUALITY OF LIFE

- Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

148

F676 QUALITY OF LIFE

- A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section …
- The facility must provide care and services for the following activities of daily living
  - Hygiene –bathing, dressing, grooming, and oral care,

149

F676 QUALITY OF LIFE

- Mobility—transfer and ambulation, including walking,
- Elimination-toileting,
- Dining-eating, including meals and snacks,
- Communication, including
  - Speech,
  - Language,
  - Other functional communication systems.

150

F676 QUALITY OF LIFE

- Florida Nursing Home Regulation N0426:
  - Every licensed facility shall maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident.
  - This record must indicate assistance with ADLs, eating, drinking and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk of malnutrition/dehydration

151

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FEDERAL REGULATIONS

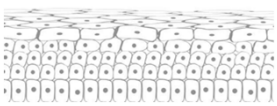
QUALITY OF CARE

152

F686 SKIN INTEGRITY

➢**QUALITY OF LIFE**

- ***§483.25(b)***
- ***Skin Integrity***
- ***§483.25(b)(1)***
- ***Pressure ulcers***



F686

153

F686 SKIN INTEGRITY

- Pressure ulcers
  - Based on the comprehensive assessment of a resident, the facility must ensure that
    - A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

154

F686 SKIN INTEGRITY

- A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing

155

F686 SKIN INTEGRITY

- Prevention of Pressure Ulcers/Injuries
  - A facility must:
    - Identify whether the resident is at risk for developing or has a pressure ulcer (PU)/injury (PI);
    - Evaluate resident specific risk factors and changes in the resident's condition that may impact the development and/or hearing of a PU/PI;

156

F686 SKIN INTEGRITY

- Prevention of Pressure Ulcers/Injuries
  - A facility must:
    - Implement, monitor, and modify interventions to attempt to stabilize, reduce, or remove underlying risk factors; and
    - If a PU/PI is present, provide treatment and services to heal it and to prevent infection and the development of additional PU/PI

157

F686 SKIN INTEGRITY

- The comprehensive assessment should address those factors that have been identified as having an impact on the development, treatment and/or healing of PU/PIs, including, at a minimum: risk factors, pressure points, under-nutrition and hydration deficits, and moisture and the impact of moisture on skin

158

F686 SKIN INTEGRITY

- The comprehensive assessment should address those factors that have been identified as having an impact on the development, treatment and/or healing of PU/PIs, including, at a minimum: risk factors, pressure points, under-nutrition and hydration deficits, and moisture and the impact of moisture on skin

159

F686 SKIN INTEGRITY

- Many clinicians utilize a standardized pressure ulcer/injury risk assessment tool to assess a resident's PU/PI risks upon admission, weekly for the first four weeks after admission, then quarterly or whenever there is a change in the resident's condition

160

F686 SKIN INTEGRITY

- Monitoring:
  - After completing a thorough evaluation, the IDT should develop a relevant care plan for prevention and management of PU/PIs
  - Many clinicians recommend evaluating skin condition at least weekly or more often, if indicated

161

F686 SKIN INTEGRITY

- The facility must have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility

162

F686 SKIN INTEGRITY

- When assessing a PU/PI, the documentation must address:
  - The type of injury;
  - The stage;
  - A description of the PU/PI's characteristics;
  - The progress toward healing and identification of potential complications;

163

F686 SKIN INTEGRITY

- When assessing a PU/PI, the documentation must address:
  - If infection is present;
  - The presence of pain
    - What was done to address it
    - The effectiveness of the interventions
  - A description of dressings and treatments

164

F686 SKIN INTEGRITY

- When a PU/PI is present, daily monitoring should include:
  - An evaluation of the PU/PI if no dressing is present;
  - An evaluation of the status of the dressing, if present;
  - The status of the area surrounding the PU/PI

165

F686 SKIN INTEGRITY

- When a PU/PI is present, daily monitoring should include:
  - The presence of possible complications, such as increasing area of ulceration or soft tissue infection
  - Whether pain, if present, is being adequately controlled

166

F686 SKIN INTEGRITY

- With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI should be documented.

167

F686 SKIN INTEGRITY

- At a minimum, documentation with each dressing change or at least weekly should include the date observed and:
  - Location and staging;
  - Size, depth; and the presence, location and extent of any undermining or tunneling/sinus tracts;
  - Exudate, if present: type, color, odor and approximate amount;

168

F686 SKIN INTEGRITY

- At a minimum, documentation with each dressing change or at least weekly should include the date observed and:
  - Pain, if present: nature and frequency;
  - Wound bed: color and type of tissue/character including evidence of healing, or necrosis; and
  - Description of wound edges and surrounding tissue as appropriate

169

F686 SKIN INTEGRITY

- If a PU/PI fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed.
- The clinicians if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing

170

F689 ACCIDENTS

- **QUALITY OF CARE**
  - ***§483.25(d)***
  - ***Accidents***

F689

171

F689 ACCIDENTS

- The facility must ensure that-
  - The resident environment remains as free of accident hazards as is possible; and
  - Each resident receives adequate supervision and assistance devices to prevent accidents

172

F689 ACCIDENTS

- Identification of Hazards and Risks
  - Identification of hazards and risks is the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident

173

F689 ACCIDENTS

- Monitoring and Modification
  - Monitoring and modification processes include:
    - Ensuring that interventions are implemented correctly and consistently
    - Evaluating the effectiveness of interventions
    - Modifying or replacing interventions as needed and
    - Evaluating the effectiveness of new interventions

174

F689 ACCIDENTS

- Resident Smoking
  - Assessment of the resident's capabilities and deficits determines whether or not supervision is required
  - If the facility identifies that the resident needs assistance and supervision for smoking, the facility includes this information in the resident's care plan, and reviews and revises the plan periodically as needed

175

F689 ACCIDENTS

- Residents who wish to use e-cigarettes should be assessed for their ability to safely handle the device

176

F689 ACCIDENTS

- Falls
  - The MDS defines a fall as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force
  - Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred

177

F689 ACCIDENTS

- Evaluation of all of the causal factors leading to a resident fall assists the facility in developing and implementing relevant, consistent, and individualized interventions to prevent future occurrences

178

F689 ACCIDENTS

- Proper actions following a fall include:
  - Ascertaining if there were injuries, and providing treatment as necessary;
  - Determining what may have caused or contributed to the fall, including ascertaining what the resident was trying to do before he or she fell;

179

F689 ACCIDENTS

- Proper actions following a fall include:
  - Addressing the risk factors for the fall such as the resident's medical conditions(s), facility environment issues, or staffing issues; and
  - Revising the resident's plan of care and/or facility practices, as needed, to reduce the likelihood of another fall

180

F689 ACCIDENTS

- If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident
- Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis

181

F689 ACCIDENTS

- Wandering and Elopement
  - Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without the facility's awareness and/or appropriate supervision
  - The resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement

182

F689 ACCIDENTS

- Substance Use Disorder (SUD)
  - Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents
  - Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address this risk

183

F689 ACCIDENTS

- A situation in which a resident with decision-making capacity leaves the facility intentionally wound generally not be considered an elopement unless the facility is unaware of the resident's departure or whereabouts.
- A resident who leaves the facility prior to his/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)

184

F689 ACCIDENTS

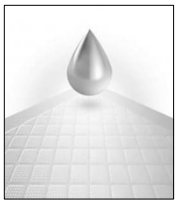
- Documentation in the medical record should show that facility staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA
- Documentation should also identify the time the facility became aware of the resident leaving the facility

185

F690 INCONTINENCE

- **QUALITY OF CARE**
  - ***§483.25(e)***
  - ***Incontinence***

F690



186

F690 INCONTINENCE

- The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

187

F690 INCONTINENCE

- For a resident with urinary incontinence, based on comprehensive assessment, the facility must ensure that –
  - A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

188

F690 INCONTINENCE

- A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
- A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible

189

F690 INCONTINENCE

- Assessment
  - A resident should be assessed at admission regarding continence status and whenever there is a change in urinary function
  - When completing the comprehensive assessment, consider the following:
    - Prior history of bladder function
    - Voiding patterns
    - Medication review

190

F690 INCONTINENCE

- Assessment
  - When completing the comprehensive assessment, consider the following:
    - Patterns of fluid intake
    - Use of urinary tract stimulants or irritants
    - Pelvic and rectal examination to identify physical features that may directly affect urinary continence
    - Functional cognitive capabilities

191

F690 INCONTINENCE

- Assessment
  - When completing the comprehensive assessment, consider the following:
    - Type and frequency of physical assistance necessary
    - Pertinent diagnoses
    - Identification of and/or potential of developing complications
    - Tests or studies indicated to identify the type of urinary incontinence
    - Environmental factors and assistive devices

192

F690 INCONTINENCE

- Indwelling Urinary Catheter Use
  - Policies and procedures must be developed and implemented that address catheter care and services, including but not limited to:
    - ❑Documentation of the involvement of the resident/representative in the discussion of the risks/benefits of the use of catheter, remove of catheter when criteria/indication for use is no longer present, and the right to decline use.

193

F690 INCONTINENCE

- ❑Timely and appropriate assessment related to the indication for use of an indwelling catheter;
- ❑Identification and documentation of clinical indications for the use of a catheter
- ❑Criteria for the discontinuance of the catheter when the indication for use is no longer present;

194

F690 INCONTINENCE

- ❑Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures;
- ❑Response of the resident during the use of the catheter; and
- ❑Ongoing monitoring for changes in condition related to potential CAUTI's and recognizing, reporting, and addressing such changes.

195

F690 INCONTINENCE

- FECAL INCONTINENCE (FI)
  - The facility and attending practitioner should complete a comprehensive assessment and determine
    - Presenting symptoms and type of FI
    - Potential reversible/irreversible causes and risks
  - The resident should be re-evaluated whenever there is a change in bowel function.

196

F692 NUTRITION/HYDRATION

- **QUALITY OF CARE**
  - ***§483.25(g)***
  - ***Assisted nutrition and hydration***

F692

197

F692 NUTRITION/HYDRATION

- Based on a resident's comprehensive assessment, the facility must ensure that a resident –
  - Maintains acceptable parameters of nutritional status, such as:
    - Usual body weight or desirable body weight range
    - Electrolyte balance

198

F692 NUTRITION/HYDRATION

- The nutritional assessment may include the following information:
  - ❑General appearance
  - ❑Height
  - ❑Weight
  - ❑Food and fluid intake

199

F692 NUTRITION/HYDRATION

- The nutritional assessment may include the following information:
  - ❑Fluid loss or retention
  - ❑Altered nutrient intake, absorption, and utilization
  - ❑Laboratory/Diagnostic Evaluation

200

F692 NUTRITION/HYDRATION

- Current professional standards recommend weighing the resident:
  - ❑ On admission/readmission
  - ❑ Weekly for the first 4 weeks
  - ❑ At least monthly thereafter

201

F693 ENTERAL NUTRITION

- **QUALITY OF CARE**
  - ***§483.25(g)(4)-(5)***
  - ***Enteral Nutrition***

F693

202

F693 ENTERAL NUTRITION

- A resident who has been to eat enough alone or with assistance is not fed by enteral methods unless the resident's condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and
- A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications

203

F693 ENTERAL NUTRITION

- A clinically pertinent rational for using a feeding tube includes, but is not limited to:
  - An assessment of the resident's nutritional status, which may include
    - Usual food and fluid intake
    - Pertinent laboratory values
    - Appetite
    - Usual weight and weight changes

204

F693 ENTERAL NUTRITION

- A clinically pertinent rational for using a feeding tube includes, but is not limited to:
  - An assessment of the resident's clinical status, which may include:
    - ❑ Ability to chew, swallow and digest food and fluid
    - ❑ Underlying conditions affecting those abilities
    - ❑ Factors affecting appetite and intake
    - ❑ Prognosis

205

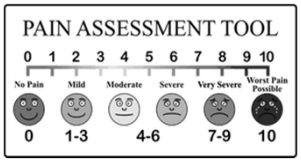
F693 ENTERAL NUTRITION

- A clinically pertinent rational for using a feeding tube includes, but is not limited to:
  - Relevant functional and psychosocial factors; and
  - Interventions attempted prior to the decision to use a feeding tube and the resident's response to them.

206

F697 PAIN MANAGEMENT

- **QUALITY OF CARE**
  - ❑ ***§483.25(k)***
  - ❑ ***Pain Management***



F697

207

F697 PAIN MANAGEMENT

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

208

F697 PAIN MANAGEMENT

- In addition to the Resident Assessment Instrument (RAI), it is important that the facility identifies how they will consistently assess pain.
- An assessment or an evaluation of pain based on professional standards of practice may necessitate gathering the following information:

209

F697 PAIN MANAGEMENT

- History of pain and its treatment
- History of addiction, past and/or ongoing
- Characteristics of pain
- Impact of pain on quality of life
- Factors such as activities, care, or treatment that precipitates or exacerbate pain, as well as those that reduce or eliminate pain

210

F697 PAIN MANAGEMENT

- Additional symptoms associated with pain
- Physical and psychosocial issues
- Current medical conditions and medications; and
- The resident's goals for pain management and his/her satisfaction with the current level of pain control

211

F697 PAIN MANAGEMENT

- The facility's evaluation of the resident at admission and during ongoing assessments helps identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment

212

F698 DIALYSIS

- **QUALITY OF CARE**
  - ***§483.25(l)***
  - ***Dialysis***

F698

213

F698 DIALYSIS

- The facility must ensure that residents who require dialysis receive such services consistent with
  - Professional standards of practice,
  - The comprehensive person-centered care plan, and
  - The resident's goals and preferences

214

F698 DIALYSIS

- There must be a coordinated plan for dialysis treatments developed with input from both the nursing home and dialysis facility
- The communication process should include how to communication will occur, who is responsible for communicating, and where communication and responses will be documented in the medical record

215

F698 DIALYSIS

- The documentation should include, but is not limited to:
  - Timely medication administration
  - Physician orders, laboratory values and vital signs
  - Advanced Directives and code status
  - Nutritional/fluid management
  - Dialysis treatment provided and resident's response

216

F698 DIALYSIS

- The documentation should include, but is not limited to:
  - Dialysis adverse reactions/complications and/or recommendations for follow up observation and monitoring
  - Changes and/or decline in condition unrelated to dialysis
  - The occurrence or risk of falls

217

F698 DIALYSIS

- When dialysis is provided at a Medicare Certified Dialysis Facility (On or Offsite)
  - The nursing home staff must provide immediate monitoring and documentation of the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications.

218

F698 DIALYSIS

- When Home Hemodialysis is provided by Nursing Home Staff
  - The nursing home must have orders for the provision of the dialysis treatment, including:
    - The number of treatments per week
    - Length of treatment time
    - The type of dialyzer

219

F698 DIALYSIS

- The nursing home must have orders for the provision of the dialysis treatment, including:
  - Specific parameters of the dialysis delivery system
  - Anticoagulation
  - The resident's target weight

220

F699 TRAUMA-INFORMED CARE

- **QUALITY OF CARE**
  - ***§483.25(m)***
  - ***Trauma-informed care***

F699

221

F699 TRAUMA-INFORMED CARE

- **TRAUMA INFORMED CARE**
  - The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident

222

F699 TRAUMA-INFORMED CARE

- Facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences

223

F699 TRAUMA-INFORMED CARE

- This would include:
  - Asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event
  - Screening tools
    - Resident assessment instrument (RAI)
    - Admission Assessment
    - History and Physical
    - Social history/assessment

224

F700 BED RAILS

- **QUALITY OF CARE**
  - ***§483.25(n)***
  - ***Bed Rails***

F700

225

F700 BED RAILS

- **Bed Rails**
  - The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements
    - Assess the resident for risk of entrapment from bed rails prior to installation

226

F700 BED RAILS

- Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation
- Ensure that the bed's dimensions are appropriate for the resident's size and weight
- Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails

227

F700 BED RAILS

- In determining whether to use bed rails to meet the needs of a resident, the following components of the assessment should be considered including, but not limited to:
  - Medical diagnosis, condition, symptoms, and/or behavior symptoms;
  - Size and weight;

228

F700 BED RAILS

- Sleep habits;
- Medication(s);
- Acute medical or surgical interventions;
- Underlying medical conditions;
- Existence of delirium;
- Ability to toilet self safely;
- Cognition;
- Communication;
- Mobility (in and out of bed); and
- Risk of falling

229

F700 BED RAILS

- The 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
  - The facility must also assess the resident's risk from using bed rails

230

F700 BED RAILS

- After appropriate alternatives have been attempted and prior to installation, the facility must obtain informed consent from the resident or the resident representative for the use of bed rails.
- The facility should maintain evidence that it has provided sufficient information so that the resident or resident representative could make an informed decision

231

F700 BED RAILS

- If no appropriate alternative was identified, the medical record would have to include evidence of the following
  - Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful
  - Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight)

232

F700 BED RAILS

- Risks and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use

233

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FEDERAL REGULATIONS

PHARMACY SERVICES

234

F757 UNNECESSARY DRUGS

- **PHARMACY SERVICES**
  - ***§483.45(d)***
  - ***Unnecessary Drugs - General***

F757

235

F757 UNNECESSARY DRUGS

- Each resident's drug regimen must be free from unnecessary drugs.

236

F757 UNNECESSARY DRUGS

- An unnecessary drug is any drug when used –
  - In excessive dose
  - For excess duration; or
  - Without adequate monitoring; or
  - Without adequate indications for its use; or
  - In the presence of adverse consequences which indicate the does should be reduced or discontinued; or
  - Any combination of reasons stated above

237

F758 PSYCHOTROPIC DRUGS

- **PHARMACY SERVICES**
  - ***§483.45(e)(1)(5)***
  - ***Psychotropic Drugs***

F758

238

F758 PSYCHOTROPIC DRUGS

- Based on a comprehensive assessment of the resident the facility must ensure that –
  - Residents who have not used psychotropic drugs are not give these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

239

F758 PSYCHOTROPIC DRUGS

- Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosis specific condition that is document in the medical record

240

F758 PSYCHOTROPIC DRUGS

- PRN order for psychotropic drugs are limited to 14-days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14-days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order

241

F758 PSYCHOTROPIC DRUGS

- PRN orders for anti-psychotic drugs are limited to 14-days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriate of that medication.

242

F757/F758 PHARMACY SERIVCES

- Key elements of noncompliance
  - Failure to document a clinical reason or clinically pertinent rationale, for using medication
  - Failure to attempt non-pharmacological approaches, unless clinically contraindicated
  - Failure to monitor the responses to or effects of the medication

243

F757/F758 PHARMACY SERIVCES

- Key elements of noncompliance
  - Failure to respond when monitoring indicate a lack of progress toward the therapeutic goal
  - Failure to care out the monitoring that was ordered or failure to monitor for potential adverse consequences
  - Failure to monitor effectiveness of non-pharmacological approaches

244

F759 MEDICATION ERRORS

- **PHARMACY SERVICES**
  - ***§483.45(f)***
  - ***Medication Errors***

F757

245

F759 MEDICATION ERRORS

- The facility must ensure that its medication error rates are not 5% or greater; and
- The facility must ensure that its residents are free of any significant medication errors

246

F759 MEDICATION ERRORS

- Medication errors means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:
  - The prescriber's order;
  - Manufacturer's specifications regarding the preparation and administration of the medication/biological; or

247

F759 MEDICATION ERRORS

- Medication errors means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:
  - Accepted professional standards and principles which apply to professionals providing services.

248

F759 MEDICATION ERRORS

- Omitted Does Errors:
  - Medication ordered, but not given
- Timing Errors:
  - Medication is administered 60 or more minutes earlier or later than its scheduled time of administration
  - Medication administered after meals, when order is written for before meals

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FEDERAL REGULATIONS

LABORATORY RADIOLOGY AND OTHER DIAGNOSTIC SERVICES

250

F773 LABS/DIAGNOSTICS

- **LABORATORY, RADIOLOGY AND DIAGNOSTIC**
  - ***§483.50(a)(2)***
  - ***Provide or obtain laboratory services only when ordered and Promptly notify the ordering physician***

F773

251

F773 LABS/DIAGNOSTICS

- The facility must
  - Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws

252

F773 LABS/DIAGNOSTICS

- Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders

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FEDERAL REGULATIONS

FOOD AND NUTRITION SERVICES

254

F808 THERAPEUTIC DIETS

- **FOOD AND NUTRITION SERVICES**
  - ***§483.60***
  - ***Therapeutic Diets***

F808

255

F808 THERAPEUTIC DIETS

- Therapeutic diets must be prescribed by the attending physician
- The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law

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FEDERAL REGULATIONS

ADMINISTRATION

257

F849 HOSPICE SERVICES

- **HOSPICE SERVICES**
  - ***§483.70(o)(3)***
  - ***Hospice Services***

F849

258

F849 HOSPICE SERIVCES

- Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff.
- The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

259

F849 HOSPICE SERIVCES

- The designated interdisciplinary team member is responsible for the following:
  - Collaborating with hospice representatives and coordinating LTC staff participation in the hospice care planning process
  - Communicating with hospice representatives and other providers participating in the provision of care for the terminal illness and related conditions to ensure quality of care for the patient and family

260

F849 HOSPICE SERIVCES

- The designated interdisciplinary team member is responsible for the following:
  - Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician and other practitioners as needed to coordinator the hospice care with the medical care provided by other physicians
  - Ensure that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, forms, and record keeping requirements, to hospice staff

261

F849 HOSPICE SERIVCES

- The designated interdisciplinary team member is responsible for the following:
  - Obtaining the following information from the hospice:
    - The most recent hospice plan of care
    - Hospice election form
    - Physician certification/recertification of terminal illness
    - Names and contact information for hospice personnel

262

F849 HOSPICE SERIVCES

- The designated interdisciplinary team member is responsible for the following:
  - Obtaining the following information from the hospice:
    - Instructions on how to access the hospice's 24-hour on-call system
    - Hospice medication information
    - Hospice physician and attending physician (in any) orders

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FEDERAL REGULATIONS

ADMISSION, TRANSFER, AND DISCHARGE

264

F622 ADMIT, TRANSFER,DC

- **ADMISSION, TRANSFER, AND DISCHARGE**
  - ***§483.15(c)***
  - ***Transfer and discharge***
  - ***§483.15(c)(1)***
  - ***Facility Requirements***

F622

265

F622 ADMIT, TRANSFER,DC

- The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless
  - (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
  - (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

266

F622 ADMIT, TRANSFER,DC

- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- (D) The health of individuals in the facility would otherwise be endangered;

267

F622 ADMIT, TRANSFER,DC

- (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay
- (F) The facility ceases to operate

268

F622 ADMIT, TRANSFER,DC

- Documentation
  - When the facility transfers or discharges a resident the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider

269

F622 ADMIT, TRANSFER,DC

- Documentation in the resident's medical record must include:
  - The basis for the transfer
  - In the case of (A), the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)
- This documentation must be made by the resident's physician

270

F622 ADMIT, TRANSFER,DC

- Information provided to the receiving provider for transfers must include a minimum of the following:
  - ❑ Contact information of the practitioner responsible for the care of the resident
  - ❑ Resident representative information including contact information
  - ❑ Advance Directive information
  - ❑ All special instructions or precautions for ongoing care, as appropriate

271

F622 ADMIT, TRANSFER,DC

- ❑ Comprehensive care plan goals
- ❑ All other necessary information, including a copy of the resident's discharge summary and any other documentation, as applicable, to ensure a safe and effective transition of care

272

F622 ADMIT, TRANSFER,DC

- ❑ All special instructions and/or precautions for ongoing care, as appropriate such as
  - ❑ Treatments and devices (oxygen, implants, IVs, tubes/catheters)
  - ❑ Transmission-based precautions such as contact, droplet, or airborne
  - ❑ Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions

273

F622 ADMIT, TRANSFER,DC

- All other information necessary to meet the resident's needs, which includes, but may not be limited to
  - Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs
  - Diagnoses and allergies

274

F622 ADMIT, TRANSFER,DC

- Medications (including when last received); and
- Most recent relevant labs, other diagnostic tests, and recent immunizations
- Additional information, if any, outlined in the transfer agreement with the acute care provider

275

F623 ADMIT, TRANSFER,DC

➢**ADMISSION, TRANSFER, AND DISCHARGE**

- ***§483.15(c)(3)***
- ***Notice before transfer***

F623

276

F623 ADMIT, TRANSFER,DC

- Before a facility transfers or discharges a resident, 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 and in a language and manner they understand
  - The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman

277

F623 ADMIT, TRANSFER,DC

- Timing of the notice
  - The notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged

278

F623 ADMIT, TRANSFER,DC

- Notice must be made as soon as practicable before transfer or discharge when
  - The safety of individuals in the facility would be endangered
  - The health of individuals in the facility would be endangered
  - The resident's health improves sufficiently to allow a more immediate transfer or discharge

279

F623 ADMIT, TRANSFER,DC

- Notice must be made as soon as practicable before transfer or discharge when
  - An immediate transfer or discharge is required by the resident's urgent medical needs
  - A resident has not resided in the facility for 30 days

280

F623 ADMIT, TRANSFER,DC

- Contents of the notice must include the following:
  - ❑ The reason for transfer or discharge
  - ❑ The effective date of transfer or discharge
  - ❑ The location to which the resident is transferred or discharged

281

F623 ADMIT, TRANSFER,DC

- ❑ A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request
- ❑ The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman

282

F623 ADMIT, TRANSFER,DC

- For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and

283

F623 ADMIT, TRANSFER,DC

- For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

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NURSING HOME TRANSFER AND DISCHARGE NOTICE

Refer to section 400.0255, Florida Statutes. This form is required for those transfers or discharges initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

Resident Information

Name: _____

Medicaid ID # (if applicable): _____

Resident Representative (if applicable)

Name: _____

Address: _____

Phone: _____

Nursing Home Information

Name: _____

Address: _____

_____

Phone: _____

Facility contact person: _____

Contact phone: _____

Date Notice is given: _____

Effective Date: _____

The effective date must be at least 30 days from date notice is given unless an exception applies. The resident may choose to move earlier than effective date.

Location to which resident is transferred or discharged (required):

Name: _____

Address: _____

_____

Phone: _____

Reason for Discharge or Transfer:

☐ Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay.

☐ This facility is closing.

The following reasons require either this form be signed by a physician or a physician's written order for discharge or transfer be attached. The signing physician may be the resident's attending or treating physician, the facility medical director, or a nurse practitioner or physician's assistant as a physician designee:

☐ Your needs cannot be met in this facility.

☐ Your health has improved sufficiently so that you no longer need the services provided by this facility.

☐ The health of other individuals in this facility is endangered.

☐ The safety of other individuals in this facility is endangered.

Brief explanation to support this action, (attach additional documentation if necessary):

_____

_____

AHCA Form 3120-0002, April 2014
Page 1 of 2

Section 59A-4.1261(1), Florida Administrative Code
Form available at: http://ahca.myflorida.com

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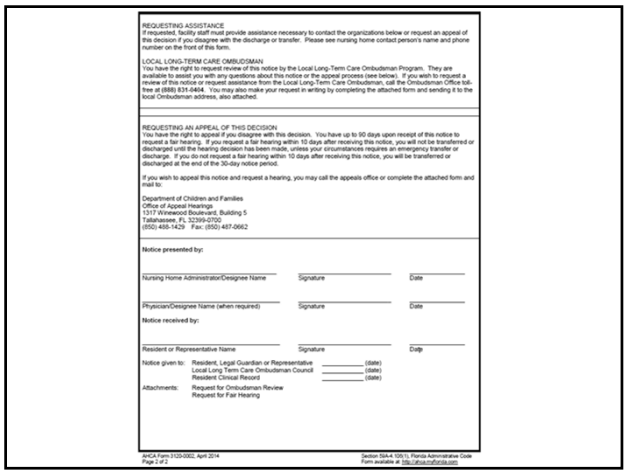

REQUESTING ASSISTANCE
If requested, facility staff must provide assistance necessary to contact the organizations below or request an appeal of this decision if you disagree with the discharge or transfer. Please see nursing home contact person's name and phone number on the front of this form.

LOCAL LONG-TERM CARE OMBUDSMAN
You have the right to request review of this notice by the Local Long-Term Care Ombudsman Program. They are available to assist you with any questions about this notice or the appeal process (see below). If you wish to request a review of this notice or request assistance from the Local Long-Term Care Ombudsman, call the Ombudsman Office toll-free at (888) 831-0404. You may also make your request in writing by completing the attached form and sending it to the local Ombudsman address, also attached.

REQUESTING AN APPEAL OF THIS DECISION
You have the right to appeal if you disagree with this decision. You have up to 90 days upon receipt of this notice to request a fair hearing. If you request a fair hearing within 10 days after receiving this notice, you will not be transferred or discharged until the hearing decision has been made, unless your circumstances requires an emergency transfer or discharge. If you do not request a fair hearing within 10 days after receiving this notice, you will be transferred or discharged at the end of the 30-day notice period.

If you wish to appeal this notice and request a hearing, you may call the appeals office or complete the attached form and mail to:

Department of Children and Families
Office of Appeal Hearings
1317 Winewood Boulevard, Building 5
Tallahassee, FL 32399-0700
(850) 488-1429 Fax: (850) 487-0662

Notice presented by:

Nursing Home Administrator/Designee Name | Signature | Date

Physician/Designee Name (when required) | Signature | Date

Notice received by:

Resident or Representative Name | Signature | Date

Notice given to: Resident, Legal Guardian or Representative _____ (date)
Local Long Term Care Ombudsman Council _____ (date)
Resident Clinical Record _____ (date)

Attachments: Request for Ombudsman Review
Request for Fair Hearing

AHCA Form 3120-0002, April 2014 Section 59A-4.109(1), Florida Administrative Code
Page 2 of 2 Form available at: http://ahcaoncfloridia.com

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F623 ADMIT, TRANSFER,DC

- Changes to the notice
  - If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available

287

F623 ADMIT, TRANSFER,DC

- When a resident initiates his or her transfer or discharge, the medical record should contain
  - Documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility,
  - A discharge care plan, and
  - Documented discussions with the resident or if appropriate his/her representative, containing details of discharge planning, and arrangements for post-discharge care

288

F625 ADMIT, TRANSFER,DC

- **ADMISSION, TRANSFER, AND DISCHARGE**
  - ***§483.15(d)***
  - ***Notice of bed-hold policy and return***

F625

289

F625 ADMIT, TRANSFER,DC

- Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies -

290

F625 ADMIT, TRANSFER,DC

- The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
- The reserve bed payment policy in the state plan, If any;
- The nursing facility's policies regarding bed-hold periods

291

F625 ADMIT, TRANSFER,DC

- At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy

292

F625 ADMIT, TRANSFER,DC

- Facilities must provide written information about these policies to residents prior to and upon transfer for such absences, to all facility residents, regardless of their payment source

293

F625 ADMIT, TRANSFER,DC

- These provisions require facilities to issue two notices related to bed-hold policies.
  - The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet.

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F625 ADMIT, TRANSFER,DC

- The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours

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DOCUMENTATION COMPLIANCE

RECORD REVIEWS

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RECORD REVIEWS

- Admission Audits
- Long-Term Care Audits
- Discharge Audits
- Billing Compliance Review

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RECORD REVIEW

- Admission Audits
  - Transfer Documentation
    - 3008
    - PASARR
  - Admission Documentation
    - Consents
    - Evaluations
    - Care Plans

298

RECORD REVIEW

- Admission Audits
  - Initial review
    - 24-72 hours after admission
  - Follow up review
    - 2 weeks post admission

299

RECORD REVIEW

- Long-Term Care Audits
  - Physician Visits
  - Physician Order
  - Quarterly Evaluations/Assessments
- Complete review quarterly following MDS schedule

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RECORD REVIEW

- Discharge/Transfer Audits
  - Discharge Summary
  - Transfer Form
  - Notice before Transfer
  - Bed hold notice
  - Discharge/Transfer Order

301

RECORD REVIEW

- Discharge/Transfer Audits
  - Complete review within 24-72 hours post discharge or transfer
  - Complete for every transfer and discharge, even if resident returns within a few hours

302

RECORD REVIEW

- Billing Compliance Review
  - Medicare Certifications
  - MDS
  - Therapy evaluations
  - Physician orders

303

RECORD REVIEW

- Billing Compliance Review
  - Medicare Certifications
  - MDS
  - Therapy evaluations
  - Physician orders
- Completed prior to monthly claims submission

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Q & A

Questions???

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Thank you for your participation

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robin@rbhealthpartners.com or call us at 727.786.3032.
Click HERE for more info about this Presenter

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References

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- State Operations Manual Appendix PP https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- RAI Manual

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References

- Medicare Benefit Policy Manual - Chapter 15 https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/bp102c15_0.pdf
- Medicare Benefit Policy Manual - Chapter 8 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf

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