HealthTech

Non-Certified - or – Subacute - or Long-Term Swing Bed

Carolyn St. Charles, MBA, BSN, RN,
Chief Clinical Officer

December 5, 2025

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a Master's degree in Business Administration from the Foster School of Business at the University of Washington and a Bachelor's degree in nursing from Northern Arizona University.

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Sept 2025 – Jan 2026 webinars

All webinars are recorded for on-demand viewing

New CoPs for safe obstetrical care

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: September 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oI6G5i

HR 101: What matters most

Presenter: Kimberly Butts - Human Resources
Date: September 19, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3V8TIjw

QAPI that matters

Presenter: Susan Runyan, Chief Executive Officer - Runyan Health Care Quality Consulting
Date: October 3, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45oIi15

An innovative approach to rehab in a CAH Swing Bed program

Presenter: Stephen Leone, PT - CEO of Rural Health Resources
Date: October 17, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oFNkxO

Swing Bed what's new? - what's changed? - what's the same?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: October 24, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Ve3iS9

Care Coordination service lines & you

Presenter: Marcella A Wright, DNP, MS, RN, Director Care Coordination & LEAN Consulting
Date: November 7, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Jko8wF

Non-Certified / Long-Term Swing Bed

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: December 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45WBzLZ

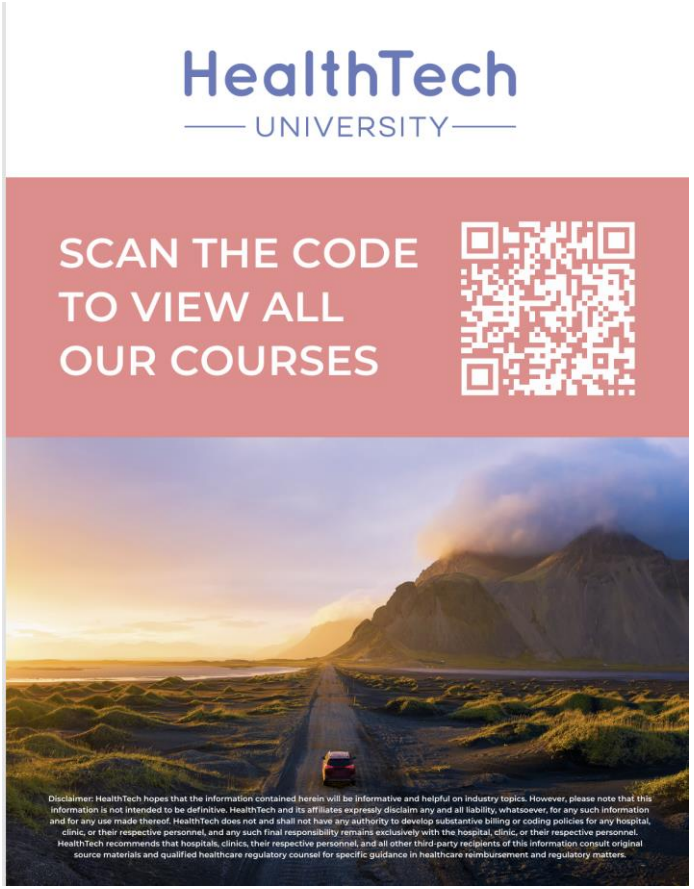
Tools to increase employee engagement: Lessons from a 99th percentile hospital

Presenter: Mike Schafer - CEO of Spooner Health
Date: January 9, 2026 | Time: 12pm CST
URL: https://bit.ly/3UAFRIR

REH 101: A compliance guide for Rural Emergency Hospitals

Presenter: Cheri Benander, RN MSN, CHC, C-NHCE, HACP-CMS
Date: January 23, 2026 | **Time:** 12pm CST
URL: https://bit.ly/41PxdUt

HealthTech University



https://www.health-tech.us/healthtech-university-courses/

Learning Objectives

1. Identify the regulatory requirements applicable to non-certified Swing Bed patients
2. Describe at least three (3) strategies for improving patients' quality of care and quality of life
3. Describe the difference in a plan of care for a short-term swing bed patient and a long-term swing bed patient
4. Identify how to implement an evidence-based restorative program

Description

Many Critical Access Hospitals care for non-certified or long-term Swing Bed patients. Non-certified generally refers to Swing Bed patients who stay in the Swing Bed for an extended period, often for the duration of their lives.

These patients must be provided with care and services to ensure that care is provided in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality.

Although caring for long-term patients is not always easy in a hospital setting, the webinar will discuss some of the applicable standards in Appendix PP as well as tips for improving quality of life, including but not limited to activities, restorative program, pharmacist review, and psychotropic drug management.

Instructions for Today

Please feel free to write questions in the Chat Box

The webinar is recorded, and you will receive the recording within 2 days

Disclaimer

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What Are Non-Certified (Long-Term) Swing Beds?

Non-Certified Swing Beds are Funded by Medicaid in Some States

Alaska
Swing beds allow rural hospitals to provide nursing home care in otherwise empty hospital beds, which provides rural residents increased access to long term care services and allows the hospital use empty beds. The swing-bed concept allows a hospital to use their beds interchangeably for either acute-care or post-acute care, for either SNF or ICF level of care.

Montana
Swing beds are to be used only when there is no appropriate nursing facility bed available within a 25-mile radius of the swing bed hospital or critical access hospital that can meet the member's needs. Swing bed hospitals and critical access hospitals must canvas all the nursing facilities within the 25-mile radius to determine the availability of an appropriate nursing facility bed prior to admission of the member to the swing bed.

California
The rural hospital swing bed program offers Long Term Care (LTC) services in areas where there is a shortage of Nursing Facility Level B (NF-B) beds. DP/NF-B services provided to patients in swing beds will be reimbursed pursuant to CCR, title 22, section 51511 (a)(4).

Non-Certified Swing Beds
A Different Level of Care

- ❑ Emergency Department
- ❑ ICU
- ❑ Med-Surg
- ❑ Obstetrics
- ❑ OP Infusion/Chemotherapy
- ❑ Certified (Short-Term) Swing Bed
- ❑ **Non-Certified (Long-Term) Swing Bed**

Certified Swing Bed
3 – 4 weeks - I'm going home!

Non-Certified Swing Bed
I live here – this is my home!

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Quality of Life Best Practices

Not Always Easy!

It's not easy in a hospital environment to provide patient-centered care for Long Term / Non-Certified patients

Especially since staff are also caring for inpatients, observation patients, and certified Swing Bed patients.

And…. It's not just about the regulations –
It's about making the environment **HOME**

The following slides include some ideas for maintaining/improving Quality of Life

Personal Possessions

Familiar Items --- Encourage patients to decorate rooms and bring in personal items

F557 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

F584 §GUIDANCE §483.10(i) A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The intent of the word “homelike” in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible.

Socialization and Communication

- ❑ **Address Isolation**
  - Encourage family visits -- Group social interaction -- Activities
- ❑ **Provide Access to Technology**
  - Access to computers, tablets, etc., for communication and entertainment
- ❑ **Foster a Sense of Community**
  - Shared meals -- Shared activities -- Social Events

F550 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

Activities

- ❑ **Provide Comfortable and Functional Spaces**
  - Provide at least one space where there is access to games/puzzles/TV/dining

- ❑ **Offer a Variety of Activities**
  - Provide routine activities --- Ideally in a group environment

(Not required in Appendix W other than meeting psycho-social needs)
F679 Activities §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Activities Calendar

February 2025

In a world where you can be anything you want... BE KIND!

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
2 11:00 TV-10 Methodist Church Services **1:00 ISB Day Room** Jetmore Methodist	3 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	4 10:00 Meaningful Movement **1:00 Resident Meeting** 3:45 Kids Can	5 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	6 10:00 Bible Study 10:00 1 on 1 Visits 2:00 Hymn Singing 3:00 Ice Cream 3:45 Kids Can	7 10:00 Manicures 1:00 Bingo 2:00 Snacks	8 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
9 11:00 TV-10 Methodist Church Services **1:00 ISB Day Room** Jetmore Baptist	10 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	11 **9:00 Rummage Sale** 1:00 1 on 1 Visits 2:00 Games 3:45 Kids Can	12 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	13 10:00 Bible Study 10:00 1 on 1 Visits **2:00 Valentine's Party**	14 10:00 Manicures 1:00 Bingo 2:00 Snacks Happy Valentine's Day	15 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
16 11:00 TV-10 Methodist Church Services **1:00 ISB Day Room** Jetmore Catholic	17 10:00 Word Games 10:45 Daily Devotion 2:00 BINGO 3:00 Snacks	18 10:00 Meaningful Movement 1:00 1 on 1 Visits 2:00 Games 3:45 Kids Can	19 10:00 Dominoes 1:00 1 on 1 visits 2:00 BINGO 3:00 Snacks	20 10:00 Bible Study 10:00 1 on 1 Visits 2:00 Hymn Singing 3:00 Ice Cream 3:45 Kids Can	21 10:00 Manicures 1:00 Bingo 2:00 Snacks	22 Family & Friends Visit 10:00 Activity 2:00 Activity 7:00 TV-9 Lawrence Welk
23 11:00 TV-10 Methodist Church Services	24 10:00 Word Games 10:45 Daily Devotion	25 10:00 Meaningful Movement	26 10:00 Dominoes 1:00 1 on 1 visits	27 10:00 Bible Study 10:00 1 on 1 Visits	28 10:00 Manicures 1:00 Bingo	

Independence

- **Encourage independence**

DO NOT DO FOR PATIENTS WHAT THEY CAN DO THEMSELVES – even if it takes longer!

Choice

Personal Choice

- ❑ Allow choice of routine (meals, activities, sleep schedule, etc.)

Family Support

- **Encourage Family Participation**
  - Facilitate family visits
  - Involve family in care planning
- **Promote Open Communication**
  - Open and transparent communication
- **Provide Resources and Support**
  - Ongoing resources and support for patients and families

Understand Me

- ❑ Focus assessments on quality of life and function ----- not illness
- ❑ Vital Signs at an appropriate frequency (NOT every shift)
- ❑ Assessments at an appropriate frequency (NOT every shift)

These are not acute care patients!

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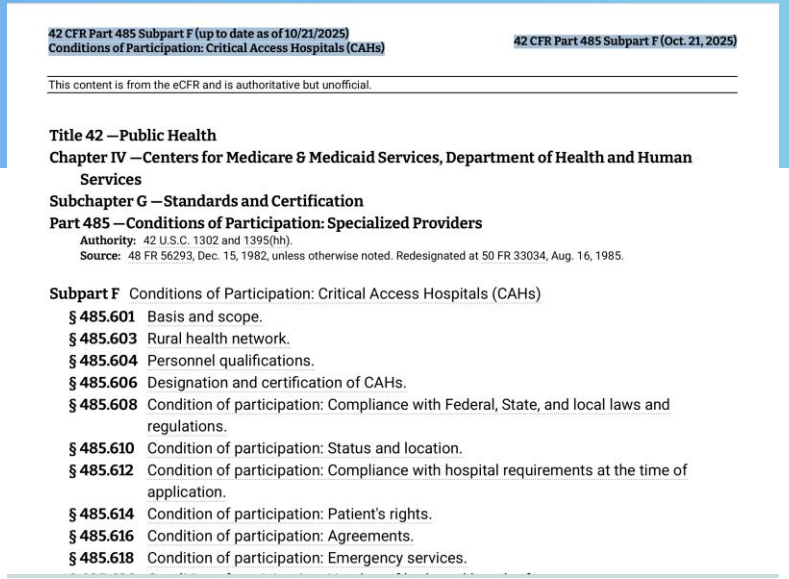
Regulatory Requirements

Regulatory Requirements Hospital Wide -- - include Certified & Non-Certified Pts.

- EOC/Life Safety
- Emergency Management
- Human Resources
- Medical Staff
- Medication Management
- Infection Prevention
- Antibiotic Stewardship
- QAPI
- **ETC.**

Regulatory Requirements



42 CFR Part 485 Subpart F (up to date as of 10/21/2025) 42 CFR Part 485 Subpart F (Oct. 21, 2025)

This content is from the eCFR and is authoritative but unofficial.

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter G —Standards and Certification
Part 485 —Conditions of Participation: Specialized Providers

Authority: 42 U.S.C. 1302 and 1395(hh).
Source: 48 FR 56293, Dec. 15, 1982, unless otherwise noted. Redesignated at 50 FR 33034, Aug. 16, 1985.

Subpart F Conditions of Participation: Critical Access Hospitals (CAHs)

New CoPs as of 10/21/25

42 CFR Part 485 Subpart F (up to date as of 10-21-2025).pdf
file:///C:/Users/carol/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/UM3J2VJS/42%20CFR%20Part%20485%20Subpart%20F%20(up%20to%20date%20as%20of%2010-21-2025).pdf

Not in Appendix W – *yet!*

Code of Federal Regulations for CAHs October 2025 – Changes since 2020

- ❑ Patient Rights 11/23/2022
  - Patient Rights
  - Trauma Informed Care
  - Restraint Death Reporting
- ❑ Emergency Services effective 7/1/2025
  - New OB standards for Emergency Care
- ❑ Staffing and Staff Responsibilities 11/23/2022
- ❑ Provision of Services 11/23/2022
- ❑ Infection Prevention 8/28/2024
  - Respiratory Illness Reporting
  - Public Health Emergency
- ❑ QAPI effective 1/1/2027
  - OB and maternal morbidity measures
  - QAPI project related to OB
- ❑ Obstetrics effective 1/1/2026
- ❑ Obstetrics effective 1/1/2027

NO Changes to Swing Bed CoPs

State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX

Survey Protocol

Regulations and Interpretive Guidelines for CAHs

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-25-14-NH

DATE: March 10, 2025

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: **REVISED**: Revised Long-Term Care (LTC) Surveyor Guidance: Significant revisions to enhance quality and oversight of the LTC survey process

Memo Revision Information:
Revisions to: *QSO-25-12-NH* ***Original release date:*** *January 16, 2025*

Memorandum Summary

Revised Surveyor Guidance: CMS is releasing the following revised guidance for nursing home surveyors:

- Admission, Transfer & Discharge, Chemical Restraints/Unnecessary Psychotropic Medication, Resident Assessment, Nursing Services, Payroll Based Journal, Quality of Life and Quality of Care, Administration, Quality Assurance Performance Improvement (QAPI), Infection Prevention and Control, and other areas.
- Clarifications and technical corrections have also been made throughout Appendix PP.

Associated Training and Resources:

- Training on this guidance will be available upon release of this memorandum for surveyors and providers.
- Advance copy of the Critical Element Pathways are attached to this memo.
- Advanced copy of Appendix PP is attached to this memo.
- Revised Survey Resources will be posted on *April 28*, 2025.

Swing Bed - 12 Tags

- C-1600 §485.645 **Special Requirements** for CAH Providers of Long-Term Care Services (“Swing-Beds”)
- C-1602 §485.645(a) **Eligibility**
- C-1604 §485.645(b) Facilities Participating as **Rural Primary Care Hospitals** (RPCHs) on September 30, 1997
- C-1606 §485.645(c) **Payment**
- C-1608 §485.645(d) **SNF Services.**
- C-1610 §485.645(d)(2) **Admission, Transfer and Discharge Rights**
- C-1612 §485.645(d)(3) **Freedom from abuse, neglect and exploitation**
- C-1616 §485.645(d)(4) **Social Services**
- C-1620 §485.645(d)(5) **Comprehensive assessment, comprehensive care plan, and discharge planning**
- C-1622 §485.645(d)(6) **Specialized Rehabilitative Services**
- C-1624 §485.645(d)(7) **Dental Services**
- C-1626 §485.645(d)(8) **Nutrition**

Appendix W Swing Bed
NO Interpretive Guidelines for Swing Bed

C-1626 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).

Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

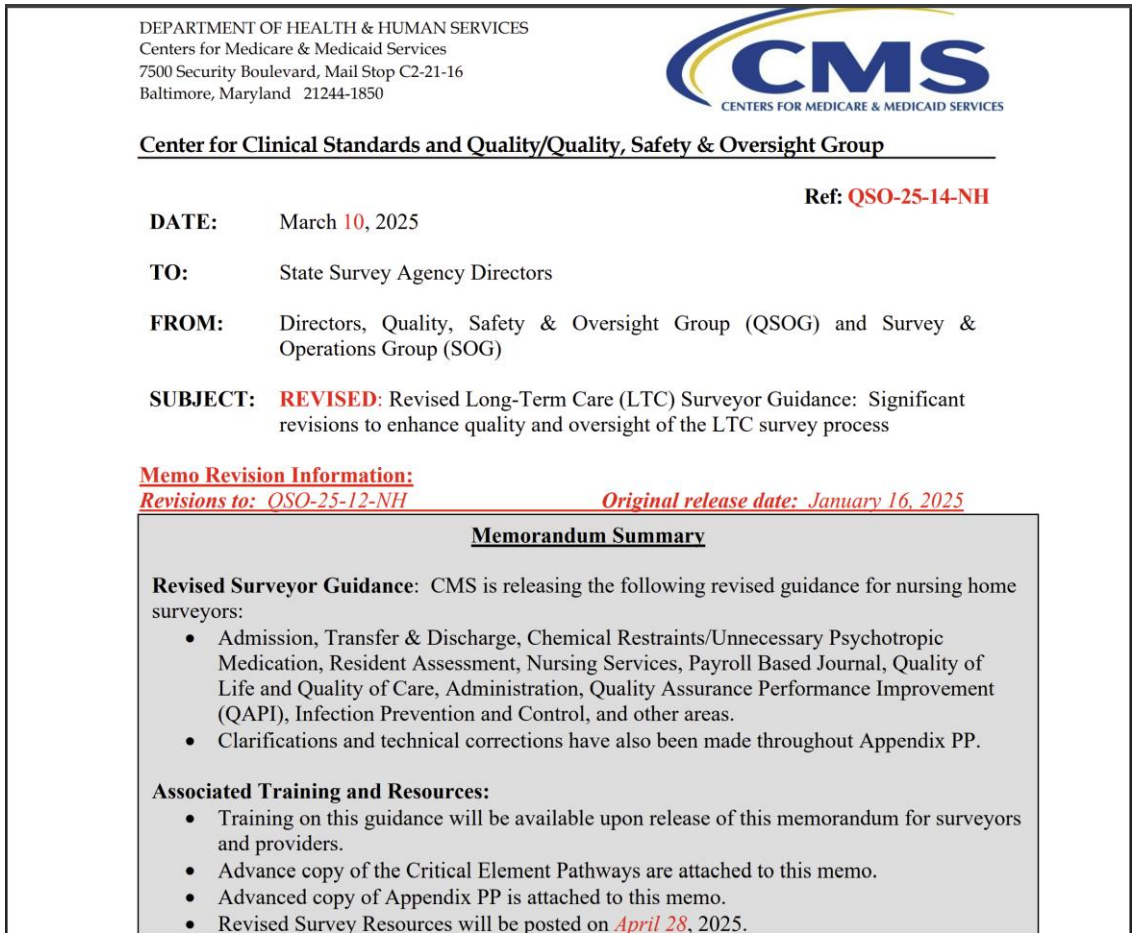
(2) Is offered sufficient fluid intake to maintain proper hydration and health.

Interpretive Guidelines §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)
Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

Long Term Care (LTC) New March 2025 Appendix PP Last Updated 8/2024

https://www.cms.gov/files/document/qso-25-14-nh.pdf



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Appendix PP Long Term Care Facilities March 10, 2025

- §483.5 Definitions
- §483.10 Resident Rights
- §483.12 Freedom from Abuse, Neglect, and Exploitation
- §483.15 Admission Transfer and Discharge Rights
- §483.20 Resident Assessment
- §483.21 Comprehensive Person-Centered Care Plans
- §483.24 Quality of Life
- §483.25 Quality of Care
- §483.30 Physician Services
- §483.35 Nursing Services
- §483.40 Behavioral health services
- §483.60 Food and483.45 Pharmacy Services
- §483.50 Laboratory Radiology and Other Diagnostic Services
- §483.55 Dental Services
- §483.60 Food and Nutrition Services
- §483.65 Specialized Rehabilitative Services
- §483.70 Administration
- §483.71 Facility Assessment
- §483.75 Quality Assurance and Performance Improvement
- §483.80 Infection Control §483.85 Compliance and Ethics Program
- §483.90 Physical Environment
- §483.95 Training Requirements

Most Frequent Question

WHICH REGS. IN APPENDIX PP SHOULD I FOLLOW?

Answer

Ideally, all of the Appendix PP regulations should be followed except those with a specific reference to the MDS process

Appendix PP Review

- Expanded Resident Rights
- Assessment - Admission - Quarterly - Annually
- Reassessment after significant change
- Interdisciplinary Care Planning with monthly updates
- Culturally Competent Trauma Informed Care
- Physician Visits and Certification
- Medication Management including psychotropics (monthly pharmacist review)
- Restorative Program
- Nutritional Care
- Activities (robust program)
- Restraints
- Other Clinical Considerations
- Resident Funds
- Staff Education and Competency

Crosswalk -- Under Construction!

Requirement	Certified	Non-Certified	
Education & Competency	No Requirements specific to Swing Bed	F726 F728 F943 (Abuse-Dementia)	F729 F730
Abuse	C-1612	F607	F726
Choice Post-Acute Care Providers	C-1425	F660 §483.21(c)(1)(vii)	
Admission: Resident Rights • Resident Rights (verbally) • Financial Disclosures • Choice of Physician • Physician Contact Info • Advance Directives • Privacy Practices • Freedom from Abuse and Neglect • Contact Info Ombudsman & Dept. of Health	C-1608 ALSO apply to Non-Certified Swing Bed	F605 Additional Resident Rights	

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Expanded Resident Rights

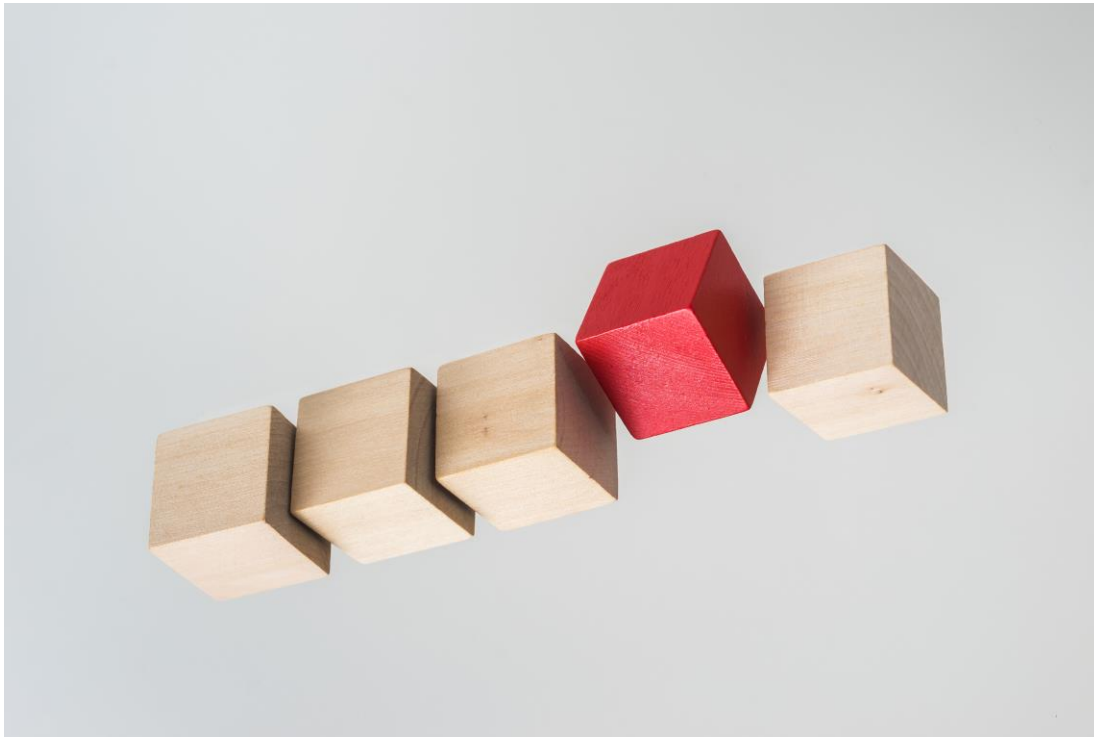
Patient Rights

Swing Bed Patient Rights are different that LTC Patient Rights published in Appendix PP

You are only accountable for the Swing Bed Patient Rights in Appendix W (and additional rights if required by State regulations)

However ---- for non-certified patients…… strongly recommend using at least some of the LTC Patient Rights

Some states also have required Patient Rights!



Patient Rights in Appendix PP (That are Not in Appendix W)

F-550: Right to exercise rights as a citizen or resident of the United States (Vote)

F-559: Right to share room with roommate of choice, when practicable

F-559: Right to receive written notice, including reason for change, before resident' room or roommate in the facility I changed

F-560: Right to refuse transfer to another room

F-561: Right to choose activities, schedules (including sleeping and waking times)

F-565: Right to organize and participate in resident groups

F-566: Right to choose or refuse to perform services for the facility

F-567: Right to manage financial affairs

F-577: Right to examine the results of the most recent survey
The facility must post the most recent survey results in a place accessible to residents, family members, legal representatives

Implementation of the additional rights ----- can help to provide Patient-Centered Care

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Assessment and Reassessment

Assessment

F636 §483.20 Comprehensive assessment at admission

F636 §483.20 The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts

F637 §483.20(b)(2)(ii) Reassessment within 14 days after significant change

F638 §483.20(c) Comprehensive Assessment at least every 3-months

Assessment Elements (Same as Appendix W)

F636 §483.20 Resident Assessment

The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. *(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS) (not applicable).* (xviii) Documentation of participation in assessment.

Assessment Process

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

Very Important to review

1) Activities of daily living
2) Normal routines
3) Preferences, including activities
4) Functional Status
5) Behaviors, if appropriate

Focus of assessment is not on illness!!

Re-Assessment After Significant Change

F637 §483.20(b)(2)(ii) 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.

(For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

What To Do

1) Ensure ALL staff who interact with patient – but especially clinical staff are aware of the definition of change
2) Complete a comprehensive reassessment after significant change

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Interdisciplinary Plan of Care

Baseline Care Plan

F655 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) 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— (i) Be developed **within 48 hours** of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to— (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.

F655 §483.21(a)(2) The facility **may develop** a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed **within 48 hours** of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

Comprehensive Care Plan

F656 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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**. The comprehensive care plan must describe the following —

(i) The **services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25 or §483.40;

The Care Plan SHOULD NOT BE FOCUSED ON ILLNESS

Comprehensive Care Plan, cont.

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) 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.

(iv)In consultation with the resident and the resident's representative(s)—

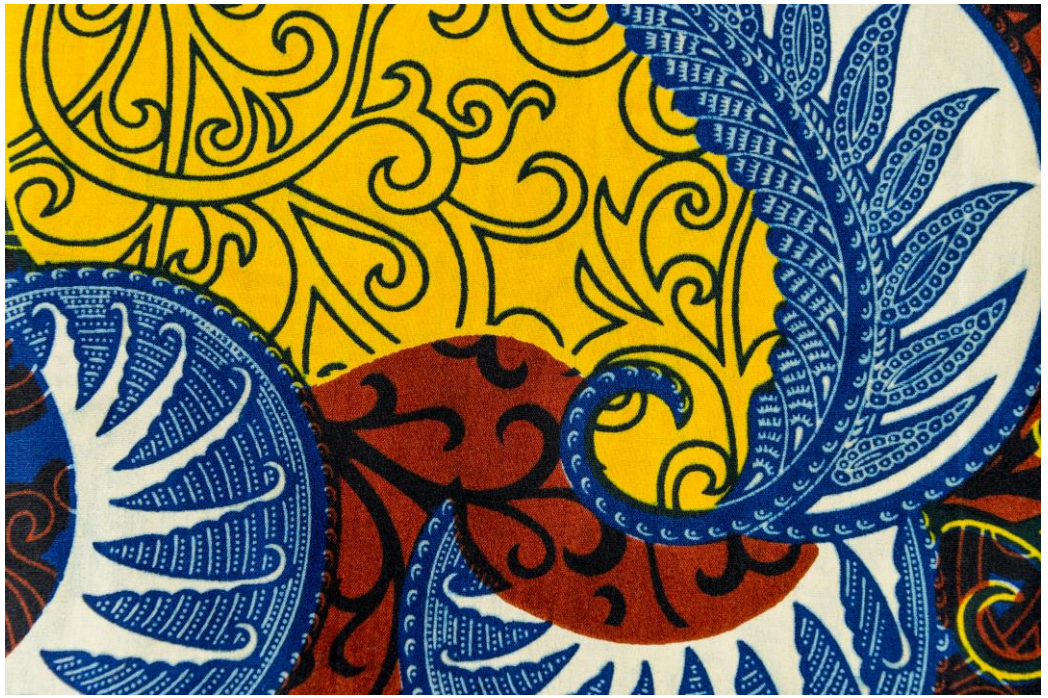
(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Comprehensive Care Plan, cont.

F656 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(iii) Be culturally-competent and trauma–informed



Comprehensive Care Plan

F657 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to–

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. \

(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Patient Right to Participate in Care Planning

F553 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.

(iv) The right to see the care plan, including the right to sign after significant changes to the plan of care.

Frequency of Care Plan Updates

When there is a change

Monthly and quarterly review

Make Care Plans Person-Centered

From (date) To (date)
Assessment / Problem: I have visual impairment due to cataracts and glaucoma. I am unable to read newspapers or print materials that are not in large print. I like to read and enjoy large print books. I am usually safe in my environment, but sometimes when things are moved, it is difficult for me to find them. I don't always see obstacles when I am walking. I sometimes forget to wear my glasses – please remind me.

Make Care Plans Person-Centered

Goal	Intervention	Responsibility	Time-Limited
I will have an eye exam by an ophthalmologist this quarter	Schedule an annual eye exam this quarter and arrange for transportation	Care Manager	By Jan. 1
I will be satisfied with the reading materials provided, and I will have at least one book I haven't read at all times	Provide large-print reading material based on the resident's preference for science fiction novels, as requested by the resident	Family will provide The nurse will notify the family if the resident needs additional books	As needed
	Provide the local newspaper at least daily	The family will subscribe to the newspaper to be delivered to the hospital The nurse aide will deliver the newspaper to the patient daily	Daily
I will be safe and free from falls	The Hendrich Fall Risk assessment will be completed quarterly	Occupational Therapy	By Oct 1
	The interventions identified as part of the Hendrich Fall Risk assessment will be implemented and included in the plan of care	Licensed Nurse All Staff	Ongoing
	Please do not relocate items in my room without my consent	All staff	Daily and ongoing
	Please remind me to wear my glasses	All staff	Daily and ongoing

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Culturally Competent Trauma Informed Care

Trauma Informed Care

F699 §483.25(m) 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

Trauma Informed Care

Trauma-Informed Care
Given the widespread nature and highly individualized experience of trauma, the utilization of trauma-informed approaches is an essential part of person-centered care.

Facilities must recognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions. Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others.

Culturally Competent Care

Culturally Competent Care

Cultural competency, (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. it means being respectful and responsive to the health beliefs, practices and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious or social groups (https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence).

The interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity.

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Provider Visits

Physician Visits

F712 §483.30(c) Frequency of physician visits. §483.30(c)(1)

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.

§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all require physician visits must be made by the physician personally

Physician Visits

DEFINITIONS §483.30(c)

Must be seen, for purposes of the visits required by §483.30(c)(1), means that 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.

There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

NPP Visits

F712 GUIDANCE §483.30(c)

After the initial physician visit in SNFs, where States allow their use, an NPP ("Non-physician practitioner) may make **every other required visit**. (See §483.30(e), F714 Physician delegation of tasks in SNFs.)

These alternate visits, as well as medically necessary visits, may be performed and signed by the NPP. (Physician co-signature is not required, unless required by State law).

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Medication Management

Pharmacist Review of Drug Regimen

1. **F756 §483.45(c)** Pharmacist comprehensive review once per month for identification of irregularities

2. **F756 §483.45(c)(4)(ii)** Any irregularities sent to medical director, attending physician, and director of nursing for review

3. **F756 §483.45(c)(4)(iii)** Attending physician must document review of medication irregularities in the medical record as well as corrective actions if appropriate. If no change in medication, attending physician must document rationale.

4. **F756 §483.45(c)(5)** Policies and procedures for monthly drug regimen review

Psychotropic Drugs

F605 §483.45(c)(3)

A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Psychotropic Drugs

1. **F605 §483.45(d) Unnecessary drugs**—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used— (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e)

2. **F605 §483.45(e) Psychotropic Drugs.** Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

Psychotropic Drugs, cont.

3. **F605 §483.45(e)(2)** Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

4. **F 605 §483.45(e)(3)** Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

Psychotropic Drugs, cont.

5. **F605 §483.45(e)(4)** PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), 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.

6. **F605 §483.45(e)(5)** 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 appropriateness of that medication

Convivence Psychotropic Drugs - NEW

F605

Convenience refers to the unnecessary administration of a medication that causes (intentionally or unintentionally) a change in a resident's behavior (e.g., sedation) such that the resident is subdued and/or requires less effort from staff. Therefore, if a medication causes symptoms consistent with sedation (e.g., excessive sleeping, drowsiness, withdrawal, decreased activity), it may take less effort to meet a resident's behavioral needs, which meets the definition of convenience.

Resident Consent for Medications

F757 Guidance
Prior to initiating or increasing a medication, the resident, family, and/or resident representative must be informed of the Advance Copy benefits, risks, and alternatives for the medication, in advance of such initiation or increase.

The resident has the right to accept or decline the initiation or increase of a medication. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred.

A written consent form may serve as evidence of a resident's consent to medication, but other types of documentation are also acceptable. If a medication has been initiated or increased, and there is not documentation demonstrating compliance with the resident's right to be informed and participate in their treatment, noncompliance with §483.10(c) exists and F552 must be cited.

Example of a Behavior Log

Behavior	Description	Frequency	Severity	Duration
Agitation				
Aggression				
Wandering				

Trigger	Description	Related Events Context
Loud Noises		
Meals		
Staff Transitions		

Interventions	Description	Effectiveness
Reassurance		
Re-Direction		
Medication		

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Restorative Program

Restorative Program – Purpose / Goals

Allow patients to achieve highest level of functioning

Restore as much independence as possible and prevent further decline

Help patients do for themselves rather than staff doing it for them

Restorative Program – Elements

- Quarterly OT/PT assessment
- Quarterly measurement of functional status
- Restorative Plan for Restorative Aides or CNAs

Restorative Program – Assessment and Plan

Physical Therapist – or – Occupational Therapist – or - both

1) Can the patient do as much as they want need to do independently?

2) If not – Why -- What are the barriers?

3) What can be done to assist the patient to overcome the barriers?

4) Develop measurable time-limited goals and interventions for EACH patient

Restorative Program – Training and Oversight

Important that restorative aides (or CNAs) are trained / educated and competent

Important that PT oversees the program

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Nutrition

Nutrition

- **The facility will serve three (3) meals, or their equivalent, daily at regular times with not more than fourteen hours between a substantial evening meal and breakfast on the following day, and not less than ten hours between breakfast and a substantial evening meal on the same day**
- Substantial food will be available for a late admission or late return from a procedure when the resident did not eat a meal and is now hungry
- Food of an appropriate quantity and at a proper temperature will be served in a form consistent with the needs of the resident
- Special eating equipment and utensils will be provided for residents who need them
- Food served and uneaten will be discarded

Nutrition, cont.

- The facility will ensure that the resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident’s clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Nutrition, cont.

- **Residents will be offered sufficient fluid intake to maintain proper hydration**
- Residents will be offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet
- **Each resident requiring assistance with eating will be provided with help and will receive training or adaptive equipment, as needed, based on patient assessment, to promote independence in eating**
- **A resident who is able to eat alone or with assistance will not be fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding is clinically indicated and consented to by the resident**
- A resident who is fed by enteral means will receive the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding

Reference: State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 225; Issued: 08-08-24) F692 §483.25(g); F693 §483.25(g); §483.25(g)(4); §483.25(g)(5)

Nutritional Care

1) Weekly weights (or minimum of monthly)

2) Dietitian assessment at admission and at least quarterly

3) Dietitian assessment with change of condition or when weight loss or gain

4) Patient's preferences for type of food honored if at all possible

5) Allow patients to feed themselves even though it takes longer

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Restraints

Restraints

Restraints … should of course… never be used unless absolutely necessary.

> *F605 §483.10(e) The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).*

There are examples of what constitutes a restraint in Appendix PP that we don’t often think of as a restraint.

Ensure your policy is current and includes definitions in Appendix PP

Restraint Examples F604 §483.10(e)(1)

1. 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 his/her physical or cognitive inability to lower the bed rail independently

2. A **lap belt** is considered to be a restraint if the resident cannot intentionally release the belt buckle

3. Placing a **chair or bed close enough to a wall** that the resident is prevented from rising out of the chair or voluntarily getting out of bed

4. Placing a resident on a **concave mattress** so that the resident cannot independently get out of bed

5. **Tucking in a sheet tightly** so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted

Restraint Examples F604 §483.10(e)(1)

6. Placing a resident in a **chair**, such as a beanbag or recliner, that **prevents a resident from rising independently**

7. Using devices in conjunction with a chair, such as **trays, tables, cushions, bars or belts**, that the resident cannot remove and prevents the resident from rising

8. Applying **leg or arm restraints, hand mitts, soft ties or vests** that the resident cannot remove

9. **Holding down a resident** in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care

10. Placing a resident in an **enclosed framed wheeled walker**, in which the resident cannot open the front gate or if the device has been altered to prevent the resident from exiting the device

11. Using a **position change alarm** to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm

Restraint Documentation

F604 §483.10(e)(1)
The regulation limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints.

There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint [See §483.12(a)(2)].

However, the practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint.

Patient / Family Request for Restraint

F604 §483.10(e)(1)
The resident or resident representative may request the use of a physical restraint; however, the nursing home is responsible for evaluating the appropriateness of the request, and must determine if the resident has a medical symptom that must be treated and must include the practitioner in the review and discussion. If there are no medical symptoms identified that require treatment, the use of the restraint is prohibited.

Also, a resident, or the resident representative, has the right to refuse treatment; however, he/she **does not have the right to demand a restraint be used when it is not necessary to treat a medical symptom.**

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Other Clinical Considerations

Bowel and Bladder: Urinary Incontinence

1) Assessment

2) Interventions

- Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, or neurological impairments
- Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode, or reducing the distance to the toilet)
- Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion)
- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction
- Implementing a fluid and/or bowel management program to meet the assessed need
- Bladder Rehabilitation/Bladder Retraining

Bowel and Bladder: Urinary Incontinence , cont.

- Pelvic Floor Muscle Rehabilitation
- Cognitively intact residents identified as having stress or urge incontinence will be instructed in Kegel exercises and reminded to perform them regularly
- Prompted Voiding
- Habit Training/Scheduled Voiding
- Medication therapy
- Intermittent catheterization (if ordered by the provider)
- Identifying signs and symptoms of Urinary Tract Infection (UTI), which may include any unexplained change in sensorium, pelvic or lower back pain, or elevated temperature
- Limiting fluid intake to one hundred and fifty (150) ml after the evening meal to prevent incontinence at night

Bowel and Bladder: Bowel Incontinence

1) **Assessment**
2) **Interventions**

- Encourage adequate fiber intake
- Encourage adequate fluid intake
- Avoid foods that may trigger symptoms
- Establish a regular toileting schedule
- Medications as ordered by the provider

Healthy Bowel Protocol

# days with no BM	Dietary Intervention (BID)	Stimulant Laxative (oral)	Dulcolax Suppository	Fleet Enema	Assess bowl sounds	Consult with MD
1						
2						
3						
4						

Stimulant laxative to be given on day two (2) of no BM

Senekot 8.6 mg 2 tabs by mouth once daily at supper _____ or bed time _____

Bisacodyl 5 mg 1 tab once daily at supper _____or bed time _____

Implement dietary intervention to be given each day with no BM

• Prunes • Prune juice • Extra flax/fiber	• Banana • Apple slices • Apple sauce

Healthy Bowel Protocol, cont.

Dulcolax suppository: insert one suppository per rectum once daily on day three (3) if no BM

Fleet enema to be administered per rectum once daily on day four (4) if no BM

DO NOT initiate bowel protocol if:
a) bowel sounds are not heard
b) abdominal mass is palpated that is of unknown origin
c) significant change in the resident's level of consciousness or mental status
d) resident complains (or shows signs of) severe abdominal pain
If the bowel protocol is used twice in a four (4) week period, refer to the dietitian to review dietary interventions.
MD signature: _____ Date: _____

Bowel and Bladder: References

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 225; Issued: 08-08-24)

F690 §483.25(e)(1); §483.25(e)(2)

Registered Nurses' Association of Ontario (RNAO). A proactive approach to bladder and bowel management in adults. 4th ed. Toronto (ON): RNAO; 2020

Lewis SJ. Heaton KW. Stool form scale as a useful guide to intestinal transit time. *Scandinavian Journal of Gastroenterology 1997; 32(9): 920-4*

Fall Risk Assessment and Intervention

AHRQ

HEAR ME

- **Hazards in the environment.**
- **Educate residents.**
- **Anticipate residents' needs.**
- **Round frequently.**
- **Materials and equipment.**
- **Exercises and ambulation**

Fall Prevention

Hazards in the environment should be noticed and eliminated. An environment free from hazards includes, but is not limited to:

- Monitor cords, equipment, and uneven surfaces to eliminate trip hazards.
- Immediately clean up spills and place caution signs if the floors are wet
- Ensure patients' immediate physical safety while notifying appropriate clinical staff if unsafe patient activity is observed
- All resident care areas will have an environmental audit quarterly by the individual responsible for safety. The audit will be reported to the Safety Committee or the Quality Committee.
- Any significant environmental concerns will be corrected immediately

Educate residents about how to accomplish their activities in a safe way.

Fall Prevention, cont.

Anticipate the needs of residents. Understand/learn routines and habits, and the times they will need your help.

Round frequently to learn residents' needs. Rounding—going from patient to patient to see how they are doing—is the activity that allows you to "keep an eye" on each resident and accommodate their needs in a timely manner.

Materials and equipment should be in good working order and used correctly.

Exercise and ambulation with residents is vital to maintaining their fitness and preventing falls.

Fall Assessment & Resources

Recommend using the **Henrich II Fall Risk Model**. There is a fee for use – but it is specific to the needs of older adults.

Assess within 48 hours of admission

Assess when change of condition

Assess at each quarterly assessment

AHRQ Falls Prevention and Management at https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod3sess2.html

Hendrich Fall Risk
https://hendrichfallriskmodel.com/

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Resident Funds

Appendix PP
Resident Funds

Develop a system for residents to deposit and access funds that meet Appendix PP requirements.

F567 §483.10(f)(10) Rights
F568 §483.10(f)(10)(iii) Accounting and Records.
F569 §483.10(f)(10)(iv) Notice of certain balances
F570 §483.10(f)(10)(vi) Assurance of financial security
F571 §483.10(f)(11) Not Charge Funds when payment made by Medicare/Medicaid

See end of the presentation for content of regulations

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Competency

Nursing Competency

F726 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. .

Nurse Aide Competency

F726 §483.35(c) Proficiency of nurse aides.

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

F730 §483.35(d)(7) Regular in-service education.

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).

Education

Topic	Who	When
Interpersonal communication that promotes mental and psychosocial well-being	All	At hire Annual
Person-centered care and services that reflect the resident's goals for care	All	At hire Annual
Culturally Competent Trauma-Informed Care	All	At hire Annual
Care specific to residents with: • Aphasia • Behavioral Health diagnosis • Dementia • Vision impairment • Hearing impairment	All	At hire Annual

Education, cont.

Topic	Who	When
Care of the combative resident	All	At hire Annual
Activities	All	At hire Annual
Non-pharmacological approaches to care	All	At hire Annual
Behavior log	Direct Care	At hire Annual
Change in Condition	Direct Care	At hire Annual
Skin and Wound Care	Direct Care	At hire Annual

Education, cont.

Topic	Who	When
Bowel and Bladder Retraining	Direct Care	At Hire As Needed
Medication Management	Licensed Staff	At hire Annual
Pain Management	Direct Care	At hire Annual
Restorative Care	Direct Care	At hire Annual

Your Questions

Thank you.

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Resident Funds Additional Info

Resident Funds

F567 §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

Resident Funds

F567 §483.10(f)(10) - GUIDANCE
Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than:
• The same day for amounts less than $100.00 ($50.00 for Medicaid residents);
• Three banking days for amounts of $100.00 ($50.00 for Medicaid residents) or more.

Residents may make requests that the facility temporarily place their funds in a safe place, without authorizing the facility to manage those funds. The facility must have a system to document the date, time, amount, and who the funds were received from or dispersed to. The facility must have systems in place to safeguard against any misappropriation of a resident's funds.

Resident Funds

F568 §483.10(f)(10)(iii) Accounting and Records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C) The individual financial record must be available to the resident through quarterly statements and upon request.

F569 §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits— (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.

Resident Funds

F570 §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

F571 §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). **(NOT ALL TEXT INCLUDED)**

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Medication Management Additional Info

Drug Regimen Review

F756 §483.45(c) Drug Regimen Review

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

Drug Regimen Review cont.

F756 §483.45(c) Drug Regimen Review
§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

Psychotropic Drug Review

F758 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that–
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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F758 §483.45(c)(3) §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), 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

§483.45(e)(5) 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 appropriateness of that medication