To:     NHPCO Provider Members  
From: NHPCO Regulatory Team  
Date:  November 10, 2016  

New Nursing Home Requirements  
Implications for Hospice Providers  

The new Requirements of Participation for Nursing Homes represent the greatest change in practice and care delivery since OBRA ‘87. The Requirements for Participation, over 700 pages, were released October 2016. The changes are of such magnitude that implementation will be phased in over a three year period with the effective date of the final rule November 28, 2016. Subsequent phase-in dates are November 2017 and November 2019. CMS is developing a new survey process that will go into effect in November 2017.

The Guidance to Surveyors for these rules has not been released and when this document is available, there will be greater understanding of CMS expectations. With this release, it is anticipated that the long awaited guidelines for implementing the companion rules for Hospice in the Nursing Home, implemented in August 2013 for nursing homes, will be included.

The only direct mention of hospice in the new rules is in §483.10(f) Self-Determination, which states that a facility may not charge the resident who is receiving hospice care in a Medicare or Medicaid covered stay. This has not been a widespread issue in nursing facilities, but more of an issue in assisted living. As with many of the regulations, there is often a “spill-over” effect into assisted living.

This document was developed to provide hospice staff with insight as to areas that may impact their care to residents.

§483.10(c) Planning and Implementing Care  
- Adds new, detailed statements of a resident’s right to participate in the development and implementation of his or her person-centered plan of care, including requirements that affects both the initial planning process and changes to the plan of care. The planning process must facilitate inclusion of the resident/representative, assess both strengths and needs, and incorporate personal and cultural preferences.
- Adds new provisions specifying the right of residents to receive advance information about care, type of professional delivering care, and risks and benefits of treatments and options.
• Broadens current §483.10(b)(4) to state that a resident not only has a right to refuse treatment and refuse experimental research, but also the right to request treatment and/or discontinue treatment.

§483.10(d) Choice of Attending Physician
• CMS has withdrawn proposed §483.10(c)(2), which would have required that physicians meet facility credentialing requirements.

§483.10(f) Self-Determination
• Amends §483.15(b)(1) as follows (underlined language is new): The resident has the right to (1) choose activities, schedules including sleeping and waking times, health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

§483.10(g) Information and Communication
• Notification of Changes:
  o Under current §483.10(b)(11) a facility must notify the resident and, if known, family/legal representative, and consult with the resident’s physician, under certain listed circumstances.
  o Includes a need to change, discontinue or commence treatment.
  o The new section inserts references to resident representative in various places, and requires that facilities keep an up-to-date email address on file for the resident representative.

§ 483.12 Freedom from Abuse, Neglect and Exploitation
• The new rule expands the list of individuals that facilities may not employ or otherwise engage to include those individuals, such as volunteers or contractors. Subsequently, there may be additional questions regarding background checks for hospice employees providing care in the facility.

§ 483.21 Comprehensive Resident-Centered Care Plans
• Requires facilities to develop a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care. Requires facilities to document in a resident’s care plan the resident’s goals for admission, assess the resident’s potential for future discharge, and include discharge planning in the comprehensive care plan, as appropriate.

• Adds a nurse aide, a member of the food and nutrition services staff, to the required members of the interdisciplinary team that develops the comprehensive care plan. Participation is not required to be in-person at the care plan meeting.
§483.45 Pharmacy Services

- In the original language, “Psychotropic drug” was proposed to mean any drug that affects brain activities associated with mental processes and behavior. These drugs would have included opioid analgesics. In response to the concerns that such actions would have negative effects for pain management, the definition was revised. The final definition reads as follows:

  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.

- CMS originally proposed that residents would not receive psychotropic drugs via a PRN order unless the medication was necessary to treat a diagnosed specific condition and would be limited to 48 hours. In the final rule, CMS finalized a 14-day limit on PRN orders for psychotropic medications. This may be extended beyond 14 days by documenting the rationale. However, CMS does not believe this exception would be appropriate for anti-psychotic drugs and requires the attending physician to write a new PRN prescription every 14 days after the resident has been evaluated. These requirements related to psychotropic drugs take effect November 28, 2017.

§483.95 Training Requirements

- Adds a new section to the rule that sets forth all the requirements of an effective training program that facilities must develop, implement, and maintain for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. This section will be implemented in Phase 3 with the exception of training on Abuse/Neglect/Exploitation, Dementia Management, and the Feeding Assistant requirement which are required in Phase 1.

Training topics must include:
  o Communication.
  o Resident Rights and Facility Responsibilities
  o Abuse, Neglect, and Exploitation
  o QAPI & Infection Control
  o Compliance and Ethics
  o In-Service Training for Nurse Aides on dementia management and resident abuse prevention
  o Behavioral Health Training
  o Feeding Assistants