

# State Operations Manual

## Appendix PP - Guidance to Surveyors for Long Term Care Facilities

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(Rev. 22, 12-15-06)

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

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

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

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

**Probes §483.20(m):**

If sampled residents have MI or MR, did the State Mental Health or Mental Retardation Authority determine:

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

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**F309**

**§483.25 Quality of Care**

**Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.**

Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).

**Intent: §483.25**

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

**Definitions: §483.25**

- “Highest practicable” is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

- “Skin Ulcer/Wound”

**NOTE:** Skin ulcer definitions are included to clarify clinical terms related to skin ulcers. At the time of the assessment and diagnosis, the clinician is expected to document the clinical basis (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

- “Arterial Ulcer” is ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis.

Inadequate blood supply to the extremity may initially present as intermittent claudication. Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders (such as arteritis), or significant vascular disease elsewhere (e.g., stroke or heart attack). The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g., top of the foot or toe, outside edge of the foot). The wound bed is frequently dry and pale with minimal or no exudate. The affected foot may exhibit: diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down (dependent) or increased pain when elevated, blanching upon elevation, delayed capillary fill time, hair loss on top of the foot and toes, toenail thickening.

- “Diabetic neuropathic ulcer” requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot, e.g., at mid-foot, at the ball of the

foot over the metatarsal heads, or on the top of toes with Charcot deformity.

- “Pressure ulcer”. See Guidance at 42 CFR 483.25(c)-F314.
- “Venous insufficiency ulcer” (previously known as “stasis ulcer”) is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are reported to be the most common vascular ulceration and may be difficult to heal, may occur off and on for several years, and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious serous drainage unless the wound is infected. The resident may experience pain which may be increased when the foot is in a dependent position, such as when a resident is seated with her or his feet on the floor. Recent literature implicates venous hypertension as a causative factor. Earlier, the ulceration was believed to be due to the pooling of blood in the veins.

Venous hypertension may be caused by one (or a combination of) factor(s) including: loss of (or compromised) valve function in the vein, partial or complete obstruction of the vein (e.g., deep vein thrombosis, obesity, malignancy), and/or failure of the calf muscle to pump the blood (e.g., paralysis, decreased activity). Venous insufficiency may result in edema and induration, dilated superficial veins, cellulitis in the lower third of the leg or dermatitis (typically characterized by change in skin pigmentation). The pigmentation may appear as darkening skin, tan or purple areas in light skinned residents and dark purple, black or dark brown in dark skinned residents.

### **Interpretive Guidelines §483.25**

Use F309 when the survey team determines there are quality of care deficiencies not covered by §§483.25(a)-(m). “Highest practicable” is defined as the highest level of functioning and well-being possible, limited only by the individual’s presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident’s right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of

unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:

- An accurate and complete assessment (see §483.20);
- A care plan which is implemented consistently and based on information from the assessment;
- Evaluation of the results of the interventions and revising the interventions as necessary.

Determine if the facility is providing the necessary care and services based on the findings of the RAI. If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine. Use Tag F309 to cite quality of care deficiencies that are not explicit in the quality of care regulations.

### **Procedures §483.25**

Assess a facility's compliance with these requirements by determining if the services noted in the plan of care, based on a comprehensive and accurate functional assessment of the resident's strengths, weaknesses, risk factors for deterioration and potential for improvement, is continually and aggressively implemented and updated by the facility staff. In looking at assessments, use both the MDS and RAPs information, any other pertinent assessments, and resulting care plans.

If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided.

If quality of care problems are noted in areas of nurse aide responsibility, review nurse aide competency requirements at §483.75(e).

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### **§483.25(a) Activities of Daily Living.**

**Based on the comprehensive assessment of a resident, the facility must ensure that**

#### **Intent §483.25(a)**

The intent of this regulation is that the facility must ensure that a resident's abilities in ADLs do not deteriorate unless the deterioration was unavoidable.

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## **F310**

**§483.25(a)(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --**

- (i) Bathe, dress, and groom;**
- (ii) Transfer and ambulate;**
- (iii) Toilet;**
- (iv) Eat; and**
- (v) Use speech, language, or other functional communication systems.**

### **Interpretive Guidelines §483.25(a)**

The mere presence of a clinical diagnosis, in itself, justify a decline in a resident's ability to perform ADLs. Conditions which may demonstrate unavoidable diminution in ADLs include:

- The natural progression of the resident's disease;
- Deterioration of the resident's physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities; and
- The resident's or his/her surrogate's or representative's refusal of care and treatment to restore or maintain functional abilities after aggressive efforts by the facility to counsel and/or offer alternatives to the resident, surrogate, or representative. Refusal of such care and treatment should be documented in the clinical record. Determine which interventions were identified on the care plan and/or could be in place to minimize or decrease complications. Note also that depression is a potential cause of excess disability and, where appropriate, therapeutic interventions should be initiated.

Appropriate treatment and services includes all care provided to residents by employees, contractors, or volunteers of the facility to maximize the individual's functional abilities. This includes pain relief and control, especially when it is causing a decline or a decrease in the quality of life of the resident.

If the survey team identifies a pattern of deterioration in ADLs, i.e., a number of residents have deteriorated in more than one ADL or a number of residents have deteriorated in only one ADL (one in bathing, one in eating, one in toileting) and it is determined there is deficient practice, cite at F310.

For evaluating a resident's ADLs and determining whether a resident's abilities have declined, improved or stayed the same within the last twelve months, use the following definitions as specified in the State's RAI:

1. **Independent** - No help or staff oversight; or staff help/oversight provided only 1 or 2 times during prior 7 days.
2. **Supervision** - Oversight encouragement or cuing provided 3 or more times during the last 7 days, or supervision plus physical assistance provided only 1 or 2 times during the last 7 days.
3. **Limited Assistance** - Resident highly involved in activity, received physical help in guided maneuvering of limbs, and/or other non-weight bearing assistance 3 or more times; or more help provided only 1 or 2 times over 7-day period.
4. **Extensive Assistance** - While resident performed part of activity, over prior 7-day period, help of following type(s) was provided 3 or more times;
  - a. Weight-bearing support; or
  - b. Full staff performance during part (but not all) of week.
5. **Total Dependence** - Full staff performance of activity over entire 7-day period.

#### **§483.25(a)(1)(i) Bathing, Dressing, Grooming**

##### **Interpretive Guidelines §483.25(a)(1)(i)**

This corresponds to MDS section E; version 2.0, section G, when specified for use by the State.

“Bathing” means how resident takes full-body bath, sponge bath, and transfers in/out of tub/shower. Exclude washing of back and hair.

“Dressing” means how resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.

“Grooming” means how resident maintains personal hygiene, including preparatory activities, combing hair, brushing teeth, shaving, applying make-up, washing/drying face, hands and perineum. Exclude baths and showers.

## **BATHING, DRESSING, GROOMING**

### **Procedures: §483.25(a)(1)(i)**

For each sampled resident selected for the comprehensive review or the focused review, as appropriate, determine:

1. Whether the resident's ability to bathe, dress and/or groom has changed since admission, or over the past 12 months;
2. Whether the resident's ability to bathe, dress and groom has improved, declined or stayed the same;
3. Whether any deterioration or lack of improvement was avoidable or unavoidable by:
4. Identifying if resident triggers RAPs for ADL functional/rehabilitation potential.
  - a. What risk factors for decline of bathing, dressing, and/or grooming abilities did the facility identify?
  - b. What care did the resident receive to address unique needs to maintain his/her bathing, dressing, and/or grooming abilities (e.g., resident needs a button hook to button his shirt; staff teaches the resident how to use it; staff provides resident with dementia with cues that allow him/her to dress him or herself)?
  - c. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of bathing, dressing, and/or grooming abilities (e.g., resident now unable to button dress, even with encouragement; will ask family if we may use velcro in place of buttons so resident can continue to dress herself)?

### **Probes: §483.25(a)(1)(i)**

If the resident's abilities in bathing, dressing, and grooming have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Identify relevant sections of the MDS and consider whether assessment triggers the RAPs and the RAPs were followed.
- Are there physical and psychosocial deficits that could affect improvement in functional abilities?

- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented?
- What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress might have been possible?

## **TRANSFER AND AMBULATION**

### **§483.25(a)(1)(ii)**

#### **Interpretive Guidelines: §483.25(a)(1)(ii)**

This corresponds to MDS section E; MDS 2.0 section G when specified for use by the State.

“Transfer” means how resident moves between surfaces - to/from: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet.)

“Ambulation” means how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

#### **Procedures: §483.25(a)(1)(ii)**

Determine for each resident selected for a comprehensive review, or a focused review as appropriate, whether the resident’s ability to transfer and ambulate has declined, improved or stayed the same and whether any deterioration or decline in function was avoidable or unavoidable.

#### **Probes: §483.25(a)(1)(ii)**

If the resident’s transferring and ambulating abilities have declined, what evidence is there that the decline was unavoidable:

- What risk factors for decline of transferring or ambulating abilities did the facility identify (e.g., necrotic area of foot ulcer becoming larger, postural hypotension)?
- What care did the resident receive to address risk factors and unique needs to maintain transferring or ambulating abilities (e.g., a transfer board is provided to maintain ability to transfer from bed to wheelchair and staff teaches the resident how to use it)?

- What evidence is there that sufficient staff time and assistance are provided to maintain transferring and ambulating abilities?
- Has resident been involved in activities that enhance mobility skills?
- Were individual objectives of the plan of care periodically evaluated, and if goals were not met, were alternative approaches developed to encourage maintenance of transferring and ambulation abilities (e.g., resident remains unsteady when using a cane, returns to walker, with staff encouraging the walker's consistent use)?
- Identify if resident triggers RAPs for ADL functional/rehabilitation potential, psychosocial well-being, or mood state and the RAPs are followed.

If the resident's abilities in transferring and ambulating have been maintained, is there evidence that the resident could have improved if appropriate treatment and services were provided?

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?
- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented? What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

## **TOILETING**

### **§483.25(a)(1)(ii)**

#### **Interpretive Guidelines: §483.25(a)(1)(iii)**

This corresponds to MDS sections E; MDS 2.0 sections G and H when specified for use by the State.

“Toilet use” means how the resident uses the toilet room (or commode, bedpan, urinal); transfers on/off the toilet, cleanses self, changes pad, manages ostomy or catheter, adjusts clothes.

#### **Procedures: §483.25(a)(1)(iii)**

Determine for each resident selected for a comprehensive review, or focused review as appropriate, whether the resident's ability to use the toilet has improved, declined or

stayed the same and whether any deterioration or decline in improvement was avoidable or unavoidable.

**Probes: §483.25(a)(1)(iii)**

If the resident's toilet use abilities have declined, what evidence is there that the decline was unavoidable.

- What risk factors for the decline of toilet use abilities did the facility identify (e.g., severe arthritis in hands makes use of toilet paper difficult)?
- What care did resident receive to address risk factors and unique needs to maintain toilet use abilities (e.g., assistive devices to maintain ability to use the toilet such as using a removable elevated toilet seat or wall grab bar to facilitate rising from seated position to standing position)?
- Is there sufficient staff time and assistance provided to maintain toilet use abilities (e.g., allowing residents enough time to use the toilet independently or with limited assistance)?
- Were individual objectives of the plan of care periodically evaluated, and if objectives were not met, were alternative approaches developed to encourage maintaining toilet use abilities (e.g., if resident has not increased sitting stability, seek occupational therapy consult to determine the need for therapy to increase sitting balance, ability to transfer safely and manipulate clothing during the toileting process. For residents with dementia, remind periodically to use the toilet)?
- Identify if resident triggers RAPs for urinary incontinence, and ADL functional/rehabilitation potential and the RAPs were used to assess causal factors for decline or potential for decline or lack of improvement.

If the resident's toilet use abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided?

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?
- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented? What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?
- Identify if resident triggers RAPs for mood state and psychosocial well-being.

## **EATING**

### **§483.25(a)(1)(iv)**

#### **Interpretive Guidelines: §483.25(a)(1)(iv)**

This corresponds to MDS sections E, L1 and MI; MDS 2.0, sections G and K when specified for use by the State.

“Eating” means how resident ingests and drinks (regardless of self-feeding skill).

#### **Procedures: §483.25(a)(1)(iv)**

Determine for each resident selected for a comprehensive review, or focused review, as appropriate, whether the resident’s ability to eat or eating skills has improved, declined, or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable.

If the resident’s eating abilities have declined, is there any evidence that the decline was unavoidable?

1. What risk factors for decline of eating skills did the facility identify?
  - a. A decrease in the ability to chew and swallow food
  - b. Deficit in neurological and muscular status necessary for moving food onto a utensil and into the mouth
  - c. Oral health status affecting eating ability
  - d. Depression or confused mental state
2. What care did the resident receive to address risk factors and unique needs to maintain eating abilities?
  - a. Assistive devices to improve resident’s grasp or coordination;
  - b. Seating arrangements to improve sociability;
  - c. Seating in a calm, quiet setting for residents with dementia.
3. Is there sufficient staff time and assistance provided to maintain eating abilities (e.g., allowing residents enough time to eat independently or with limited assistance)?

4. Identify if resident triggers RAPs for ADL functional/rehabilitation potential, feeding tubes, and dehydration/fluid maintenance, and the RAPs were used to assess causal reasons for decline, potential for decline or lack of improvement.
5. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintaining eating abilities?

**Probes: §483.25(a)(1)(iv)**

If the resident's eating abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?
- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented? What changes are made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

**Interpretive Guidelines: §483.25(a)(1)(v)**

This corresponds to MDS, section C; MDS 2.0 sections B and C when specified for use by the State.

“Speech, language or other functional communication systems” is defined as the ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture or a combination of these (e.g., a communication board or electronic augmentative communication device).

**USE OF SPEECH, LANGUAGE, OR OTHER FUNCTIONAL COMMUNICATION SYSTEMS**

**§483.25(a)(1)(v)**

**Procedures: §483.25(a)(1)(v)**

Determine for each resident selected for a comprehensive review, or focused review, as appropriate, if resident's ability to communicate has declined, improved or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable.

Identify if resident triggers RAPs for communication, psychosocial well-being, mood state, and visual function, and if the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement.

**Probes: §483.25(a)(1)(v)**

If the resident's communication abilities have diminished, is there any evidence that the decline was unavoidable:

- What risk factors for decline of communication abilities did the facility identify and how did they address them (e.g., dysarthria, poor fitting dentures, few visitors, poor relationships with staff, Alzheimer's disease)?
- Has the resident received audiologic and vision evaluation? If not, did the resident refuse such services? (See also §483.10(b)(4).)
- What unique resident needs and risk factors did the facility identify (e.g., does the resident have specific difficulties in transmitting messages, comprehending messages, and/or using a variety of communication skills such as questions and commands; does the resident receive evaluation and training in the use of assistive devices to increase and/or maintain writing skills)?
- What care does the resident receive to improve communication abilities (e.g., nurse aides communicate in writing with deaf residents or residents with severe hearing problems; practice exercises with residents receiving speech-language pathology services; increase number of resident's communication opportunities; non-verbal means of communication; review of the effect of medications on communication ability)?
- Is there sufficient staff time and assistance provided to maintain communication abilities?
- Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of communication abilities (e.g., if drill-oriented therapy is frustrating the resident, a less didactic approach should be attempted)?

**Probes: §483.25(a)(1)(v)**

If the resident's speech, language, and other communication abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?
- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented?
- What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

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## **F311**

### **§483.25(a)(2)**

**(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and**

#### **Intent §483.25(a)(2)**

The intent of this regulation is to stress that the facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome.

#### **Procedures §483.25(a)(2)**

Use the survey procedures and probes at §483.25(a)(1)(i) through (v) to assist in making this determination

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## **F312**

### **§483.25(a)(3)**

**(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.**

#### **Intent: §483.25(a)(3)**

The intent of this regulation is that the resident receives the care and services needed because he/she is unable to do their own ADL care independently.