

Title: **OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA)
EXCERPTS FROM FEDERAL LAW AND REGULATIONS ON:
RESIDENTS' RIGHTS – QUALITY OF LIFE – RESIDENT ASSESSMENT – QUALITY OF
CARE**

(1) QUALITY OF LIFE

(A) IN GENERAL

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS

(1) GENERAL RIGHTS

(A) SPECIFIED RIGHTS

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) FREE CHOICE

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) FREE FROM RESTRAINTS

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed;

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(v) ACCOMMODATION OF NEEDS

The right –

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES

(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which –

- (A)** describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;
- (B)** is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and
- (C)** is periodically reviewed and revised by such team after each assessment under paragraph (3).

(4) PROVISION OF SERVICES AND ACTIVITIES

(A) IN GENERAL

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of) –

- (i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;
- (ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident;
- (iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;
- (iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;
- (v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial wellbeing of each resident;
- (vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and
- (vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(3) RESIDENTS' ASSESSMENT

(A) REQUIREMENT.

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment –

- (i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;
- (ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A); of this section;
- (iii) uses an instrument which is specified by the State under subsection (e)(5); and
- (iv) includes the identification of medical problems.

(B) CERTIFICATION

(i) IN GENERAL

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) PENALTY FOR FALSIFICATION

(I) An individual who willfully and knowingly certifies under clause

(i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 with respect to each assessment.

(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) USE OF INDEPENDENT ASSESSORS

If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) FREQUENCY

(i) IN GENERAL

Such an assessment must be conducted –

(I) promptly upon (but no later than not later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) RESIDENT REVIEW

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) USE

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

Sec. 483.10 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. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) Exercise of rights.

(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

(d) Free choice.

The resident has the right to –

- (1) Choose a personal attending physician;
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

Sec. 483.13 Resident behavior and facility practices.

(a) Restraints.

The resident has 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.

Sec. 483.15 Quality of life.

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) Dignity.

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) Self-determination and participation.

The resident has the right to –

- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
- (2) Interact with members of the community both inside and outside the facility; and
- (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(e) Accommodation of needs.

A resident has the right to—

- (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
- (2) Receive notice before the resident's room or roommate in the facility is changed.

Sec. 483.20 Resident assessment.

(b) Comprehensive assessments.

(1) A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. 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) Psychosocial well-being.
- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnoses and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin condition.
- (xiii) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures.
- (xvi) Discharge potential.
- (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
- (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in Sec. 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in Sec. 413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar 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 purposes 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.)

(iii) Not less often than once every 12 months.

(c) *Quarterly review assessment.*

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(d) *Use.*

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

(k) *Comprehensive care plans.*

(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The 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 Sec. 483.25; and
 - (ii) Any services that would otherwise be required under Sec. 483.25 but are not provided due to the resident's exercise of rights under Sec. 483.10, including the right to refuse treatment under Sec. 483.10(b)(4).
- (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 the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and
 - (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.
- (3) The services provided or arranged by the facility must –
- (i) Meet professional standards of quality; and
 - (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

Sec. 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.

(a) *Activities of daily living.*

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

- (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 residents' 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.
- (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
- (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.

(b) *Vision and hearing.*

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident –

- (1) In making appointments, and
- (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) Pressure sores.

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

- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence.

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

- (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and
- (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion.

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

- (1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and
- (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Mental and Psychosocial functioning.

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

- (1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and
- (2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) Naso-gastric tubes.

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

- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and
- (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents.

The facility must ensure that –

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition.

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

- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
- (2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration.

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs.

The facility must ensure that residents receive proper treatment and care for the following special services:

- (1) Injections;
- (2) Parenteral and enteral fluids;
- (3) Colostomy, ureterostomy, or ileostomy care;
- (4) Tracheostomy care;
- (5) Tracheal suctioning;
- (6) Respiratory care;
- (7) Foot care; and
- (8) Prostheses.

(l) Unnecessary drugs.

(1) General.

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- (i) In excessive dose (including duplicate drug therapy); or
- (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or
- (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that –

- (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
- (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors.

The facility must ensure that –

- (1) It is free of medication error rates of five percent or greater; and
- (2) Residents are free of any significant medication errors.