July 16, 2012

Patrick Conway, M.D.
Director, Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Patrick.Conway@cms.hhs.gov

Dear Dr. Conway:

We understand that the Office of Clinical Standards and Quality is reviewing the Conditions of Participation (referred to here as “Requirements of Participation” or RoPs), pursuant to Executive Order 13563, “Improving Regulations and Regulatory Review” issued on January 2011 and a more recent Executive Order, “Identifying and Reducing Regulatory Burdens” released in May 2012. In response to your request for input, the National Consumer Voice for Quality Long-Term Care strongly:

- Opposes any changes that would weaken the current regulations.
- Supports revisions that improve residents’ quality of care and quality of life, promote person-centered care, and further protect residents’ safety and well-being.
- Urges you to conduct any review that is undertaken using an unrushed, transparent and inclusive (multi-stakeholder) process.

This letter discusses each of these points in detail.

**Opposition to any changes that would weaken current regulations**

The landmark Nursing Home Reform Law and the Requirements of Participation that implement the law’s regulations have established higher standards of care that are much more resident-centered than what existed prior to 1987. For example, the quality of care regulation as currently written requires the facility to provide each resident with the care, services and treatment necessary to reach his or her highest level of functioning. Other regulations state that a resident’s abilities and functioning must not decline or the resident must not develop a new condition, such as pressure ulcers, unless it is medically unavoidable for the resident. These regulations—and others—greatly elevate the quality that is to be expected in nursing homes and establish that decline is not inevitable just because someone is in a nursing home.

The Requirements of Participation have resulted in significantly positive changes in facilities. One of the biggest improvements has been the reduction in the use of physical restraints in nursing homes...
(Institute of Medicine, 2001). In the late 1980s, the prevalence of physical restraint use was estimated to be as high as 41%; in 2010, it was approximately 3% (Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2005-2010. Charlene Harrington, Ph.D.; Helen Carrillo, M.S.; Megan Dowdell, M.A.; Paul P. Tang, B.S.; Brandee Woleslagle Blank, M.A.).

In addition, as a result of the Nursing Home Reform Law and its regulations, residents have the right to make choices about life in nursing homes that they never had before, participate in planning their own care, and receive visits from their family whenever they wish. They are protected against arbitrary eviction from the facility and must be told about their rights to hold their bed when transferred to the hospital. The nursing assistants who care for them must receive at least 75 hours of training and be certified – a requirement which was non-existent before 1987 when the typical nurse aide began her career with no formal training at all and “right off the street.”

These are just a few of the regulations that make an enormous difference in the daily lives of nursing home residents. These requirements evidenced the beginnings of, and epitomize, the qualities of “person-centered care” that we espouse today.

The January 2011 Executive Order “directs agencies to select the least burdensome approaches, to minimize cumulative costs, to simplify and harmonize overlapping regulations, and to identify and consider flexible approaches that maintain freedom of choice for the American public” (Federal Register Vo. 77, No. 95 at 29036). It tells agencies to identify rules that are “outmoded, ineffective, insufficient, or excessively burdensome” and to “modify, streamline, expand, or repeal them.” While we understand the goal of reducing burdens and improving efficiencies, such efforts must not be done at the expense of reducing rights and protections for a very frail, vulnerable population.

Claims of burdensome paperwork must not be alleviated to the detriment of residents’ health, safety and well-being. For example, without sufficient documentation:

- Residents could receive poor quality care that may lead to injuries and even death.
- Nurses and CNAs do not receive information they need to provide high quality nursing care.
- Nursing supervisors do not have information needed to determine if care has been effective.

Another example of the importance of “paperwork” is the notice of transfer/discharge that must be issued to residents when the facility proposes to transfer a resident. Without this notice, residents have no idea that they can appeal or contact the long-term care ombudsman for assistance. We repeatedly hear of situations where the ombudsman has helped a resident to appeal successfully, allowing the resident to obtain the care he or she needs in the facility without facing the trauma of transfer.

We urge CMS to encourage efficiency through innovative solutions, such as employing new technologies, but to not step back the frequency or thoroughness of information collected in nursing homes.

In addition, we anticipate you will hear the need for “flexibility.” Advocate experience has been that this often translates into broader, more general requirements that are so subjective and hard to measure that they become almost meaningless. Perhaps the best example of a regulation that is already “flexible” is the requirement that a facility have “sufficient” nurse staffing to meet residents’ needs. We have lived with this flexible requirement for more than 20 years, with the result that according to CMS’s
own study, more than 90% of nursing facilities do not have adequate staff to prevent avoidable harm or meet care requirements under federal law (CMS, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report).

In conversations with your staff in May and June of this year, the regulatory review that is being undertaken was described as modernizing the requirements while protecting beneficiaries (and promoting patient-centered care). The recent revision of the hospital Conditions of Participation was given as an example of how CMS is accomplishing this goal.

We echo what Toby Edelman, with the Center for Medicare Advocacy, wrote about the hospital Conditions of Participation in her June 27, 2012 letter to your office and CMS Administrator Marilyn Tavenner: “We have looked at the newly-published hospital CoPs and are now more alarmed than ever about revisions to the nursing home RoPs.” Ms. Edelman cites several examples indicating that changes to the hospital regulations involved deletion of federal standards and deference to state standards and even a hospital’s own standards.

As Ms. Edelman notes, deferring to state law and hospital practice “is contrary to the federal law that governs nursing homes.” She points out that the Nursing Home Reform Law changed the standards of care that all Medicaid and Medicare-certified nursing homes must meet. If instead, many practices were left up to states or facilities, residents across the country would not be guaranteed at least a certain minimum standard of care – their protections would depend on where they lived. Further, it has been our experience that state standards are often weaker than federal standards in a number of areas, and it was only because of the federal requirements passed in 1987 that many states revised their regulations to be consistent with federal law.

If the new hospital CoPs are indicative of the end result of this regulatory review, the revisions could undermine, if not eliminate, important resident protections. The Consumer Voice would adamantly oppose any such weakening of the current Requirements of Participation.

**Support of changes that improve residents’ quality of care, quality of life, and rights**

While the President’s Executive Order 13563 instructs federal agencies to identify rules that are excessively burdensome and change them, it also states that agencies should look for rules that are “insufficient” and “expand” them. In the advocate meeting with you and other CMS officials on June 21, 2012, you clarified that the primary goal of the review was quality of care. Stronger regulations are needed now more than ever. Since the implementation of the Nursing Home Reform Law and its regulations, nursing home residents have become more frail and vulnerable. Yesterday’s nursing home residents are today’s assisted living facility residents, resulting in residents in nursing homes being more dependent than in the past. In addition, the case-mix acuity of residents has risen 1% per year from 1996-2002 (Mor, Caswell, Littlehale, Niemi, Fogel, 2009). Nursing home residents now have a higher level of medical intensity and complexity. With greater needs and a higher level of acuity comes a need for stronger protections.

Yet another reason why strong regulations are more important than ever is the increasing shift of the nursing home industry to ownership by multistate chains. As explained by Ms. Edelman in her letter, “the federal regulatory system does not address corporate-wide behavior (i.e. enforcement is done on a facility-by-facility basis) and it has difficulty overseeing, and enforcing sanctions against, corporate
nursing homes. If anything, regulatory standards need to be stronger and stated with more specificity and detail in the future, as well as more effectively enforced, in order to assure that corporate nursing homes provide residents with the care they need and are entitled to receive under federal law.

In order to provide thoughtful and comprehensive comments to your office on the Requirements of Participation, the Consumer Voice convened in June 2012 a workgroup consisting of members of citizen advocacy groups, long-term care ombudsmen, national experts and residents, as well as others from our network. Based on the recommendations of this workgroup, the Consumer Voice has developed a detailed set of recommendations that we are submitting to you with this letter. The changes we recommend would improve (and modernize) the health, safety, welfare and rights of nursing home residents nationwide.

While we believe that each recommendation benefits nursing home residents, we want to highlight five key suggestions:

1. **Staffing:** Require a staffing standard for direct care nursing staff.
2. **Staffing:** Require a registered nurse 24 hours a day, 7 days a week.
3. **Antipsychotics:** Adopt the 1992 proposed regulations (57 Federal Register 4516 (Feb 5, 1992)) regarding chemical restraints, psychopharmacologic drugs, and informed consent.
4. **Abuse:** Explicitly state that a facility is responsible for the acts of its employees, contractors and volunteers.
5. **Distinct part:** Eliminate distinct parts.

**Staffing**

1) **Require a staffing standard for direct care nursing staff**

The number one complaint about nursing homes that the Consumer Voice hears from residents, families, and advocates is that there is not enough nursing staff to care for residents. This severe and chronic understaffing can and does harm nursing home residents.

Study after study has shown the relationship between staffing levels and quality of nursing home care. In fact, CMS’s own study reported that facilities with staffing levels below 4.1 hours per resident day for long stay residents may provide care that results in harm and jeopardy to residents (Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report). A study by Schnelle and colleagues (2004) also supports a threshold level of 4.1 total nursing hours per resident day to ensure that the processes of nursing care are adequate (Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2005-2010. Charlene Harrington, Ph.D.; Helen Carrillo, M.S.; Megan Dowdell, M.A.; Paul P. Tang, B.S.; Brandee Woleslagle Blank, M.A.).

The current requirements - a registered nurse 8 hours a day, licensed nurses 24 hours a day and “sufficient staff” to meet residents needs - are inadequate. The term “sufficient” is unclear, ambiguous and impossible to objectively measure. Its vagueness allows nursing homes to understaff on a regular basis and owners and operators to keep staffing levels low in order to maximize profit. The result: total average nursing home staffing levels have remained relatively steady since 1994 while the acuity level of residents has increased (Mor, Caswell, Littlehale, Niemi, Fogel, 2009), and there has been a 25% decline
in RN staffing levels since passage of the Balanced Budget Act in 1997 (Harrington et al. 2003; Konetzka et al. 2004).

Evidence shows that understaffing is associated with high urinary catheter use, poor skin care, poor feeding, malnutrition, dehydration, and low participation in activities. Experts recommend minimum nurse staffing standards for nursing facilities in the United States (Harrington C, Kovner C, Mezey M, Kayser-Jones J, Burger S, Mohler M, Burke R, Zimmerman D.). These conditions directly relate to the complaints of insufficient staff, and specifically the lack of staff to address these preventable conditions, the Consumer Voice hears weekly from residents, families, and advocates.

In addition to the human cost, the financial cost of poor care in America’s nursing homes is staggering. In 2011, the Consumer Voice released, “The High Cost of Poor Care: The Financial Case for Prevention in American Nursing Homes,” in which we documented the cost associated with avoidable falls, pressure ulcers, urinary incontinence, malnutrition, dehydration and hospitalization. These costs place an enormous financial burden on Medicare, Medicaid and the American taxpayers. Costs to providers, such as workers’ compensation claims, staff turnover, staff training, medical/nursing errors by temporary/pool staff, and tort liability, could also be reduced or avoided if facilities had enough staff to properly care for nursing home residents.

2) Require a registered nurse 24 hours a day 7 days a week

As noted in the comments submitted by the Coalition of Geriatric Nursing Organizations (July 2, 2012), there is mounting research evidence that higher levels of RN time is associated with positive outcomes and less RN time associated with negative outcomes.

Positive outcomes with more RN time:

- RNs have been found to have a positive effect in decreasing unnecessary hospitalizations of nursing home residents. (Decker 2008), (O’Malley, Caudry & Brabowski 2011), (Dorr, Horn and Smout 2005), (Horn, Buerhaus, Bergstrom and Smout 2005).

- Higher RN levels significantly and positively affect quality resident outcomes including lower antipsychotic use, and fewer pressure ulcers, restraint use and cognitive decline (Weech-Maldonado, Meret Hanke, Neff, and Mor 2004); reduced incidences in four related conditions, catheterizations, Urinary Tract Infections(UTI) antibiotic use and pressure sore development (Cherry, 1991); decreased pressure ulcers and UTIs (Konetzka, Stearns, Park 2007); and Horn et al showed that increasing RN time was associated with less decrease in function, fewer urinary tract infections, catheterizations, weight loss and pressure ulcers.

Negative outcomes with lower RN time:

- The importance of RNs is also reflected in the negative results of increased RN turnover on restraint use, urinary catheters, psychoactive drugs and an increased risk of pressure ulcers and catheters. (Castle, Engeberg 2005). Lower RN levels are associated with an increase in antipsychotic drug use and the number of pressure ulcers (Castle and Engberg 2010). Castle,
using a longitudinal study design, quarterly staffing data, and a large sample size, showed that RN staffing significantly affected four quality measures: restraint use, catheter use, pain management and pressure sores (Castle and Anderson, 2011).

There is also evidence that RN time is associated with nursing home citations for deficient practice by state survey agencies. Lower RN and total staffing levels are associated with more deficiencies (Johnson-Paulson & Infeld 1996), (Konestski, Yi, Norton, Kilpatrick 2004), (Castle, Engberg, 2010) (Harrington, Zimmerman, Karon, Robinson, Beutel, 2000). In one large study, RN levels were consistently associated with fewer care safety deficiencies (Castle. Wagner, Castleton, Wagner 2011). Increases in RN turnover can result in increased deficiencies (Castle and Engberg 2005).

The Consumer Voice supports the content and recommendations of the Coalition of Geriatric Nursing Organizations in their letter to CMS, July 2, 2012.

**Antipsychotics**

3) **Adopt the 1992 proposed regulations (57 Federal Register 4516 (Feb 5, 1992)) regarding chemical restraints, psychopharmacologic drugs, and informed consent**

Each day, about one of every four nursing home residents is given dangerous antipsychotic drugs despite black box warnings by the Food and Drug Administration (FDA) that these drugs may cause their death (CMS MDS Active Resident Information Report, 3rd quarter, 2010). Numerous studies show that antipsychotic drugs, even when they do not lead to death, often cause far more harm than good for individuals with dementia.

In their “National Action Plan to Stop the Misuse of Antipsychotic Drugs and to Improve the Care of Nursing Home Residents with Dementia and Related Conditions,” several advocate groups note that twenty years ago, the U.S. Department of Health and Human Services (HHS) published strong proposed regulations to crack down on the routine nursing home use of chemical restraints. HHS explained the need for the proposed rules with the following statement:

> We believe the proposed regulations on psychopharmacologic drugs and chemical restraints are necessary to cope with a significant public health problem in many, but not all of this nation’s long-term care facilities. For many years, there have been allegations of misuse of psychoactive drugs in these facilities. In 1975, the Special Committee on Aging of the U.S. Senate held hearings on this public health problem and made reference to “chemical straight jackets” in nursing homes. In 1980, the House Select Committee on Aging held hearings on the same subject. They entitled their report, “Drug Abuse in Nursing Homes.” Most recently, articles that deal with this subject have appeared in a number of medical journals. These papers generally question the extent of the use of psychopharmacologic drugs in nursing homes and question whether adequate monitoring of the use of these drugs exists.1

Today, after the emergence of a new class of “atypical” antipsychotics, the use of chemical restraints is worse than ever. Including the language from the 1992 proposed regulations in the RoPs would help deter the use of chemical restraints and ensure that residents and their legal representative are

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1 57 Federal Register 4516, at 4519 (Feb. 5, 1992).
adequately informed. It would also save millions of dollars. Antipsychotic drug use is extraordinarily costly to Medicare and taxpayers; in just a six-month period in 2007, the HHS Office of Inspector General found that Medicare overpaid $116 million in erroneous nursing home claims for atypical antipsychotic drugs.

Abuse

4) Explicitly state that a facility is responsible for the acts of its employees, contractors and volunteers

Given the vulnerability and dependence of nursing home residents, nursing homes must be held accountable for ensuring that residents are free from abuse, mistreatment and misappropriation of resident property. Taking steps such as creating policies, and conducting screening and training, while required and important, does not relieve the facility of this responsibility. This is supported by Section 1819(h)(2)(B)(ii) of the Social Security Act, which gives the Secretary of the Department of Health and Human Services the authority to imposes CMPs, incorporates the provisions of section 1128A(a) of the Act, which states at subpart (l), “A principal is liable for penalties . . . for the actions of the principal's agent acting within the scope of the agency.”

The Departmental Appeals Board has also made this clear. “The rationale for holding a facility accountable for the actions of its staff applies equally to all staff members who, in the course of carrying out their assigned duties, fail to act in a manner consistent with the regulations and the facility's policies pertaining to resident abuse. That is, “since the facility elected to rely on them to carry out its commitments, the facility cannot ‘disown’ their ‘acts and omissions.’” N.C. State Veterans Home v. CMS, DAB No. 1855 (2008).

As Richard Mollott of the Long-Term Care Community Coalition states in his letter to Thomas Hamilton dated June 15, 2012, “Given the largely closed environment of the nursing home, wherein residents are entirely dependent upon the facility for food, shelter, care and all other services, coupled with the frailty and vulnerability of the nursing home resident population, it should go without saying that nursing home residents and their families justifiably rely on the nursing home and can (or should be able to) safely assume that someone working in the nursing home is doing so under the authority and auspices of the home.”

Distinct Parts

5) Eliminate distinct parts.

The CMS regulation allowing partial certification and requiring distinct parts should be eliminated because it is harmful to residents and violates provisions of the Nursing Home Reform Law.

Distinct parts are harmful to residents
Partial certification and distinct parts allow facilities to segregate residents by payment source, forcing residents to move as their payment source changes. They also permit a facility to limit the number of beds they certify for Medicaid/Medicare. As a result:

- Residents returning from a hospital stay must go to the Medicare section of the facility instead of returning to the familiar, comfortable surroundings of their own room.
- Potential Medicaid-eligible residents are denied admission, and current residents who have just become Medicaid-eligible are forced to move to another facility if the nursing home has no available Medicaid beds. In addition, residents must move within the facility as their payment source changes.

Every time residents are required to relocate to another unit or another facility, they are uprooted. Distinct part certification based on source of payment results in transfers that can cause both physical and psychological harm to a resident. The effect of transfer trauma on residents has been well documented (Pamela S. Manion & Marilyn J. Rantz, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995 at 108; Matt Smith, Diagnosis: Eviction, Oct. 23, 1999; Susan M. Lander et al, Intraintitutional Relocation Effects on Resident's Behavior and Psychosocial Functioning, Journal of Gerontological Nursing, April 1997 at 35; Susan M Friedman et al, Increased Fall Rates in Nursing Home Residents After Relocation to a New Facility, Journal of American Geriatrics Society, November, 1995 at 1237).

In an Indiana case in which a 98-year-old woman was being forced to move to the Medicaid part of the nursing home after paying privately for 24 years, even the threat of being moved caused trauma. According to the affidavit of an expert who had extensively researched the effects of relocation on older adults, the resident was exhibiting signs of psychological harm prior to the proposed move:

* Nursing notes indicate that she is upset. Social services notes document that she is upset and angry at the proposed move and has stated that “she might have to kill herself if they move me.”
* Previous social services notes show that while Mrs. ____ has stated that she wished she were dead, she has never said that she might have to kill herself.
* She has expressed that the proposed move is making her feel that she has no control over what is happening to her and that she is losing her sense of confidence.

The expert concludes, “It is my expert opinion that moving __________ to the _______ unit ... is likely to cause her psychological harm and could even hasten her death” (Affidavit of Sheldon Tobin, March 2003).

Distinct parts violate the Nursing Home Reform Law

Distinct parts violate the following provisions of the law:

* Equal access to quality care
  The equal access regulation and CMS’s guidance require that facilities must treat all residents alike when making transfer and discharge decisions. “Identical policies and practices” concerning services means that facilities must not distinguish between residents based on their source of payment when providing
services that are required to be provided under law. CMS’s own procedures for determining compliance with this rule, as detailed in the interpretive guidelines, tell surveyors to “determine if residents are grouped in separate wings or floors for reasons other than care needs.”

The rule, guidance and procedures all confirm that segregation based on source of payment violates federal law guaranteeing equal treatment in transfer, discharge, and covered services.

**Admission, transfer and discharge rights**
Federal law specifies permissible reasons for transfer, and change in source of payment is not an allowable reason for transfer. Becoming a Medicaid beneficiary does not create a non-payment situation.

**Admission and continued stay rights**
Federal law and rules prohibit facilities from requiring individuals to waive their rights to Medicaid benefits as a condition of admission and from requiring individuals to give assurances, oral or in writing, that they are not eligible for, or will not apply for, Medicaid. When facilities tell beneficiaries that there is no Medicaid bed available in the distinct part unit and that Medicaid beneficiaries may only be admitted as private-pay residents, they are asking individuals to waive their rights to Medicaid benefits as a condition of admission or continued stay.

Additionally, CMS’s guidance for this regulation specifically states, “This provision prohibits both direct and indirect request for waiver of rights to Medicare or Medicaid,” and its interpretive guidelines specifically direct surveyors to:

- Ask staff what factors lead to decisions to place residents in different wings or floors. Note if factors other than medical and nursing needs affect these decisions. Do staff know the source of payment for the residents they take care of?

- Ask the ombudsman if the facility treats residents differently in transfer, discharge and covered services based on source of payment.

**Refusal of certain transfers**
Federal Medicare law authorizes residents “to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled facility (for purposes of title XVIII) to a portion of the facility that is such a skilled facility.” Federal Medicaid law includes comparable language. Both the Medicare and Medicaid provisions also confirm that a resident’s eligibility and entitlement to Medicaid is not affected despite a resident’s refusal to move to another room. The Requirements of Participation restate the language of the statutes.

The interpretive guidelines further support that residents may refuse to move for being Medicare or Medicaid-eligible: “These provisions allow a resident to refuse transfer from a room in one distinct part of an institution to a room in another distinct part of the institution for purposes of obtaining Medicare or Medicaid eligibility.”

Partial certification, which forces a resident to move to a distinct part even when they refuse such a transfer, is another example of how such a requirement violates the Nursing Home Reform Law.
**Resident Rights**

- **Privacy and Confidentiality**
  Forcing residents to live in a part of the facility that is reserved solely for residents on Medicaid discloses their financial status and payment source – information that is confidential – to other residents, staff, visitors and the public. Moreover, this information is publicly revealed without resident consent.

- **Dignity**
  The Nursing Home Reform Law requires that facilities care for residents in a manner or in an environment that maintains or enhances their dignity and respect. Residents must be treated in a way that supports their self-esteem and makes them feel good about themselves. Many residents are embarrassed by their Medicaid status. They feel humiliated and ashamed at being on “welfare” and having to obtain public assistance. These feelings are greatly magnified when residents are required to move to the part of the facility that everyone knows is the “Medicaid section.” Relocation due to distinct parts can severely undermine residents’ sense of worth and self-respect.

  In addition, the interpretive guidelines state that dignity includes:
  - Maintaining an environment in which there are no signs posted in residents’ rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status).

  For Medicaid beneficiaries grouped together in one part of a nursing home that is only partially certified, it is as if a giant “Medicaid only” sign is posted in that section of the facility. As noted earlier, for many residents, their Medicaid status is very personal information that they do not wish disclosed.

**Use an open, unrushed and multi-stakeholder process**

In order to get the best input possible for any proposed changes to the Requirements of Participation, CMS should solicit feedback from a wide range of organizations from the very beginning and give any review the time and careful consideration it requires. We suggest that CMS convene a stakeholder meeting to discuss the regulations together in one room with CMS, in addition to giving individual organizations the opportunity to submit written comments.

To-date it appears that CMS’s outreach to groups asking for feedback has been limited (in our call with CMS those stakeholders included were listed as provider groups, Advancing Excellence, the Consumer Voice and a couple of other advocates). We know that a much broader range of stakeholders would want to and should be involved in this dialogue. Limiting feedback (or not taking the time needed to engage everyone) is detrimental to the process for all of us. There are many other organizations, such as the National Committee to Preserve Social Security and Medicare, AARP, the Alliance for Retired Americans, the National Association of Social Workers, the National Association of Area Agencies on Aging, PHI - to name just a few - whose recommendations should be included in any pre-rule making process.
Any revision of the RoPs requires great thought and deliberation. The timeline for the feedback provided herein was rushed and inadequate to engage the broad, diverse groups of stakeholders CMS needs to promote the best possible result for residents.

If CMS decides to move forward with this review process, the Consumer Voice requests that it:

- Share all the comments it receives.
- Establish a broad-based stakeholder group to discuss, share different perspectives and strive to reach consensus for any proposed revisions.
- Allow sufficient time for such a stakeholder process to be conducted.
- Be open and transparent in all its actions related to the RoPs.

Thank you for your consideration of these recommendations.

Sincerely,

Sarah Wells
Executive Director

Robyn Grant
Director, Public Policy and Advocacy
The National Consumer Voice for Quality-Long Term Care’s Comments on TITLE 42—Public Health

CHAPTER IV—CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER G—STANDARDS AND CERTIFICATION

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

<table>
<thead>
<tr>
<th>Section</th>
<th>Regulation</th>
<th>Suggested Language</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>§ 483.1 BASIS AND SCOPE.</td>
<td>§ 483.1 (a) Statutory basis.</td>
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<td>(1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—</td>
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<td>(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and</td>
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<td>(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.</td>
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<td>(2) Section 1861(i) of the Act requires the facility to have in effect a transfer agreement with a hospital.</td>
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<td>(3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.</td>
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<td>(b) Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.</td>
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<td>§ 483.5 DEFINITIONS.</td>
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<td>§ 483.5 (a) Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. A facility must certify all of its beds for the program in which it participates (i.e., a facility participating in Medicare must certify all of its beds for Medicare). Partial certification is only permitted when a SNF or NF is part of a larger institution. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the “facility” is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, an NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter.</td>
<td></td>
<td>The language should be revised here in order to eliminate distinct parts. See below for rationale.</td>
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The CMS regulation requiring distinct part certification should be eliminated because it is harmful to residents and violates provisions of the Nursing Home Reform Law.

Harmful to residents
Distinct parts allow facilities to segregate residents by payment source, forcing residents to move as their payment source changes. They also permit a facility to limit the number of beds they certify for Medicaid. As a result:

- Residents returning from a hospital stay must go to the Medicare section of the facility instead of returning to the familiar, comfortable surroundings of their own room.
- Potential Medicaid-eligible residents are denied admission and current residents who have just become Medicaid-eligible are forced to move to another facility if the nursing home has no available Medicaid beds.
- Residents who have exhausted their resources and become Medicaid-eligible must move to the Medicaid section of the facility, leaving roommates, staff and the familiarity of their room behind.

Every time residents are required to relocate to another unit or another facility, they are uprooted from familiar surroundings and are at risk of both physical and psychological harm, and even death.

Violation of the following provisions of the Nursing Home Reform Law:
- Equal access to quality care
- Admission, transfer and discharge rights
- Admission and continued stay rights
- Refusal of certain transfers
- Resident Rights: Privacy and Confidentiality

Facilities, not beds, should be certified. In this way a nursing home is either fully certified for Medicaid, Medicare or both - or not. This allows residents to receive the care where they want it – in their rooms.

(b) Distinct part — Delete (b).

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<tr>
<th>Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term &quot;distinct part&quot; also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.</th>
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<tbody>
<tr>
<td>(2) Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:</td>
</tr>
<tr>
<td>(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:</td>
</tr>
<tr>
<td>(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.</td>
</tr>
<tr>
<td>(B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body.</td>
</tr>
<tr>
<td>(C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.</td>
</tr>
<tr>
<td>(ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part.</td>
</tr>
<tr>
<td>(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.</td>
</tr>
<tr>
<td>(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution’s cost report.</td>
</tr>
<tr>
<td>(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.</td>
</tr>
<tr>
<td>(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.</td>
</tr>
<tr>
<td>(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.</td>
</tr>
<tr>
<td>(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.</td>
</tr>
<tr>
<td>(c) Composite distinct part —</td>
</tr>
<tr>
<td>(1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.</td>
</tr>
<tr>
<td>(2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:</td>
</tr>
<tr>
<td>(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.</td>
</tr>
<tr>
<td>(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public moneys without sacrificing the quality of care.</td>
</tr>
<tr>
<td>(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.</td>
</tr>
<tr>
<td>(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.</td>
</tr>
<tr>
<td>(d) Common area. Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.</td>
</tr>
<tr>
<td>Change the language of (d) to: &quot;Common area. Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.&quot;</td>
</tr>
<tr>
<td>The definition should be expanded to include living rooms since there are facilities that have such an area.</td>
</tr>
</tbody>
</table>
Fully sprinklered. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.

(b) Notice of rights and services.

Each resident, including each of the following 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 preserved. If the resident is adjudged incompetent, the person appointed under State law to act on the resident’s behalf may exercise the resident’s rights to the extent the resident has authorized him or her to do so, and a resident, even though adjudged incapacitated, must be permitted to exercise his or her rights to the degree he or she is capable.

(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.

(a) Exercise of rights.

§ 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:

Add the following definitions after (d): Family and family member(s): When reference is made to "family" or "family member(s)" in these regulations, the phrase refers to the spouse, domestic partner (including a same-sex domestic partner), a biological, adoptive, step or foster father or mother, or any other person who stands in loco parentis to the resident; a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a resident standing in loco parentis; or any other person related by blood or affinity to the resident. Domestic partner means an adult in a committed relationship with another adult, including both same-sex and opposite-sex relationships. [Committed relationship] means one in which the resident and the domestic partner of the resident, are each other’s sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other’s common welfare and financial obligations. This includes, but is not limited to, any relationship between two individuals of the same or opposite sex that is granted legal recognition by a State or by the District of Columbia as a marriage or analogous relationship (including, but not limited to, a civil union).

Add the following language after (e): Sexual abuse: Non-consensual sexual contact of any type with a resident. (g) Willful, as used in the definition of abuse at 42 C.F.R. §488.301, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

It should be stated and not just implied that the elements which define Quality of Care and Quality of Life are Resident Rights.

Far too often, nursing homes give a legal representative or guardian more authority than they actually have, which robs residents of their rights. In addition facilities frequently go directly to the legal representative or guardian instead of to the resident. Simply because a resident has a legal representative or guardian does not mean that he or she cannot express his/her wishes and preferences.
| (1) | The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident’s stay. Receipt of such information, and any amendments to it, must be acknowledged in writing; | Change the following language in (b) (1): “Such notification must be made prior to or upon admission and during the resident’s stay” to “Such notification must be made prior to upon admission, 10 days after admission and at least annually during the resident’s stay.” | Residents are generally only given a written copy of their rights during the admissions process. Admission is a very stressful time for residents. They are given many documents all at once at a time when they are likely anxious, upset and dealing with a major life change. The copy of their rights often just ends up in a stack of papers in a drawer. Facilities should be required to go over their rights with residents again shortly after admission and then once a year. This helps to ensure that residents have a better understanding of their rights. |
| (2) | The resident or his or her legal representative has the right— | | |
| (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and | Define community standard as: The cost standard set by state law or by organizations such as a public library or local copy centers. Add the following language to (b) (2) (i): The resident’s representative or family has the right to access the resident’s records upon the resident’s death and to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. | Cost standard: Many families are charged exorbitant fees for copies of the resident’s records. Access to records after death: Many facilities refuse to give families a copy of the resident’s records after death or delay for months before releasing them, even with assistance from an attorney. The right of families to obtain these records within a reasonable amount of time needs to be made explicit. Electronic records: The requirements need to be updated to reflect the fact that an increasing number of records are kept electronically. |
| (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. | | |
| (3) | The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; | Change the language of (b) (4) to: The resident has the right to refuse treatment and to formulate an advance directive as specified in paragraph (8) of this section; and | Many clinical trials are conducted in nursing homes. It is critical that residents truly understand what they are agreeing to and that they have the information they need to give informed consent prior to participation in research. |
| (4) | The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and | | |
| (5) | The facility must— | Change the following language in (b) (5) (i): “Resident who is entitled to Medicaid benefits” should be changed to “Medicaid-eligible resident.” | This term is more consistent with language used in the rest of the regulations. |
| (i) | Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of— | | |
| (A) | The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; and | | |
| (B) | Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and | | |
| (ii) | Inform each resident when changes are made to the items and services specified in paragraphs (5)(i) (A) and (B) of this section. | | |
| (6) | The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate. | | |
| (7) | The facility must furnish a written description of legal rights which includes— | Change the language of (b) (7) to: “The facility must furnish a written description of legal rights that is understandable to the resident, which includes—” | Residents’ legal rights should be presented to them in non-bureaucratic, non-legal language that is easy for them to understand. Residents can’t exercise their rights if they don’t understand them. |

Change the following language in (b) (7) to: “The facility must furnish a written description of legal rights that is understandable to the resident, which includes—”

Residents’ legal rights should be presented to them in non-bureaucratic, non-legal language that is easy for them to understand. Residents can’t exercise their rights if they don’t understand them.
(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

Add the following language to (b)(7)(ii) "and which also includes the protections specifically applicable to same-sex spouses or domestic partners;"

The federal regulations require that a "community spouse" receive notice of Medicaid's protections against spousal impoverishment. The same notification requirement should be made more inclusive to include same-sex partners, consistent with CMS's recent explanation of how state Medicaid programs may provide financial protections for a nursing facility resident's same-sex partner. These financial protections should also be expanded to include domestic partners.

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

Add the following language to (b)(7)(ii) "and which also includes the protections specifically applicable to same-sex spouses or domestic partners;"

The federal regulations require that a "community spouse" receive notice of Medicaid's protections against spousal impoverishment. The same notification requirement should be made more inclusive to include same-sex partners, consistent with CMS's recent explanation of how state Medicaid programs may provide financial protections for a nursing facility resident's same-sex partner. These financial protections should also be expanded to include domestic partners.

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

Add the following language to (b) (7) (iii) to: This information must also be given to the resident in writing; and

Posting this information in the facility is not sufficient because many residents may not see it. Providing each resident with his/her own written copy of state client advocacy group contact information ensures that residents can easily and readily access this information as needed.

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(d) The facility must comply with the requirements specified in subpart I of part 488 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

Add the following language to (b) (6): "The facility must honor the resident's wishes as documented in the advance directive."

Facilities often make health care decisions based on the wishes of the resident's family or legal representative rather than on the resident's wishes. Requiring the facility to honor a resident's advance directives better ensures that the facility will act on what the resident wants.
(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

Add the following new requirement after (b) (9): The facility must inform each resident of his or her right to go to the hospital when deemed necessary by the resident or his or her representative or family member. The facility may not prevent the resident from going to the hospital.

Advocates are aware of situations in which facility staff insist that the resident does not need to go to the hospital and refuse to call the doctor. Some families, who believe that something is very wrong with the resident, then call 911 or transport the resident to the hospital themselves. Once there, families are frequently told by hospital staff that the resident is very ill or medically at risk and that getting the resident to the hospital may have saved the resident's life. Many family members do not realize they can take action on their own and do not take steps that could be life-saving. Informing families about their right to send or take a loved one to the hospital helps residents get the care they need when they need it.

(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(11) Notification of changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

- An accident involving the resident which results in injury and has the potential for requiring physician intervention;
- A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
- A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
- A decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is—

- A change in room or roommate assignment as specified in §483.15(e)(2); or
- A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

- Change the language of (b) (11) (i) to: "A facility must immediately inform the resident; consult with the resident's physician; and notify the resident's legal representative, and with resident consent, an interested family member when there is." Some residents may not want family members to receive this information. The resident, not the facility, should have the right to decide whether or not family members are notified.

Residents should have the right to refuse a change in room or roommate because moving to another room or being assigned a new roommate is a major change; can have an enormous impact on a resident's life; and is part of the resident's right to make choices about aspects of his or her life that are significant to the resident.

- Change the language of (b) (11) (ii) (A) to: "A change in room or roommate assignment as specified in §483.15(e)(2), including the resident's right to refuse such a change." Keeping this information up-to-date is critical so that a resident's legal representative or family member can be quickly notified if necessary. Requiring this information to be updated annually or when new information is provided by the resident or others better ensures that the information will be current and accurate.

(12) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.12(a)(10).

(16) Protection of resident funds.

Changing the language to: The facility must record and annually update the address and phone number of the resident's legal representative or interested family member. The facility must also update contact information anytime the facility is contacted by the resident, the resident's legal representative or interested family member with new information.

Keeping this information up-to-date is critical so that a resident's legal representative or family member can be quickly notified if necessary. Requiring this information to be updated annually or when new information is provided by the resident or others better ensures that the information will be current and accurate.
<table>
<thead>
<tr>
<th>(1)</th>
<th>The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2)</td>
<td>Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)–(8) of this section.</td>
</tr>
<tr>
<td>(3)</td>
<td>Deposit of funds. (i) Funds in excess of $50. The facility must deposit any 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.)</td>
</tr>
<tr>
<td>(4)</td>
<td>Accounting and records. 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.</td>
</tr>
<tr>
<td>(5)</td>
<td>Accounting and records. (i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</td>
</tr>
<tr>
<td>(6)</td>
<td>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</td>
</tr>
<tr>
<td>(7)</td>
<td>Notice of certain balances. The facility must notify each resident that receives Medicaid benefits—</td>
</tr>
<tr>
<td>(8)</td>
<td>Notice of certain balances. (i) 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</td>
</tr>
<tr>
<td>(9)</td>
<td>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.</td>
</tr>
<tr>
<td>(10)</td>
<td>Conveyance upon death. Upon the 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 individual or probate jurisdiction administering the resident’s estate.</td>
</tr>
<tr>
<td>(11)</td>
<td>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.</td>
</tr>
<tr>
<td>(12)</td>
<td>Limitation on charges to personal funds. The facility may 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). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or co-payment required by the plan to be paid by the individual.)</td>
</tr>
<tr>
<td>Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>(A) Nursing services as required at §483.30 of this subpart.</td>
<td></td>
</tr>
<tr>
<td>(B) Dietary services as required at §483.35 of this subpart.</td>
<td></td>
</tr>
<tr>
<td>(C) An activities program as required at §483.15(f) of this subpart.</td>
<td></td>
</tr>
<tr>
<td>(D) Room/bed maintenance services.</td>
<td></td>
</tr>
<tr>
<td>(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.</td>
<td></td>
</tr>
<tr>
<td>(F) Medically-related social services as required at §483.15(g) of this subpart.</td>
<td></td>
</tr>
</tbody>
</table>

Add the following new requirement after (B)(i)(A): Hospice services. Hospice services should be added to this list because they are now frequently provided in nursing facilities, and residents may not know that this is a covered service.

<table>
<thead>
<tr>
<th>Items and services that may be charged to residents’ funds. Listed below are general categories and examples of items and services that the facility may charge to residents’ funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Telephone.</td>
</tr>
<tr>
<td>(B) Television/radio for personal use.</td>
</tr>
<tr>
<td>(C) Personal comfort items, including smoking materials, notions and novelties, and confections.</td>
</tr>
<tr>
<td>(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.</td>
</tr>
<tr>
<td>(E) Personal clothing.</td>
</tr>
<tr>
<td>(F) Personal reading matter.</td>
</tr>
<tr>
<td>(G) Gifts purchased on behalf of a resident.</td>
</tr>
<tr>
<td>(H) Flowers and plants.</td>
</tr>
<tr>
<td>(I) Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.</td>
</tr>
<tr>
<td>(J) Noncovered special care services such as privately hired nurses or aides.</td>
</tr>
</tbody>
</table>

Change the language of (c) (8) (ii) (J) to: "Noncovered special care services that supplement but do not substitute for the care the facility must provide." Residents should not pay for services that the facility is required to provide.

<table>
<thead>
<tr>
<th>Items and services that may be charged to residents’ funds. Listed below are general categories and examples of items and services that the facility may charge to residents’ funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(K) Private room, except when therapeutically required (for example, isolation for infection control).</td>
</tr>
<tr>
<td>(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.</td>
</tr>
</tbody>
</table>

Delete (c) (8) (ii) (K). The regulation as written allows facilities to charge for a private room in all cases. However, there are circumstances when a facility may not charge for a private room. For instance, some states assume a certain number of private rooms when they calculate the Medicaid rate. Since these facilities are already receiving payment, it is illegal for them to charge residents for a private room.

Delete(c) (ii) (L). Facilities must accommodate residents’ needs and preferences, including their food preferences. Honoring resident choice in food is a critical part of culture change and is particularly important when alternative food is being requested for religious or cultural reasons.

<table>
<thead>
<tr>
<th>Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.</th>
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<tbody>
<tr>
<td>(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.</td>
</tr>
</tbody>
</table>
(c) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. Change the following language of (c) (8) (iii) (C): "must inform the resident" to "must inform, orally and in writing, the resident"

Residents or their representative should be informed in writing so that they may retain a copy of this information and refer back to it. Written information also provides documentation that notification was given.

<table>
<thead>
<tr>
<th>(d) Free choice. The resident has the right to—</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Choose a personal attending physician;</td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td></td>
</tr>
</tbody>
</table>

Residents have the same right as individuals in the community to take part in determining their care/treatment and to make important decisions affecting their lives to whatever extent they are able. Even residents who have been declared incapacitated by a court of law may be able to understand the situation, express their preferences and indicate their wishes.

<table>
<thead>
<tr>
<th>(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</th>
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</thead>
<tbody>
<tr>
<td>(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;</td>
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<tr>
<td>(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;</td>
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<tr>
<td>(3) The resident’s right to refuse release of personal and clinical records does not apply when—</td>
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<tr>
<td>(i) The resident is transferred to another health care institution; or</td>
<td></td>
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<tr>
<td>(ii) Record release is required by law.</td>
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</table>

Residents have the same right as individuals in the community to be presented with a proposed treatment, informed about its risks and benefits, and then given the option to choose the treatment or not. Informed consent for care and treatment is a critical part of good health care practices in all settings, and essential for resident-directed/centered care.

<table>
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<tr>
<th>(f) Grievances. A resident has the right to—</th>
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<tbody>
<tr>
<td>(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and</td>
<td></td>
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<tr>
<td>(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</td>
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</table>

Residents may feel uncomfortable voicing concerns about staff and may believe that such concerns would not be addressed or taken as seriously. Adding “and staff” indicates to both residents and the facility that all grievances, including those about staff, must be resolved.

<table>
<thead>
<tr>
<th>(g) Examination of survey results. A resident has the right to—</th>
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</thead>
<tbody>
<tr>
<td>(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors, and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and</td>
<td></td>
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<tr>
<td>(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.</td>
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</table>

This language must be updated to reflect the requirements of the Nursing Home Transparency and Improvement Act and to give residents, families and the public greater access to survey information.
Work. The resident has the right to—

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when—

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care.

Mail. The resident has the right to privacy in written communications, including the right to—

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident's own expense.

Access and visitation rights.

(1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;

(iii) The resident's individual physician;

(iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(v) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.
(k) Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Add the following language to (k): (1) Reasonable access includes, but is not limited to, cordless phones, telephone jacks in resident rooms, phones that are available on the hall and not in staff offices or at the nurses station. Add the following new requirement after (k): Computer. The resident has the right to access a computer with Internet connections at any time.

Reasonable access: Because many facilities severely limit residents' access to a telephone, what "reasonable access" includes should be explicitly stated. Computer: This requirement needs to be updated to reflect a change in technology. Computer access plays an important role in the quality of life of many residents. An increasing number of residents are using computers for a variety of reasons, including to connect with family, friends and others. In fact, some residents may use the computer more than the phone.

(l) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Change the language of (m) to: Sharing of rooms. The resident has the right to share a room with his or her spouse or the person of the resident's choice when both spouses or individuals consent to the arrangement.

The current language on "married couples" is exclusionary and discriminatory. It should be broadened to reflect CMS guidelines supporting the accommodation of residents who wish to room with another nursing home resident of their choice.

(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

Add a new requirement after (n): - Community. The resident has the right to return to the community.

Residents may not be aware of the option to return to the community and that services and supports may be available to meet their needs. While facilities are required to explore this option during the resident assessment, there is currently no requirement that residents be notified in writing of their right to return to the community.

(n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Add a new requirement after (n): - Community. The resident has the right to return to the community.

Residents may not be aware of the option to return to the community and that services and supports may be available to meet their needs. While facilities are required to explore this option during the resident assessment, there is currently no requirement that residents be notified in writing of their right to return to the community.

(o) Refusal of certain transfers.

1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

Add the following new requirement after (o)(2): The resident must receive written information explaining these rights prior to any proposed transfer.

Most residents do not realize they have the right to refuse certain transfers or that their Medicare/Medicaid eligibility will not be jeopardized if they do refuse. Receiving this information in writing before a proposed transfer will ensure they are properly informed.

§ 483.12 Admission, Transfer and Discharge Rights.

(a) Transfer and discharge—

1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
| (i) | The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility. |
| (ii) | The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility; |
| (iii) | The safety of individuals in the facility is endangered; |
| (iv) | The health of individuals in the facility would otherwise be endangered; |
| (v) | The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or |
| (vi) | The facility ceases to operate; |
| (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident’s clinical record must be documented. The documentation must be made by— |
| (i) | The resident’s physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and |

"Cannot meet the residents' needs" is one of the most common reasons given for a proposed transfer/discharge. Advocate experience has been that facilities often say they cannot meet a resident's needs when the resident is exhibiting challenging behaviors. Instead of carefully assessing the resident, figuring out how to provide individualized care and ensuring enough staff, facilities frequently turn to transfer/discharge as a first option rather than as a last option of last resort. In other cases, a facility may not wish to continue to deal with a family member who is complaining about the resident's care, so the facility also states it "cannot meet the resident's needs." In these and other instances, the facility often moves the resident to another facility that offers exactly the same set of services. This makes little sense since the receiving facility is held to the same standards as the transferring facility. Research and experience show that transferring a resident can harm him or her physically and psychologically. Forcing a resident to move should only be done after all other interventions and options have been tried and failed. Requiring that the facility document all the steps it has taken and exactly what it is unable to do for care for the resident would better ensure that the nursing home has done everything it can before considering a transfer/discharge. At the same time, documenting why the receiving facility is better able to care for the resident may reveal that it is not that the facility cannot meet the resident's needs, but that it does not choose to. These requirements would help prevent unnecessary and traumatic transfers.

As much as possible, the nursing home should be the resident's home. Thus, under the standards set by the Nursing Home Reform Law, involuntary transfer and discharge should happen rarely. Under the Reform Law, one reason for transfer/discharge is that "the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility." The question occasionally arises: does this mean that the resident can be forced out when she no longer needs a particular service in which the nursing home specializes? For example, can the resident be forced to move when she no longer needs intensive physical therapy, and the facility has developed and marketed itself as specializing in therapy?

The answer to this question is "no." Under the Reform Law, care should be resident-centered to the extent possible. Residents should be allowed to remain in the same nursing home whenever possible, and the resident’s right to remain cannot be overridden by a nursing home’s desire to care only for a certain type of resident, or to specialize in a particular type of care.

For this reason, the regulation should be revised slightly to say that transfer/discharge is allowed only when "the resident no longer needs the services provided by a nursing facility." This change will give residents more stability, consistent with the Reform Law and resident-centered care.

CMS guidelines state that a resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay. The regulation should be revised to reflect the guideline.
<table>
<thead>
<tr>
<th>(ii) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</th>
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</thead>
<tbody>
<tr>
<td>Add the following language to (a) (4) (i): (A) A copy of the notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman. The facility must provide documentation that notice was given to the resident, a family member or legal representative of the resident and the ombudsman representative.</td>
</tr>
<tr>
<td>(iii) Include in the notice the items described in paragraph (a)(6) of this section.</td>
</tr>
<tr>
<td>Add the following language after (a) (3) (ii): (iii) For discharges under paragraph (a)(2)(ii) and (a)(2)(iv), the facility must document the specific risk to health and safety of individuals in the facility and provide documentation of previous interventions in the resident's plan of care that have been attempted and determined ineffective at mitigating risk to the health and safety of individuals in the facility.</td>
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<tr>
<td>(iv) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—</td>
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<tr>
<td>Add the following subsection to (a) (6) (iv): &quot;(A) The facility must provide a resident with an appeal hearing request form as part of this notice. The notice should state that the resident can file for an appeal by completing the appeal hearing request form and submitting it to the state entity responsible for conducting appeal hearings. Upon resident request, nursing facility staff must assist the resident in filing and submitting the appeal hearing request.&quot;</td>
</tr>
<tr>
<td>Change the language of (a) (5) (ii) to: Notice may be made as many days as is practicable before transfer or discharge when—</td>
</tr>
<tr>
<td>The language in this part of the regulation is weaker than it is in the statute and should be revised to mirror the Nursing Home Reform Law language that requires residents to be given notice &quot;as many days as is practicable.&quot; Residents are often given very little notice. This language would at least better ensure that residents and families receive the required information.</td>
</tr>
<tr>
<td>(5) Timing of the notice. (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</td>
</tr>
<tr>
<td>(ii) Notice may be made as soon as practicable before transfer or discharge when—</td>
</tr>
<tr>
<td>The language in this part of the regulation is weaker than it is in the statute and should be revised to mirror the Nursing Home Reform Law language that requires residents to be given notice &quot;as many days as is practicable.&quot; Residents are often given very little notice. This language would at least better ensure that residents and families receive the required information.</td>
</tr>
<tr>
<td>(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;</td>
</tr>
<tr>
<td>(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(ii) of this section;</td>
</tr>
<tr>
<td>(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;</td>
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<tr>
<td>(D) An immediate transfer or discharge is required by the resident’s urgent medical needs, under paragraph (a)(2)(ii) of this section; or</td>
</tr>
<tr>
<td>(E) A resident has not resided in the facility for 30 days.</td>
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<tr>
<td>(6) Contents of the notice. The written notice specified in paragraph (a) (4) of this section must include the following:</td>
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<tr>
<td>(i) The reason for transfer or discharge;</td>
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<tr>
<td>(ii) The effective date of transfer or discharge;</td>
</tr>
<tr>
<td>(iii) The location to which the resident is transferred or discharged;</td>
</tr>
<tr>
<td>(iv) A statement that the resident has the right to appeal the action to the State;</td>
</tr>
<tr>
<td>Add the following subsubsection to (a) (6) (iv): &quot;(A) The facility must provide a resident with an appeal hearing request form as part of this notice. The notice should state that the resident can file for an appeal by completing the appeal hearing request form and submitting it to the state entity responsible for conducting appeal hearings. Upon resident request, nursing facility staff must assist the resident in filing and submitting the appeal hearing request.&quot;</td>
</tr>
<tr>
<td>Appeal hearing request form: Many residents and family members do not know exactly what they need to do to file an appeal and the process is intimidating and overwhelming. They are also dealing with the stress and anxiety that often accompanies a transfer/discharge notice. Providing a written appeal request form makes it easier for residents and families to file such an appeal.</td>
</tr>
<tr>
<td>Copy of notice to ombudsman: Long-term care ombudsmen are often able to assist a resident whom the facility wishes to transfer/discharge. They can explain the resident’s rights and options, work with the resident and the facility to find a way to resolve the issue, or help the resident appeal the transfer/discharge. However, it is difficult for many residents to contact the ombudsman themselves or they do not understand that help is available. If the ombudsman knows the resident is facing transfer or discharge, the ombudsman can call or visit the resident. Documentation of notice: Advocates frequently hear from residents and family that they did not receive notice of the transfer/discharge. Without notice, residents cannot exercise their transfer/discharge rights. Facility documentation that notice was given would better ensure that residents and families receive the required information.</td>
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<tr>
<td>As noted above, transfers/discharges should be the last resort, not the first. Given the risk of transfer trauma, the facility should not be permitted to move a resident for these reasons without demonstrating that interventions and alternative approaches have been tried and failed first.</td>
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</tbody>
</table>
(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, the nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

Add to (2): The notice must explain the right of Medicaid-eligible residents to be readmitted to the first available bed regardless of the length of the hospital stay.

Many rehospitalizations that occur within a month after discharge are the result of a poor discharge plan. A well-prepared discharge plan is essential for ensuring that the setting to which the resident is being transferred is appropriate of the resident's choice and that services and supports are in place to meet the resident's needs. To be successful, the plan must be resident-directed and written in terms the resident can understand. Discharge summary: Adding this language to this section emphasizes the importance of discharge planning.

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Add the following new requirement after (a) (7): Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes— (A) A recapitulation of the resident's stay; (B) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (C) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

In many states, there are facilities that force a resident to move or refuse to readmit a resident who is not currently residing in the nursing home (for instance he or she is in a hospital) even when the appeal decision is favorable to the resident. If facilities are permitted to do so they wish regardless of the results of the hearing, the right to appeal is meaningless.

(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).

(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

Add the following language after (9): (10) "The State must enforce appeal decisions and ensure that a prevailing resident is able to remain in or return to the facility, as the case may be."

Many rehospitalizations that occur within a month after discharge are the result of a poor discharge plan. A well-prepared discharge plan is essential for ensuring that the setting to which the resident is being transferred is appropriate of the resident's choice and that services and supports are in place to meet the resident's needs. To be successful, the plan must be resident-directed and written in terms the resident can understand. Discharge summary: Adding this language to this section emphasizes the importance of discharge planning.

(b) Notice of bed-hold policy and readmission —

(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

Add to (1): The notice must include a description of community-based services and supports.

(2) Notice of bed-hold policy and readmission —

Readmission: Residents on Medicaid do not know that they can be readmitted to the first available bed regardless of length of hospitalization. This information must be part of the notice because facilities frequently do not inform residents of this right and hospital discharge planners are unaware of the regulation.
### (3) Permitting resident to return to facility.
A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(4) Readmission to a composite distinct part.
When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in §483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

### (c) Equal access to quality care.
Change the language of (c) to: “Equal access to quality care and quality of life.”

Residents should have equal access to quality of life in addition to quality care since quality of life is as important as quality of care under the Nursing Home Reform Law.

(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

Change the following requirement to: (1) “A facility must establish and maintain identical policies and practices regarding admission, transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;”

The Nursing Home Reform Law requires Medicare and Medicaid certified facilities to establish and maintain identical policies and procedures regarding transfer, discharge, and the provision of services for all residents regardless of source of payment. However, nothing in the law expressly prohibits unfair admission practices based on source of payment. While a number of provisions, such as not requiring oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits, are designed to protect individuals from Medicaid discrimination, nursing homes have found a number of ways to work around those provisions, such as asking for a potential resident’s financial information. Consequently, there are states where Medicaid eligible individuals are refused admission or placed on Medicaid-only waiting lists even though beds are available. This allows the facility to save the beds for private pay or Medicare residents. Medicaid discrimination in nursing home admissions also contributes to racial segregation and poor care for minorities. If nursing homes are allowed to cherry-pick from among white, private-pay residents, low-income minorities are far more likely to be isolated in nursing homes that are identifiable by race and that provide a lower quality of care. Medicaid discrimination practices related to admission will continue unless they are prohibited. The Secretary should use his/her authority to “assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys” (1) (42 U.S.C. §§13956l-3(y)(1), 1396n(y)(1), Medicare and Medicaid, respectively) to end this harmful practice. Unless prohibited, facilities will continue to find ways to manipulate the system.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

### (d) Admissions policy.

(1) The facility must—

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.
(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Add the following new requirement after (d) (1) (iii): "Not require financial information as part of the admissions process."

| (ii) | Change language of § 483.13 to: Resident Protection and Freedom from Abuse and Neglect. |
|      | The title of this section should be revised to reflect more person-centered language. |

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Change the language of (d) (2): "The facility must not obtain or accept a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources and such a contract shall not support a claim that the individual with legal access is personally liable.

| (2) | Change the language of (d) (2): "The facility must not obtain or accept a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources and such a contract shall not support a claim that the individual with legal access is personally liable. |
|      | While facilities do not require a third party guarantee in agreements or contracts, many do require families, legal representatives or friends to agree to ensure that fees for a resident's stay are paid. Such agreements make these individuals personally liable for the resident's fees if the facility bill is not paid. The end result permits facilities to do directly (make someone pay for the resident's stay out of their own pocket) what they are not allowed to do indirectly (require a third party guarantee). This practice should be illegal. |

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However, ---

Add to (d) (4): A facility may not discriminate against residents, or people applying for residence, using ways or methods that violate state law.

| (3) | Add to (d) (4): A facility may not discriminate against residents, or people applying for residence, using ways or methods that violate state law. |
|      | Prospective and current residents are often discriminated against for non-financial reasons, such as level of care or the facility's first impression of the family. Residents and potential residents need to be protected against such discrimination. |

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

Add a new requirement after (d)(4): Admission agreements must not include arbitration provisions.

| (i) | Add a new requirement after (d)(4): Admission agreements must not include arbitration provisions. |
|      | Nursing homes are increasingly inserting arbitration clauses or agreements into the enormous stack of documents that must be signed upon admission. Many residents and their families or legal representatives are under tremendous stress at this time, may not understand what they are signing, and are unlikely to realize that they are signing away their constitutional right to a trial by jury in the event that abuse or neglect occurs. Furthermore, many residents, families or legal representatives may be led to believe that admission is contingent upon agreeing to arbitration and feel they have no choice but to sign. In addition, nursing homes facing the threat of substantial jury verdicts for poor care have an incentive to maintain staffing levels and quality; nursing homes that have eliminated the threat of substantial jury verdicts through pre-dispute binding arbitration agreements have an incentive to cut the number and quality of staff, thereby having an adverse effect on nursing home residents. |

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

| (ii) | Add to (d) (4): A facility may not discriminate against residents, or people applying for residence, using ways or methods that violate state law. |
|      | Add a new requirement after (d)(4): Admission agreements must not include arbitration provisions. |
|      | Prospective and current residents are often discriminated against for non-financial reasons, such as level of care or the facility's first impression of the family. Residents and potential residents need to be protected against such discrimination. |

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§ 483.13 Resident Behavior and Facility Practices.

Change language of § 483.13 to: Resident Protection and Freedom from Abuse and Neglect.

| § 483.13 | Change language of § 483.13 to: Resident Protection and Freedom from Abuse and Neglect. |
|          | The title of this section should be revised to reflect more person-centered language. |
Add the following subsections to (a) (1): (i) Limitations on use. The facility may only impose physical restraints to treat the resident’s medical symptoms, which include but are not limited to physical, emotional, and behavioral problems, if the restraint is—

(A) Necessary to ensure the safety of the resident or of other residents;
(B) Imposed in accordance with a physician’s written order specifying the circumstances and duration under which the restraint is to be used; and
(C) Not ordered on a standing, blanket, or “as needed” basis.

(iii) Non-emergency use. Restraints may not be ordered in non-emergency circumstances unless the restraints are applied so as to cause no physical injury and the least possible discomfort. Except when necessary to allow the conduct of a medical or surgical procedure, restraints may not be ordered in non-emergency circumstances unless the restraints—

(A) Enable the resident to reach his or her highest practicable physical, mental, and psychosocial well-being;
(B) Are used only as a last resort if the facility, after completing, implementing, and evaluating the resident’s comprehensive assessment and plan of care determines that less restrictive means have failed; and
(C) Are used in accordance with the plan of care on the comprehensive assessment, which allows for their progressive removal or the progressive use of less restrictive means.

(iv) Emergency use.

(A) Restraints may not be ordered in emergency circumstances unless they are necessary to alleviate an unanticipated immediate and serious danger to the resident or other individuals in the facility.
(B) Emergency orders for restraints may not be in effect for longer than 12 hours and must be confirmed in writing as soon as possible.
(v) Notice for non-emergency use. If a restraint is used in a non-emergency, the facility must—

(A) Explain the use of the restraint to the resident, or, if the resident has been declared to be legally incompetent or cannot understand his or her rights, to the resident’s legal representative, in accordance with § 483.10 (d) and State law;
(B) Explain the resident’s right to refuse the restraint in accordance with § 483.10(b)(4); and
(C) Obtain the written consent of the resident or the resident’s legal representative.

(vi) Restraints may be applied only—

(A) By staff who are trained in their use; and
(B) If the facility assures that the resident’s condition will be closely monitored.

(vii) At a minimum, for a resident placed in a restraint, the facility must—

(A) Check the resident at least every 30 minutes;
(B) Assist the resident as often as is necessary for the resident’s safety, comfort, exercises and elimination needs;
(C) Provide an opportunity for motion, exercise and elimination for not less than 10 minutes during each two hour period in which a restraint is employed.

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Numerous studies show that antipsychotic drugs, even when they do not lead to death, often cause far more harm than good. In their “National Action Plan to Stop the Misuse of Antipsychotic Drugs and to Improve the Care of Nursing Home Residents with Dementia and Related Conditions,” several advocate groups note that twenty years ago, the U.S. Department of Health and Human Services (HHS) published strong proposed regulations to crack down on the routine nursing home use of chemical restraints, noting, “We believe the proposed regulations on antipsychotic drugs and chemical restraints are necessary to cope with a significant public health problem in many, but not all of this nation’s long-term care facilities.” Today, after the emergence of a new class of “atypical” antipsychotics, the use of chemical restraints is worse than ever. Including the language from the 1992 proposed regulations in the Requirements of Participation would help deter the use of chemical restraints and ensure that residents and their legal representative are adequately informed. It would also save millions of dollars. Antipsychotic drug use is extraordinarily costly to Medicare and taxpayers; in just a six-month period in 2007, the HHS Office of Inspector General found that Medicare overpaid $116 million in erroneous nursing home claims for atypical antipsychotic drugs.
(D) Release the resident from the restraint as quickly as possible; and
(E) Keep a record of restraint usage and checks.

(2) Definition of psychopharmacologic drug. In these regulations psychopharmacologic drug means any drug prescribed with the intent of controlling mood, mental status or behavior.

(3) Any psychopharmacologic drug administered to a resident must—

(i) Be ordered by a physician who specifies the dose, duration and reason for the use of the drug;

(ii) Be used only as an integral part of the resident's comprehensive care plan that is directed specifically towards the elimination or modification of the symptoms for which the drugs are prescribed;

(iii) Not be used unless it can be justified in the clinical record that the potential beneficial of the drug clearly outweigh its potential harmful effects.

(iv) Be monitored closely, in conjunction with the drug regimen review requirements at § 483.60(e) for desired responses and adverse consequences by facility staff;

(v) Be reviewed at least annually by a physician who has training or experience in geriatrics and psychopharmacology and who must not serve a facility with which he or she has had a contractual, financial, employment or familial relationship with the facility, its owner, its attending physicians, medical director, or administrator within any of the 36 consecutive months prior to the date of the review (This review may be conducted as part of the annual review and determination of residents for mental illness conducted in accordance with § 483.114 of this part provided it is conducted by a physician with the above qualifications);

(vi) Be used only when a record is maintained of the administration of the drug, the dose, the route of administration, side effect monitoring, a description of the behavior, mood or mental status of the resident, and any other change in behavior, mood, mental status or adverse drug reaction which occurs with the administration of the drug.

(4) Before a psychopharmacologic drug is used in a non-emergency situation, the facility must—

(i) Explain the use of the drug to the resident, or, if the resident has been declared to be legally incompetent or cannot understand his or her rights, to the resident's legal representative, in accordance with § 483.10(d) and State law;

(ii) Explain the resident's right to refuse the drug in accordance with § 483.10(b)(4); and

(iii) Obtain the written consent of the resident or the resident's legal representative.

(5) The drug review specified in paragraph (a) (3) (vi) of this section must—

(i) Determine whether—

(A) The drug has an appropriate indication for use;

(B) The dose is appropriate;
(C) The duration of therapy is appropriate;

(D) Valid justification exists for the use of chemical restraints as permitted under paragraph (a)(7) of this section;

(F) The benefits of using the drug outweigh the risk to the resident; and

(G) Non-drug therapy approaches have failed.

(ii) Be sent to the attending physician; and

(iii) Become a permanent part of the resident's clinical record;

(8) Chemical restraints. Except as provided in paragraph (a)(8) of this section, a facility may not use a chemical restraint.

(7) In these regulations chemical restraint means a psychopharmacologic drug, as defined under paragraph (a)(2) of this section, that is used for the purpose of discipline or convenience and not required to treat the resident's medical symptoms, including when the drug is used in one or more of the following ways:

(i) In excessive dose (including duplicate drug therapy);

(ii) For excessive duration;

(iii) Without adequate monitoring;

(iv) Without adequate indications for its use;

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; and

(vi) In a manner that results in a decline in the resident's functional status.

(8) A chemical restraint may only be ordered in an emergency situation when necessary to ensure the physical safety of the resident or other residents.

(i) The orders must be in writing, signed by a physician who specifies the duration and circumstances under which the chemical restraint is to be used.

(ii) The orders may be oral when an emergency necessitates parenteral administration of the chemical restraint but only until a written order can reasonably be obtained.

(iii) Emergency orders for chemical restraints may—

(a) Not be in effect for more than 12 hours; and

(B) Be administered only if the resident is monitored continually for the first 30 minutes after administration and every 15 minutes thereafter and for as long as the resident is under the influence of the drug to ensure that any adverse side effects would be noticed and appropriate action taken as soon as possible.
### (b) Abuse
The resident has the right to be free from verbal, sexual, physical, and mental abuse, financial exploitation, corporal punishment, and involuntary seclusion.

1. **Abuse.** The resident has the right to be free from verbal, sexual, physical, and mental abuse, financial exploitation, corporal punishment, and involuntary seclusion.

2. A facility is responsible for failing to take all reasonable measures to protect residents from abuse of any source.

   (i) A facility is responsible for the abusive actions of its employees, contractors, and volunteers, even if the employees' actions conflict with the facility's policies and procedures on abuse.

   (ii) A facility is responsible for protecting residents from foreseeable threats of harm posed by other cognitively intact and cognitively impaired residents.

3. The facility must have evidence that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property and financial exploitation are reported immediately to the administrator of the facility, and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), and to law enforcement.

4. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

### (c) Staff Treatment of Residents
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

1. The facility must—

   (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

   (ii) Not employ individuals who have been—

      (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

      (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

   (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

   (2) The facility must ensure that all alleged violations of suspected crimes involving mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property and financial exploitation are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), and to law enforcement.

   (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

### Financial Exploitation
Financial exploitation needs to be added because it is a growing problem among vulnerable adults such as nursing home residents. Individuals with cognitive impairments, mental health conditions, or physical disabilities are often dependent upon others (family members, friends, formal and informal caregivers, or court appointed representatives) for assistance in making financial decisions, paying bills, or carrying out daily transactions, and therefore may be even more vulnerable to theft, exploitation or undue influence.

### Elder Justice Act Provisions of the Affordable Care Act
Financial exploitation: See rationale for (c)(1)(i). Law enforcement: The Elder Justice Act Provisions of the Affordable Care Act require that facilities and their staff report any reasonable suspicion of a crime in a long-term care facility that receives federal funds to local law enforcement. This regulation needs to be updated to include this provision.
<table>
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<tr>
<td><strong>§ 483.15 Quality of Life</strong></td>
<td>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.</td>
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(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; |

Change the language of (b)(1) to: Choose activities, schedules (including bedtime schedules), health care, providers of service, including pharmacy, consistent with his or her interests, assessments, and plans of care. |

Bedtime schedules: The CMS guidelines state that residents have the right to have a choice over their schedules, and that this includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking and the time for going to bed at night. Because many residents are still forced to wake up and go to sleep according to the facility's schedule, this guideline should be put into regulation to better ensure residents truly have choice in their schedules. Providers of services: Residents may have providers from whom they have received services in the past, such as dentists and podiatrists, and with whom they have a longstanding relationship. Forcing residents to use the service providers with whom the facility has contracted disrupts this relationship and can negatively impact a resident's health and well-being. Moreover, many residents, notably those paying privately, can purchase their medications far more cheaply than they can if they must use the facility's pharmacy. This allows them to save money and defer becoming Medicaid-eligible, thus reducing Medicaid costs. |

2) Interact with members of the community both inside and outside the facility; and |

Add the following new requirement after (b) (1): “Go outside and move freely within and outside the facility as he or she chooses”. Change the language of (b) (2) to: “Interact with members of the community both inside and outside the facility and make informed choices about when, and under what circumstances, he or she leaves the facility for outings in the community and” |

We are aware of numerous instances when residents have not been allowed to go outside, and families have not been permitted to take them outside. While other rights can be interpreted as giving residents the right to go outside, explicitly stating this removes any doubt. Residents should be able to go outside of the facility when they choose. |

3) Make choices about aspects of his or her life in the facility that are significant to the resident. |

Change the language of (b)(3): Make choices about aspects of his or her life in the facility. |

“Significant” should be removed from this section, because the resident should be able to make choices in all aspects of his or her life. |

(c) Participation in resident and family groups. |

Change the language in (c) to: Participation in resident and family councils. |

Most facility staff, residents and families use the term “council.” |
| (1) A resident has the right to organize and participate in resident groups in the facility; |
| Change the language of (c) (1) to: “A resident has the right to organize and participate in a resident council in the facility.” |
| Add the following requirements after (c) (1): Family members have the right to organize and participate in a family council in the facility. (i) A facility may not prohibit the formation of a resident or family council, and, if requested, the resident or family council shall be allowed to meet in a common meeting room of the facility at least once a month during mutually agreed upon hours. (ii) A facility shall not willfully interfere with the formation, maintenance, or promotion of a resident or family council. Willful interference includes, but is not limited to, discrimination or retaliation in any way against an individual as a result of his or her participation in a resident or family council, or the willful scheduling of facility events in conflict with a previously scheduled resident or family council meeting. |

| (2) A resident’s family has the right to meet in the facility with the families of other residents in the facility; |
| Add the following subsections under (c) (2): (i) The facility must inform each new resident and family member of each new resident of their right to form a resident or family council. (ii) The facility must post notices of the resident or family council’s meetings upon request. (iii) The facility must provide each new resident and the family member of each new resident with information about any resident or family council. Information shall include the time, place and date of meeting and the person to contact regarding involvement in the resident/family council, as well as the resident/family council’s brochure or other introductory materials. (iv) The facility must indicate whether the council is family-run or facility-run in any of its materials or advertising about the family council. (v) The facility must keep a record of whether or not notice of the right to form a resident/family council, and when a resident/family council exists, the resident/family council meeting and contact information was provided. These records must be maintained in the facility and may be requested by state surveyors during the survey or complaint process. (vi) A resident’s family has the right to meet in the facility with the families of other residents. “The term ‘family’ includes a current, or prior, resident’s family members, friends, health care proxies, and legal representatives. |

| (3) The facility must provide a resident or family group, if one exists, with private space; |
| Add the following language to (d) (3): “The facility must provide a resident or family council adequate space on a prominent bulletin board or other posting area for the display of notices, newsletters, or other information pertaining to the operation or interest of the council.” |

| (4) Staff or visitors may attend meetings at the group’s invitation; |
| Change the language of (c) (4) to: Staff or visitors may attend meetings only at the group’s invitation; |

| (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; |
| Change the language of (c) (5) to: The facility must provide a designated staff person of the resident’s choice responsible for providing assistance and responding to written requests that result from group meetings. |

| (6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. |
| Add the following language to (c) (6): The facility must respond in writing to any grievances or recommendations within 10 days and address what the facility will do to address grievances or adopt recommendations. |

| (d) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. |

| (e) Accommodation of needs. A resident has the right to— |

| Family councils may encounter resistance from administration in establishing and running the council. Resistance can take many forms, including not helping families to promote the council, scheduling other events at times that conflict with the family council meeting, not allowing families to meet at a convenient time in the facility and more. Requirements are needed to strengthen the rights of family councils. |

| Information about council: Families face significant barriers in forming and maintaining a family council. One of the major problems is difficulty informing new family members about the council and publicizing its meetings. Families interested in starting a council or participating in an existing council must rely heavily on the facility administration and staff to advertise and promote the council. However, there are nursing homes that will not distribute family council information or allow families to post notices. Regulations requiring such activities are necessary in order to support family council development and growth. Definition of family: There are facilities that refuse to allow family members whose loved ones have died or friends of residents to participate in the council. Expanding the definition of “family” addresses this issue and allows these individuals to contribute to the council in important ways. |

| Requirements are needed to ensure that family councils have access to a facility common meeting room of the facility at least once a month during mutually agreed upon hours. A facility shall not willfully interfere with the formation, maintenance, or promotion of a resident or family council. Willful interference includes, but is not limited to, discrimination or retaliation in any way against an individual as a result of his or her participation in a resident or family council, or the willful scheduling of facility events in conflict with a previously scheduled resident or family council meeting. |

| There are facilities that insist on having staff present during family council meetings. Adding “only” to this requirement makes it very clear that staff may only attend if invited. |

| Resident councils often need a great deal of staff support and assistance so it is important that the designated staff person be someone the council wants to work with. In addition, resident councils serve to empower residents and give them the opportunity to regain some sense of control over their lives in the facility. Selecting their own staff person supports resident choice and self-determination. |

| Many family councils report that they must wait for weeks for a response to a grievance or recommendation they have submitted to the facility, if they get a response at all. Requiring a response within a set amount of time will help address this problem. |
(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.

Add the following subsections to (e) (2) : Notice must be in writing and given at least one week prior to any change, unless waived by the resident. A resident has the right to participate in any decisions relating to a change in his or her room or roommate and to refuse such a change. A resident should have the right to participate in the decision about a change and to refuse a change in room or roommate because moving to another room or being assigned a new roommate is a major change; can have an enormous impact on a resident's life; and is part of the resident's right to make choices about aspects of his or her life that are significant to the resident. Residents also need time to adjust and cope with any proposed move, so notice must be given sufficiently in advance.

(7) Activities.

(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program must be directed by a qualified professional who—

(i) Is a qualified therapeutic recreation specialist or an activities professional who—

(A) Is licensed or registered, if applicable, by the State in which practicing; and

(B) Is certified as a therapeutic recreation specialist by the National Council for Therapeutic Recreation Certification (NCTRC) or as an activities professional by the National Certification Council for Activities Professionals (NCCAP)

Activity directors need to provide the very best socially, mentally, and physically engaging programs for nursing home residents. Requiring National Certification Council of Activity Professionals (NCCAP) certification or certification by the National Council for Therapeutic Recreation Certification raises the skill and knowledge level of the activities professional because the certification process focuses on the needs of the resident and the specific role of the activity professional in long term care facilities. The individual should already be certified prior to assuming the position of activities director.

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

Delete.

Experience alone does not adequately prepare a person to be an activities director.

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

Delete.

Occupational therapists or assistants do not have the training or qualifications necessary to direct the activities program.

(iv) Has completed a training course approved by the State.

Change the language of (f) (2) (iv) to: "Has completed a NCCAP Modular Education Course for Activity Professionals (MEPAP) of 90 or more hours."

There should be consistency and standardization in training courses across the country to ensure that all activities directors, no matter where they work, are adequately trained.

(8) Social Services.

(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
### Social Worker Requirements

1. **Qualifications of social worker.** A qualified social worker is an individual with—
   - A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
   - One year of supervised social work experience in a health care setting working directly with individuals.
   - A safe, clean, and comfortable home environment allowing the resident to use his or her personal belongings to the extent possible; and
   - A safe, comfortable outdoor environment.

2. **Environment. The facility must provide—**
   - A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; and
   - A safe, comfortable outdoor environment.

3. **Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;**

### Facility Size

- A facility with more than 120 beds must employ a qualified social worker on a full-time basis. Add the following language to (g) (2): There must be at least one full-time social worker for every 50 long-stay residents and at least one full-time social worker for every 15 short-stay residents.

### Additional Requirements

- The duties of the social worker need to be defined. Too often social workers spend time on non-social work activities, such as marketing, admissions or billing. They are frequently assigned tasks that no one else in the facility has. The regulations should establish what the minimum duties of the social worker are.

- Social worker: The psychosocial needs of residents in nursing homes are complex. Yet facilities with more than 120 beds must have a qualified social worker, while smaller facilities do not. This makes little sense since the needs of a resident in a nursing home with fewer than 120 beds are no less critical than those in larger facilities; these residents still require the services of a social worker. Number of social workers: An appropriate number of social workers is a key factor contributing to quality of care and quality of life for nursing home residents. One full-time social worker cannot meet the needs of all residents. According to an Office of Inspector General report in 2003, some 39% of residents with psychosocial needs had care plans that were inadequate to meet those needs; 41% of those with psychosocial needs addressed in their care plans did not receive all of their planned psychosocial services, and 5% received none of these services; and a total of 45% of social workers reported barriers to providing psychosocial services, including not having enough time, and insufficient staff (Psychosocial Services in Skilled Nursing Facilities. Office of Inspector General. Department of Health and Human Services. March 2003.)

- Nursing home social workers advocate for residents and watch for signs of stress and depression. They connect residents and families with resources in and outside the nursing home and facilitate transitions such as hospice, a hospital stay or a return to independence. They guide families, residents and care providers through difficult conversations or conflicts. They also handle very serious emotional issues. In order to best ensure that these important responsibilities are fulfilled and residents' psychosocial needs are met, a qualified social worker must be trained in the discipline of social work and meet professional social work licensing standards.

- The regulation should establish what the minimum duties of the social worker are.
| (1) | Clean bed and bath linens that are in good condition; |
| (4) | Private closet space in each resident room, as specified in §483.70 (4)(2)(v) of this part; |
| (5) | Adequate and comfortable lighting levels in all areas; |
| (6) | Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81 °F; and |
| (7) | For the maintenance of comfortable sound levels. Change the language of (h) (7) to: For the maintenance of comfortable sound levels that do not disturb residents or interfere with their hearing, enhance privacy and encourage interaction when social participation is desired. |

§ 483.20 Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.

(b) Comprehensive assessments —

(1) Resident assessment instrument. 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. Add the following new requirement after (b) (1) (i): “The resident’s personal and medical history.” |
| (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. Change the language of (b) (1) (x) to: Dental and oral health care. Add the following after (b)(1)(x): “Nutritional status.” |
| (xi) | Dental and nutritional status. |
| (xii) | Skin condition. |
| (xiii) | Activity pursuit. Change the language of (b) (1) (xiii) to: Activity pursuit, including outings and overnight leaves of absence in the community. |
| (xiv) | Medications. |
| (xv) | Special treatments and procedures. |
| (xvi) | Discharge potential. |
| (xvii) | Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). Add the following new requirement after (b) (1) (xvii): Risks for decline. |
| (xviii) | Documentation of participation in assessment. |

"Comfortable" is too vague. Adding this language, much of which comes from the CMS interpretive guidelines, is more specific and would enhance residents’ quality of life.

A thorough assessment should include the resident’s personal and medical history as well to best determine the type of care and treatment the resident requires or prefers.

Poor oral health can result in serious health care problems, such as infections. Because of its importance to overall resident health, oral health care as well as dental health must be included in the resident assessment.

Leaving the facility for outings and overnights are important activities for many residents and should be clearly stated as being part of activity pursuits.

Assessments should not only include a resident’s current condition, but also any potential risks for decline. This allows facilities to be aware of such risks and develop a care plan to prevent decline.

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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. Residents should have an active role in their assessments (as should their family members, with their consent); this input is essential in gathering the information necessary to develop an effective care plan. In addition, certified nursing assistants should be specifically mentioned since they are often the staff members who can provide the best firsthand information about the resident.

(2) When required. Subject to the timeframes prescribed in §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 §413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding re-admissions 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 requires interdisciplinary review or revision of the care plan, or both.)

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

(ii) 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 of care.

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicate testing and effort.

(1) Automated data processing requirement —

(1) Encoding data. Within 7 days after a facility completes a resident’s assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.

(ii) Annual assessment updates.

(iii) Significant change in status assessments.

(iv) Quarterly review assessments.

(v) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

Fourteen days is too long to wait for an assessment after admission since a care plan cannot be developed until the assessment is completed. Changing the time frame to 5 days is consistent with the standards for Medicare reimbursement. If facilities can conduct the assessment within 5 days for Medicare beneficiaries, they should be able to meet the same time frame for all residents.

If there has been a significant change in the resident's condition, 14 days is too long to wait for an assessment.
(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

- (i) Admission assessment.
- (ii) Annual assessment.
- (iii) Significant change in status assessment.
- (iv) Significant correction of prior full assessment.
- (v) Significant correction of prior quarterly assessment.
- (vi) Quarterly review.
- (vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.
- (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

Change the language of (f) (5) (ii) to: "The facility may release information that is resident-identifiable to an agent of the facility only in accordance with a contract under which the facility's agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so."

"Agent" should be better defined to clarify that it refers to a facility's agent and not a resident's agent.

(g) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification.

1. A registered nurse must sign and certify that the assessment is completed.

Change the language of (i) (1) to: A registered nurse must sign and certify that the assessment is completed and that it included direct observation and communication with the resident, communication with licensed and nonlicensed direct care staff members on all shifts and participation of the resident, and with resident consent, the resident's family members.

Certification by the registered nurse that there has been communication with the resident, family and staff better ensures that this requirement is met and that vital information is obtained from these individuals as part of the assessment process.

2. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for falsification.

1. Under Medicare and Medicaid, an individual who willfully and knowingly—

   (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

   (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

2. Clinical disagreement does not constitute a material and false statement.

(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 §483.25; and
(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

(2) A comprehensive care plan must be—

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

(ii) 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.

(6) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—

1. A recapitulation of the resident's stay;

2. A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

3. A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(7) Discharge Summary. When the facility anticipates discharge a resident must have a discharge summary that includes—

1. A recapitulation of the resident's stay;

2. A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

3. A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Change the following language of (m) (ii): "Preadmission screening for mentally ill individuals and individuals with mental retardation. (1) A nursing facility must not admit on or after January 1, 1989, any new resident with—"

Mental retardation: Language should be changed from "mental retardation" to "intellectual disabilities" to reflect the more current and accepted terminology.

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Mental retardation: Language should be changed from "mental retardation" to "intellectual disabilities" to reflect the more current and accepted terminology.
An individual is considered to be mentally retarded if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.

§ 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 resident's ability to—

   1. Bathe, dress, and groom;
   2. Transfer and ambulate;
   3. Toilet;
   4. Eat; and
   5. 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. 

Add the following language to (a) (3): “These necessary services will be provided to residents at times that correlate with each individual resident's schedule and preferences.”

Many facilities still provide assistance with activities of daily living at a time that is convenient for staff, not for residents. Helping residents with these activities at a time that is best for them would enhance their ability to perform these tasks and their quality of life.

(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.

(6) 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;
As noted earlier, poor oral health can result in serious health care problems, such as infections. In addition, there is research indicating that nursing home residents may not receive the oral health care they need. Dental and oral health care should be added to the special needs section to better ensure that these critical services are provided regularly.

### 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.

Add the following requirement: (2) (iii) to: Any antipsychotic drug administered to a resident must—

(A) Be ordered by a physician who specifies the dose, duration and reason for the use of the drug; The physician must assess the resident in person before ordering the drug except in emergency circumstances.

(B) Be used only as an integral part of the resident's comprehensive care plan that is directed specifically towards the elimination or modification of the symptoms for which the drugs are prescribed;

(C) Not be used unless it can be justified in the clinical record that the potential beneficial effects of the drug clearly outweigh its potential harmful effects.

(E) Be monitored closely, in conjunction with the drug regimen review requirements at § 483.60(e) for desired responses and adverse consequences by facility staff;

(F) Be gradually withdrawn at least semi-annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence demonstrates that this is contraindicated;

(G) Be reviewed at least annually by a physician who has training or experience in geriatrics and psychopharmacology and who must not serve a facility with which he or she has had a contractual, financial, employment or familial relationship with the facility, its owner, its attending physicians, medical director, or administrator within any of the 36 consecutive months prior to the date of the review (This review may be conducted as part of the annual review and determination of residents for mental illness conducted in accordance with § 483.114 of this part provided it is conducted by a physician with the above qualifications.);

(H) Be used only when a record is maintained of the administration of the drug, the dose, the route of administration, side effect monitoring, a description of the behavior, mood or mental status which the drug is intended to alter, the effect of the drug on the behavior, mood and mental status of the resident, and any other change in behavior, mood, mental status or adverse drug reaction which occurs with the administration of the drug.

Before an antipsychotic drug is used in a non-emergency situation, the facility must—

(A) Explain the use of the drug to the resident, or, if the resident has been declared to be legally incompetent or cannot understand his or her rights, to the resident's legal representative, in accordance with § 483.10(d) and State law;

(B) Explain the risks and benefit of the antipsychotic drug and alternatives;

(C) Explain the resident's right to refuse the drug in accordance with § 483.10(b)(4); and

(D) Obtain the written consent of the resident or the resident's legal representative.

Each day, about one of every four nursing home residents is given dangerous antipsychotic drugs despite black box warnings by the Food and Drug Administration (FDA) that these drugs may cause their death. Numerous studies show that antipsychotic drugs, even when they do not lead to death, often cause far more harm than good. Stringent requirements are needed to combat the prevalent misuse of antipsychotics in long-term care facilities. In addition, antipsychotic drug use is extraordinarily costly to Medicare and taxpayers; in just a six-month period in 2007, the HHS Office of Inspector General found that Medicare overpaid $116 million in erroneous nursing home claims for atypical antipsychotic 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.

(n) Influenza and pneumococcal immunizations —

1. Influenza. The facility must develop policies and procedures that ensure that—

(i) Before offering the influenza immunization, each resident or the resident’s legal representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident’s legal representative has the opportunity to refuse immunization; and
The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures that ensure that—

(i) Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

(v) Exception. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

§ 483.30 Nursing Services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) Sufficient staff.
The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

- Direct care nursing staff
  - The facility must provide at least 2.8 hours of certified nursing assistant time, .75 hours of registered nurse time and .55 hours of licensed vocational/practical nurse time per resident per day. Staffing levels shall be adjusted upward based on residents' needs. This time includes only time spent providing direct care to residents and does not include time spent on administrative tasks.


- These conditions directly relate to the complaints of insufficient staff, and specifically the lack of staff on-hand to address these preventable conditions, the Consumer Voice hears weekly from residents, families, and advocates.

- In addition to the human cost, the financial cost of poor care in America’s nursing homes is staggering. In 2011, the Consumer Voice released, “The High Cost of Poor Care: The Financial Case for Prevention In American Nursing Homes,” which documented the cost associated with avoidable falls, pressure ulcers, urinary incontinence, malnutrition, dehydration and hospitalization. These costs place an enormous financial burden on Medicare, Medicaid and the American taxpayers. Costs to providers, such as workers’ compensation claims, staff turnover, staff training, medical/nursing errors by temporary/pool staff, and tort liability, could also be reduced or avoided if facilities had enough staff to properly care for nursing home residents.

- While the NCONHR (now the Consumer Voice) recommended staffing standard is higher, the evidence-based direct care staffing standard of 4.1 hours per resident day will greatly improve the quality of care for nursing home residents across the country.
(1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Change the language of (b) (1) to: The facility must use the services of a registered nurse 24 hours a day, 7 days a week.

As noted in the comments submitted by the Coalition of Geriatric Nursing Organizations (July 2, 2012), there is mounting research evidence that higher levels of RN time is associated with positive outcomes and less RN time associated with negative outcomes. Positive outcomes with more RN time:

- RNs have been found to have a positive effect in decreasing unnecessary hospitalizations of nursing home residents (Decker 2008), (O'Malley, Cauthry & Brabowski 2011), (Dorr, Horn & Smout 2005). (Horn, Buerhaus, Bergstrom and Smout 2005).
- Higher RN levels significantly and positively affect quality resident outcomes including lower antipsychotic use, and fewer pressure ulcers, restraint use and cognitive decline (Weech-Maldonado, Meret Hanka, Neff, and Mor 2004); reduced incidences in four related conditions, catheterizations, Urinary Tract Infections, antibiotic use and pressure sore development (Cherry, 1991); decreased pressure ulcers and UTIs (Konestski, Staars, Park 2007); and Horn et al showed that increasing RN time was associated with less decrease in function, fewer urinary tract infections, catheterizations, weight loss and pressure ulcers.

Negative outcomes with lower RN time:

- The importance of RNs is also reflected in the negative results of increased RN turnover on restraint use, urinary catheters, psychoactive drugs and an increased risk of pressure ulcers and catheters (Castle, Engeborg 2005). Lower RN levels are associated with an increase in antipsychotic drug use and the number of pressure ulcers (Castle and Engberg 2010). Castle, using a longitudinal study design, quarterly staffing data, and a large sample size, showed the RN staffing significantly affected four quality measures: restraint use, catheter use, pain management and pressure sores (Castle and Anderson, 2011). There is also evidence that RN time is associated with nursing home citations for deficient practice by state survey agencies. Lower RN and total staffing levels are associated with more deficiencies (Johnson Paulson & Infield 1998), (Konestski, Yi, Norton, Kaplatisch 2004), (Castle, Engberg, 2010), (Harrington, Zimmerman, Karon, Robinson, Beutel, 2000). In one large study, RN levels were consistently associated with fewer care safety deficiencies (Castle et al., 2011). Increases in RN turnover can result in increased deficiencies (Castle and Engberg 2005). These studies and three Institute of Medicine reports (2004, 2001, 1996)

(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

Change the language of (b)(2) to: The facility must designate a registered nurse to serve as the director of nursing on a full-time basis.

As stated in the July 2, 2012 letter from the Coalition of Geriatric Nursing Organizations, research shows the importance of the Director of Nursing position in that high retention levels are associated with better outcomes (Anderson, Issel, McDaniel, 2003). These same authors also showed that an experienced DON is associated with lower immobility prevalence (Anderson, Issel, McDaniel, 2003). The role of the DON is critical to quality resident care. The DON is responsible for administrative, clinical, educational, staff and public relations; the core competencies include such skills as conducting root cause analysis, setting benchmarks, directing change, and mentoring and teaching. RNs are best equipped to fulfill these responsibilities based on their education and training.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;
(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

Add the following new requirement after (c) (7): The facility must post notice of any waiver with the nurse staffing information in a prominent place in the residential living area of the facility. The Secretary will assure that waiver information is posted on Nursing Home Compare.

(d) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians’ orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

Add the following new requirement after (d)(1)(2): The facility must post notice of any waiver of 483.30 (c) or (d) with the nurse staffing information required under 483.30 (e). The Secretary will assure that waiver information is posted on Nursing Home Compare.

Posting the information in the facility: In addition to notifying residents and families, the waiver should be posted to ensure that residents and families are aware that the facility is not meeting this staffing requirement and to provide potential residents and families who are choosing a nursing home with this information. Nursing Home Compare: Information about staffing is very important to consumers looking for a nursing home. Posting waiver information on Nursing Home Compare allows people who are researching nursing homes to access this information without having to go to the facility.

(e) Nurse staffing information —

Add the following new subsection after (d): Training. "Nursing staff must receive trainings in cultural competence at least annually."

In order to provide quality care, nursing staff must be sensitive to and respectful of people who are different from them in terms of culture, race, ethnicity, religion, sexual orientation, etc.
Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors in a residential living area of the facility.

Advocates have observed that this information is not always placed where it can be easily seen. Staffing information should be posted in an area that residents, families and visitors frequent to best ensure they have the opportunity to view it.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.


§ 483.35 Dietary Services.

(a) Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

Dietary Managers are trained to apply nutrition principles and document nutrition information, as well as manage menus, food purchasing, and food preparation; ensure food safety, manage work teams, and more. Because the director of food services only receives periodic consultation from a dietitian, this nutrition-related training makes certified dietary manager more equipped and better qualified to meet residents' nutritional and dietary needs.

Change the language of (a) (1) to: "If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who is a certified dietary manager and who receives frequently scheduled consultation from a qualified dietitian."

(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

The name of the American Dietetic Association has been changed to the Academy of Nutrition and Dietetics.

Change the language of (a) (2) to: A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration or the Academy of Nutrition and Dietetics.

(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) Menus and nutritional adequacy. Menus must—
<table>
<thead>
<tr>
<th>Paragraph</th>
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<tr>
<td>1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;</td>
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<td>2) Be prepared in advance; and</td>
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<td>3) Be followed.</td>
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<td>(d) Food. Each resident receives and the facility provides—</td>
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<td>1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</td>
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<td>2) Food that is palatable, attractive, and at the proper temperature;</td>
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<td>3) Food prepared in a form designed to meet individual needs; and</td>
<td>3) Food prepared in a form designed to meet individual needs; and</td>
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<td>4) Substitutes offered of similar nutritive value to residents who refuse food served.</td>
<td>4) Substitutes offered of similar nutritive value to residents who refuse food served.</td>
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<td>Change the language of (d) (4) to: “A variety of substitutes offered of nutritive value to residents who choose not to eat food that is initially offered.”</td>
<td>Varied of substitutes: In order to promote resident choice and preference, the facility should provide a number of different substitutes, not just one or two. Refuse: this term has a negative connotation and should be changed to more person-centered language.</td>
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<td>(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.</td>
<td>(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician with the informed consent of the resident or representative.</td>
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<tr>
<td>Change the language of (e) to: “Therapeutic diets. Therapeutic diets must be prescribed by the attending physician with the informed consent of the resident or representative.”</td>
<td>Consulting with the resident first to see what the resident wants is a critical part of person-centered care. It allows residents to exercise their right to participate in planning their care and treatment.</td>
</tr>
<tr>
<td>(f) Frequency of meals.</td>
<td>(f) Frequency of meals.</td>
</tr>
<tr>
<td>1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</td>
<td>Add the following language to (f) (1): “Each resident receives and the facility provides at least three meals daily, at times that accommodate resident preferences, and a full range of food options available to him or her 24 hours a day.”</td>
</tr>
<tr>
<td>2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.</td>
<td>Residents should have a choice of food and eat when they choose just as they would in their own homes. This is essential for person-centered care.</td>
</tr>
<tr>
<td>3) The facility must offer snacks at bedtime daily.</td>
<td>Change the language in (f) (3) to: “The facility must offer a variety of snacks that are available 24 hours a day.”</td>
</tr>
<tr>
<td>Snacks should be available to residents 24 hours a day, not solely at bedtime. Residents should also have a choice of snacks that they can eat when they wish.</td>
<td></td>
</tr>
<tr>
<td>4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</td>
<td>Change the language in (f) (4) to: “Residents should have access to snacks of their choice between the evening meal and breakfast. The meal span between these two meals should be revisited and reviewed annually by the resident council.”</td>
</tr>
<tr>
<td>Residents should have access to snacks of their choice between the evening meal and breakfast. The meal span between these two meals should be reviewed annually by the resident council.</td>
<td>16 hours between meals: Residents should have a snack between these two meals. The time frame between meals should be revisited annually by the resident council because the wishes and preferences of residents may change.</td>
</tr>
<tr>
<td>(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.</td>
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</tr>
<tr>
<td>The concept of feeding assistants was created in response to the lack of sufficient numbers of staff to help residents eat. Residents who need help with eating have physical or cognitive problems that prevent them from being able to feed themselves. Feeding assistants, who have extremely little training, are ill-equipped to help residents who may have difficulty swallowing or who may resist being fed. Staff who assist such residents need the skills and training of a CNA to provide services to these residents. Furthermore, assigning staff to provide such assistance does not promote continuity of care or respond to what certified nursing assistants say is most rewarding in their jobs—their ongoing relationships with individual residents (Statement about Nurse Staffing in Nursing Homes. Toby Edelman. 2002).</td>
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</tr>
<tr>
<td>(h) Paid feeding assistants —</td>
<td>(h) Paid feeding assistants — Delete (h).</td>
</tr>
<tr>
<td>1) State-approved training course. A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if—</td>
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</tr>
<tr>
<td>(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents, and</td>
<td>(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents, and</td>
</tr>
<tr>
<td>(ii) The use of feeding assistants is consistent with State law.</td>
<td>(ii) The use of feeding assistants is consistent with State law.</td>
</tr>
<tr>
<td>2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).</td>
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</tr>
<tr>
<td>(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.</td>
<td>(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.</td>
</tr>
</tbody>
</table>
Resident selection criteria.  (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the charge nurse’s assessment and the resident’s latest assessment and plan of care.

Sanitary conditions. The facility must—

1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;

Add the following language to (i) (1): “Food may be brought in from local sources such as home-grown garden produce, fish caught by residents and by family members, and the facility must keep it safe by following safe food-handling techniques.”

Bringing in food from local sources promotes resident choice. It also adds variety to residents’ diets and allows them to eat foods that are fresh as they would in their own homes.

2. Store, prepare, distribute, and serve food under sanitary conditions; and

3. Dispose of garbage and refuse properly.

PHYSICIAN SERVICES. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

Physician supervision. The facility must ensure that—

1. The medical care of each resident is supervised by a physician; and

2. Another physician supervises the medical care of residents when their attending physician is unavailable.

Physician visits. The physician must—

1. Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

2. Write, sign, and date progress notes at each visit; and

3. Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

Frequency of physician visits.

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.

Add the following to (c) (1): “The resident must be seen in person by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Telemedicine shall not be substituted for these visits.”

In person: Residents and their families should be able to consult with the doctor and ask questions, just as individuals living in the community do. However, many residents and families report that they rarely see the attending physician. Requiring that there be an in person visit would give residents greater access to the physician and is supported by the CMS guidelines that “must be seen” means actual face-to-face contact with the resident. It also would provide the physician a better picture of how the resident is doing. Telemedicine: A visit conducted via telecommunications does not provide residents with the one-on-one attention necessary for their care.

2. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

3. Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.
(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(e) Physician delegation of tasks in SNFs.

1. Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—
   (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;
   (ii) Is acting within the scope of practice as defined by State law; and
   (iii) Is under the supervision of the physician.

2. A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.


§ 483.45 SPECIALIZED REHABILITATIVE SERVICES.

(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must—

1. Provide the required services; or

2. Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.


§ 483.55 DENTAL SERVICES. The facility must assist residents in obtaining routine and 24-hour emergency dental care.

(a) Skilled nursing facilities. A facility -

1. Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident.

Add the following as (m): Residents and families report that there are times when physicians do not respond quickly enough in an emergency. This can jeopardize a resident's health. The facility should be responsible for ensuring that there are no delays in physician responses in an emergency.

Residents and families report that there are times when physicians do not respond quickly enough in an emergency. This can jeopardize a resident's health. The facility should be responsible for ensuring that there are no delays in physician responses in an emergency.

Add the following to (d): The facility must assure that physicians respond promptly to emergency calls.

Residents and families report that there are times when physicians do not respond quickly enough in an emergency. This can jeopardize a resident's health. The facility should be responsible for ensuring that there are no delays in physician responses in an emergency.

Add the following new requirements after (a) (2): -The resident and/or his or her legal representative has the right to choose a service provider. Counseling services must be offered to residents requiring rehabilitative services.

Choice of provider: Residents should be able to work with the provider whom they believe can best meet their needs. Counseling: Residents who need rehabilitative services have often broken a hip, suffered a stroke or experienced another potentially life-threatening or life-changing medical event. Such an event can affect emotional well-being as much as physical function. Residents may experience feelings of loss, helplessness, frustration, depression and apathy. Receiving counseling, if desired, can help residents develop strategies to cope with these feelings.
May charge a Medicare resident an additional amount for routine and emergency dental services; 
(3) Must if necessary, assist the resident—
(i) In making appointments; and 
(ii) By arranging for transportation to and from the dentist’s office; 
(4) Promptly refer residents with lost or damaged dentures to a dentist. 
Change the following language in (a) (4): “promptly refer” to “refer residents with lost or damaged dentures to a dentist within three working days of determining that the dentures had been lost or damaged.”
Residents should be given the opportunity to request that someone accompany them.

Advocates are aware of instances when residents have been dropped off in front of the dentist’s office and left alone without assistance, often for long periods of time, because nursing home staff did not think they needed help. Residents should be given the opportunity to request that someone accompany them.

(a) Procedures. A facility must provide 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.
Add the following language to (a): “The facility must permit residents to choose their provider of pharmaceutical services and to obtain their drugs through their health insurance prescription drug coverage for routine maintenance drugs.”
Residents should be able to work with the provider whom they believe can best meet their needs. Moreover, many residents, notably those paying privately, can obtain medications through their own health insurance prescription drug coverage that cost them much less than medications provided by the pharmacy the facility selects. This allows them to save money and defer becoming Medicaid-eligible, thus reducing Medicaid costs.

(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—
(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
(2) Establishes a system of records of receipt and disposal of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 
(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

§ 483.60 PHARMACY SERVICES. 
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

Add the following new language to (b)(3): “In the event that the facility is responsible for the loss or damage of a resident’s dentures, the facility must replace the resident’s dentures without charge to the resident.”
Dentures can be expensive and difficult to replace. Residents should not be charged with replacing dentures that were lost as a result of facility inattention, mistakes or failure to put measures in place to prevent loss.

(h) Other services. The facility must provide other additional services that are necessary to meet the needs of each resident.

(i) In making appointments; 
(ii) By arranging for transportation to and from the dentist’s office; 
(iii) By accompanying the resident during the appointment if necessary or requested by the resident.
The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

Add the following new requirements after (c)(1): The licensed pharmacist must be independent of any affiliations with the facility’s long-term care pharmacies, pharmaceutical manufacturers and distributors, or any affiliates of these entities. - When conducting the drug regimen review, the pharmacist must consult the resident’s clinical record. - The pharmacist’s report must include documentation of any incidents of a resident being prescribed an antipsychotic medication as a means of controlling behavior, and whether there is a diagnosis to support the use of an antipsychotic medication.

Documentation of incidents: The drug regimen review is an important component of the overall management and monitoring of a resident’s medication regimen. The CMS guidelines indicate that factors to be considered in a review, include “Whether the physician and staff have documented objective findings, diagnoses and/or symptom(s) to support indications for use.” The rampant misuse of antipsychotics illustrates the importance of requiring consultant pharmacists to indicate if there is a diagnosis justifying the use of antipsychotics and if/when it is being used to control behavior.

Independence: Ties to long-term care pharmacies and drug manufacturers create strong incentives for consultant pharmacists to recommend unnecessary and inappropriate drugs. For instance, the Department of Justice alleged that Omnicare received kickbacks from the manufacturer Johnson & Johnson to recommend that nursing home doctors prescribe Risperdal, a drug that increases the risk of heart attacks and strokes in persons with dementia. The government said Omnicare then paid kickbacks to nursing homes by providing them consultant pharmacist services at rates below the fair market value, and it alleged that Johnson & Johnson knew that physicians accepted consultant pharmacists’ recommendations 80 percent of the time and considered them an “extension of [J&J]’s sales force” (Press Release, “U.S. Files Suit Against Johnson & Johnson for Paying Kickbacks to Nation’s Largest Nursing Home Pharmacy, U.S. Department of Justice, Jan. 15, 2010). In the April 12 Federal Register response to public comments [77 FR 22072], CMS itself concluded that commenters had corroborated that industry practices pressure pharmacists to recommend certain drugs but also allow them to benefit directly from the rebates and price breaks that pharmaceutical companies give to long-term care pharmacies. Commenters, many of whom were consultant pharmacists or former consultant pharmacists, described practices that “strongly influenced utilization” and “often resulted in a higher number of medications per resident and use of inappropriate drugs:

- LTC pharmacies gave consultant pharmacists lists of preferred drugs that they were expected to recommend.
- Some pharmacies had “therapeutic change programs” in which consultant pharmacists recommended that prescribers switch to a related drug.
- Automatic prescription changes were generated by the pharmacy when the doctor accepted the recommendation.
- Pharmacists’ performance evaluations and bonuses were based on their LTC pharmacy’s market share of preferred brands.
- Some pharmacies recouped the cost of providing consultant pharmacists to nursing homes by requiring them to recommend drugs that yielded the highest profits. Commenters also described other aspects of the financial relationships among drug manufacturers, LTC pharmacies, nursing homes, and consultant pharmacists that “subvert” drug regimen reviews required to ensure resident safety, such as quotas and other polices that limit the amount of time consultant pharmacists are allocated to conduct reviews and that make reviews perfunctory. Consultant pharmacists must be able to review residents’ drug regimens in an objective way and be able to make recommendations based on what is best for the residents. To be able to do so, consultant pharmacists must be independent of the interests or control of long-term care pharmacies, pharmaceutical manufacturers and distributors, or their affiliates. Residents’ records: In order to accurately evaluate a resident’s drug regimen, consultant pharmacists must have knowledge of the resident, including his/her diagnoses, reasons for the use of each medication, how the resident has responded to the drug, and side effects. This information is found in the resident’s clinical records. However, in the April 12 Federal Register response to public comments [77 FR 22072], commenters, many of whom were current or former consultant pharmacists, stated that long-term care pharmacies that employ consultant pharmacists often require pharmacists to conduct reviews at the pharmacy rather than the nursing home. This means that consultant pharmacists do not have access to the resident’s records and cannot conduct a thorough drug regimen review. To assure residents’ health, safety and well-being, consultant pharmacists must be required to consult the resident’s clinical record during their review.
Add the following language to (c)(2): The pharmacist must report any irregularities to the attending physician, the director of nursing, and these reports must be acted upon.

Add the following new requirement after (c)(2): A facility must have in place a system to conduct drug regimen reviews on an as-needed basis when there is a significant change in the resident's condition or a new drug order.

Change the following language in (a): "The facility must establish an infection control program which follows CDC guidelines under which" Add the following new language after (a)(3): Conducts in service training on infection control at least annually.

CDC guidelines: CMS guidelines state that "It is important that all infection prevention and control practices reflect current Centers for Disease Control (CDC) guidelines. In service training: In order to create and maintain an effective infection control program, staff must be adequately trained. Such training is supported by CMS guidelines indicating that activities involved in infection control program development and oversight include, "Developing and implementing appropriate infection control policies and procedures, and training staff on them." Given staff turnover rates, such training should be provided at least once a year.
(3) Maintains a record of incidents and corrective actions related to infections. Add the following language to (a) (3) to: "Maintains a record of incidents and corrective actions related to infections and makes a summary of this record available to residents and/or their legal guardians, residents’ family members, and the general public.”

(b) Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. Change the following language in (b) (1): "must isolate the resident" to "must isolate the resident after informing the resident and/or the resident’s family member or legal representative of the need for isolation. Staff must monitor and work to prevent any adverse psychological effects that may arise due to isolation.”

Residents that are isolated to prevent the spread of infection should be thoroughly informed about the isolation before it occurs and monitored during it to prevent any unattended negative psychological effects isolation may cause.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

3) Change the language in (b)(3) to: All staff must follow CDC guidelines on hand hygiene and glove use. The facility must make materials for hand hygiene readily available.

CDC guidelines: Hand hygiene is the primary means of preventing the transmission of infection. Use of gloves is also critical. Because it is not possible to identify every situation in which hand hygiene or glove use is necessary, staff should follow CDC guidelines which provide the best and most current practice information. Materials: As indicated in the CMS guidelines, "It is necessary for staff to have access to proper hand washing facilities with available soap (regular or anti-microbial), warm water, and disposable towels and/or heat/air drying methods.”

(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. Change the following language in (c) to: Personnel must handle, store, process, and transport linens in compliance with the Centers for Disease Control and Prevention’s guidelines so as to prevent the spread of infection.

CDC guidelines should be followed because they reflect the most current and up-to-date practices.

§ 483.70 PHYSICAL ENVIRONMENT. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) Life safety from fire.


(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.
(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.

(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Battery March Park, Quincy, MA 02269; and

(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.

(7) A long term care facility must:

(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.

(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.

(iii) Exception:

(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or

(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

(viii) A long term care facility must:
(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.


(b) Emergency power.

1. An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

2. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

(c) Space and equipment. The facility must—

1. Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident’s plan of care; and

2. Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

1. Bedrooms must—

   (i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.
| i) Accommodate no more than four residents; | Change the following language in (D) (1) (i): from "no more than four to" to "no more than two after EFFECTIVE DATE OF REGULATIONS. Effective upon the implementation of this rule, any facility remodeling or new facility construction must include enough private rooms to accommodate all residents who wish to live by themselves.

Number of people per room: Resident rooms should be as much as possible like rooms that people have in their own homes. We would not put 4 people together in one bedroom in our houses, so residents should not be forced to share a room with three other people. This infringes on resident privacy and can negatively affect their quality of life. Private rooms: Research literature provides strong evidence that elderly adults overwhelmingly prefer single rooms over shared rooms. Single rooms provide privacy and give residents a greater sense of control over their environment. Interviews and focus groups conducted with staff and families also support single rooms. Nursing home staff have noted that shared rooms sometimes prevented family members from visiting as long as they would have preferred. Family members reported that they were visiting dying relatives, being in the presence of roommates made them feel uncomfortable. An AARP study found that older adults (over age 50) prefer private to shared rooms by 20 to 1 (The Gerontologist, April 2007, 47(2):169–83. Margaret Calkins, Ph.D., Christine Cassella). |
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<td>(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;</td>
<td>Given how important privacy is to residents (see above), every effort must be made to provide individuals sharing a room with as much privacy as possible. Ceiling suspended curtains do not provide residents with sufficient visual and auditory privacy.</td>
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<td>(iii) Have direct access to an exit corridor;</td>
<td>Delete.</td>
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| (iv) Be designed or equipped to assure full visual privacy for each resident; | Change the following language in (D) (1) (i): from "no more than four" to "no more than two after EFFECTIVE DATE OF REGULATIONS. Effective upon the implementation of this rule, any facility remodeling or new facility construction must include enough private rooms to accommodate all residents who wish to live by themselves.

As referenced above, residents overwhelmingly prefer single rooms. Placing more than two residents in a room is unacceptable to most individuals. The current language referencing ‘variations’ should be deleted because it gives facilities too much freedom to place too many residents in a room together. |
| (v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; | Add the following language to (e): "After the effective date of these rules, when a facility remodels or there is new construction, each semi-private room must include a barrier that provides each bed with total visual and auditory privacy in combination with adjacent walls."

Residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (vi) Have at least one window to the outside; and | Add the following language to (f): "After the effective date of these rules, when a facility remodels or there is new construction, each resident room shall have a private bathroom with toilet and bathing facilities.*"

Residents cannot use their call button or pull cord if they cannot reach it. Advocates have observed situations where residents are in a bed or chair that is far away from the pull cord/call button. |
| (vii) Have a floor at or above grade level; | Add the following language to (g): "After the effective date of these rules, when a facility remodels or there is new construction, each resident room shall have a private bathroom with toilet and bathing facilities.*"

Residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (v) A separate bed of proper size and height for the convenience of the resident; | Delete. |
| (vi) A clean, comfortable mattress; | As referenced above, residents overwhelmingly prefer single rooms. Placing more than two residents in a room is unacceptable to most individuals. The current language referencing ‘variations’ should be deleted because it gives facilities too much freedom to place too many residents in a room together. |
| (vii) Bedding appropriate to the weather and climate; and | Add the following language to (i): "Are in accordance with the special needs of the residents; and"

Residents must be treated with respect and dignity. |
| (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. | Add the following language to (j): "Be designed or equipped to assure full visual privacy for each resident;"

Residents have the right to privacy and should not be forced to share a room with three other people. |
| (v) CMS, or in the case of a nursing facility the survey agency, may demonstrate in writing that the variations— | Add the following language to (k): "A call button or pull cord must be positioned within easy reach of the resident."

Residents can negatively affect their quality of life. |
| (i) Are in accordance with the special needs of the residents; and | Add the following language to (l): "A call button or pull cord must be positioned within easy reach of the resident."

Residents can negatively affect their quality of life. |
| (ii) Will not adversely affect residents' health and safety. | Add the following language to (m): "Be designed or equipped to assure full visual privacy for each resident;"

Residents have the right to privacy and should not be forced to share a room with three other people. |
| (e) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. | Residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from— | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (1) Resident rooms; and | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (2) Toilet and bathing facilities. | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must— | Residents cannot use their call button or pull cord if they cannot reach it. Advocates have observed situations where residents are in a bed or chair that is far away from the pull cord/call button. |
| (i) Be well lighted; | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (ii) Be well ventilated, with nonsmoking areas identified; | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (iii) Be adequately furnished; and | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
| (iv) Have sufficient space to accommodate all activities. | residents should not have to go down the hall or even farther to access toilet or bathing facilities. Private bathrooms make facilities more like home. |
Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff, and the public. The facility must—

1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

3) Equip corridors with firmly secured handrails on each side; and

4) Maintain an effective pest control program so that the facility is free of pests and rodents.

§ 483.75 ADMINISTRATION. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(a) Licensure. A facility must be licensed under applicable State and local law.

(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(d) Governing body.

1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

Add the following language to (d) (1): "and includes at least one resident. The names, addresses and phone numbers of members of the governing body must be posted at the facility in an easily accessible location.

2) The governing body appoints the administrator who is—

Including a resident: As part of resident-directed and person-centered care, residents should have input into how the nursing home is governed. The presence of at least one resident on the governing body would give the governing body firsthand information about the resident experience and the impact of policies on residents. Posting governing body information: It is difficult for residents, families and even staff to obtain information about who serves on the governing body. These individuals have the right to know who is legally responsible for the operation of the facility. Access to this information is particularly important when residents, family or staff have concerns about the facility that are not being addressed by the administrator.

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(i) Licensed by the State where licensing is required; and

Add the following language after (d)(2)(i): A facility may not employ an individual as a nursing home administrator unless that individual and facility meet the requirements of this section.

(a) State licensure. The individual must be licensed to serve in a nursing home as an administrator in accordance with State law.

(b) Age. The individual must be at least 21 years of age.

(c) Education. The individual must possess at least a baccalaureate degree.

(c) Internship. (1) The individual must complete to the State’s satisfaction an internship of one year. The internship shall not be take place in a Special Focus Facility.

(d) Examinations: The individual must pass with a score of at least 80 percent the National Association of Long-Term Care Administrators Board (NAB) and a state examination.

(e) Continuing education. The individual must complete at least 40 clock hours of continuing education for any calendar year in which the individual serves as an administrator.

(ii) Responsible for management of the facility.

(c) Required training of nursing aides —

<table>
<thead>
<tr>
<th>Definition</th>
<th>Add the following new language after (e)(2):</th>
<th>Add the following new language after (e)(2)(ii):</th>
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<tr>
<td>Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.</td>
<td>Training must include how to care for individuals with dementia, prevention of abuse and person-centered care.</td>
<td>That individual is at least 18 years old.</td>
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<tr>
<td>Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietician, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</td>
<td>Nurse aides should be required to be of legal adult age to better ensure that they are mature and responsible enough for the work required of a nurse aide.</td>
<td>Nurse aides should be required to be of legal adult age to better ensure that they are mature and responsible enough for the work required of a nurse aide.</td>
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(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing-related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or

Add the following language to (e)(2)(ii): Training must include how to care for individuals with dementia.

(b) That individual has been deemed or determined competent as provided in §483.150 (a) and (b).

(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2) (i) and (ii) of this section.

(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—

Add the following new language after (d)(2)(i): A facility may not employ an individual as a nursing home administrator unless that individual and facility meet the requirements of this section.

(a) State licensure. The individual must be licensed to serve in a nursing home as an administrator in accordance with State law.

(b) Age. The individual must be at least 21 years of age.

(c) Education. The individual must possess at least a baccalaureate degree.

(c) Internship. (1) The individual must complete to the State’s satisfaction an internship of one year. The internship shall not be take place in a Special Focus Facility.

(d) Examinations: The individual must pass with a score of at least 80 percent the National Association of Long-Term Care Administrators Board (NAB) and a state examination.

(e) Continuing education. The individual must complete at least 40 clock hours of continuing education for any calendar year in which the individual serves as an administrator.

The Institute of Medicine in “Improving the Quality of Long-Term Care,” stated that there is no more “central” position in a nursing home than that of the nursing home administrator (Institute of Medicine, 2001). However, despite their importance, the Requirements of Participation do not require minimum qualifications for nursing home administrators, although they do so for nursing assistants, activities and dietary personnel and other staff. Currently, state requirements vary for administrators, with some states only requiring administrators to have a high school diploma and be eighteen years old. There should be a standard set of requirements so that all administrators in the country are adequately prepared to run a facility. CMS itself acknowledged this need when it published proposed rules for the qualifications of nursing home administrators in 1992. Given the increasing complexity of administering a health care facility, the qualifications must be sufficient to prepare a person to effectively manage a nursing home in a way that ensures the best possible quality of care and quality of life for its residents.
<table>
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<tr>
<th>(i) Is a full-time employee in a State-approved training and competency evaluation program;</th>
<th>Add the following language to (e)(4)(i): The employee must only perform tasks for which he or she has demonstrated competency during this four month period.</th>
<th>Current regulations allow employees to perform tasks if they are enrolled in a training and competency program even if they have not yet shown their ability to carry out a particular activity. To protect resident safety and health, employees should only be permitted to carry out tasks for which they have demonstrated competency. This can be done on a task by task basis.</th>
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<td>(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or</td>
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<td>(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).</td>
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<td>(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—</td>
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<td>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or</td>
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<td>(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</td>
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<td>(6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act if the facility believes will include information on the individual.</td>
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<td>(7) Required retraining. If, since an individual’s most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</td>
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<td>(8) 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. The in-service training must—</td>
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<td>(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;</td>
<td>Add the following language to (e)(8)(i): “one hour of which must be dedicated to educating nurse aides on fear of retaliation among residents and families and how to foster an atmosphere of respect and trust.”</td>
<td>Nursing home residents’ fear of retaliation is well documented in the work of the Long-Term Care Ombudsman Program and borne out in research conducted by the University of Connecticut. As individuals become more frail and dependent on their caregivers and the longer they reside in a long-term care facility, the more prevalent are their concerns and fears about retaliation when voicing grievances. There are times when staff do not recognize that their actions and behavior are perceived as retaliation by the resident. At the heart of residents’ rights is the resident’s ability to feel comfortable exercising his or her rights. Staff need better awareness and understanding of the resident perspective. Staff training on this subject would foster more open communication in the nursing home setting (Nancy Schaffer, Connecticut State Long-Term Care Ombudsman, Statement to CT Aging Committee in support of legislation requiring training on fear of retaliation in nursing homes, March 8, 2012).</td>
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<tr>
<td>(ii) Address areas of weakness as determined in nurse aides’ performance reviews and may address the special needs of residents as determined by the facility staff; and</td>
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<tr>
<td>(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</td>
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</table>
(f) 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.

(g) Staff qualifications.

1. The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

(h) Use of outside resources.

1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.

2. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for—

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

(i) Medical director.

1. The facility must designate a physician to serve as medical director. Change the language of (i) (1) to: "The facility must designate a physician to serve as medical director who is certified through the American Medical Director Association's Certified Medical Director in Long Term Care Program."

2. The medical director is responsible for—

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

(j) Laboratory services.

1. The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.
(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.

(2) The facility must—

(i) Provide or obtain laboratory services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(A) Radiology and other diagnostic services.

(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility must—

(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

(l) Clinical records.

(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(2) Clinical records must be retained for—

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law; or

(iii) For a minor, three years after a resident reaches legal age under State law.

(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by—

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

(5) The clinical record must contain—

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;
(iv) The plan of care and services provided; and

(v) Progress notes.

**(iv) Disaster and emergency preparedness.**

1. The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

2. The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

Change the following language in (m) (2): "periodically" to "at least twice a year."

The 2012 OIG investigation referenced above found that 28% of nursing facilities were found deficient for inadequately training staff to respond to disasters. Given the critical importance of this training, facilities should be specifically required to hold a certain number of trainings each year. The term "periodically" is too vague.

**(ii) Transfer agreement.**

1. In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that—

   (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and

   (ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

2. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

**(c) Quality assessment and assurance.**

1. A facility must maintain a quality assessment and assurance committee consisting of—

   (i) The director of nursing services;

   (ii) A physician designated by the facility; and

   (iii) At least 3 other members of the facility’s staff.

   Add the following subsection after (o) (1) (iii): "(iv) At least one resident and family member."

   Residents and family members should be included in the quality assessment and assurance committee because their observations and experience can help in identifying issues and improving care.

2. The quality assessment and assurance committee—

   Add the following language to (m) (1): The plan must include at least the following core elements: - Plan for evacuation, including travel; provision of supplies; transport of records, medications and belongings; agreement for host facility; and reentry to facility after evacuation. - Plan for sheltering in place, including a backup source of electricity and sufficient supplies of food, water, and medications. - Plan for addressing specific needs of residents, including needs of residents in hospice care, and of those with Alzheimer’s disease, bowel/bladder problems, and limited mobility. - Plan for adequate staffing levels, including clear expectations for relocation, if necessary, and for assistance with residents in an emergency; as well as including provisions for staff’s family members. - Plan for collaboration with emergency managers and other community entities to better assure success of emergency plans.

The devastating consequences and lives lost in Hurricanes Katrina and Rita showed the country how necessary it is for nursing homes to have well-prepared emergency plans. However, a report published by the Department of Health and Human Services Office of Inspector General in 2006 found that nursing home emergency plans were often missing a number of suggested plan provisions; these 25 provisions, while not required by CMS, have been identified by experts as strengthening emergency preparedness. The OIG report recommended that CMS strengthen federal certification standards by including requirements for specific elements of emergency planning. In 2012 the OIG released another report on nursing home emergency preparedness and found many of the same gaps in nursing home preparedness and response that it found in its 2006 report. Emergency plans lacked relevant information-including only about half of the 25 provisions recommended by experts. The Requirements of Participation should be revised to require nursing home emergency plans to include all of these provisions (Nursing Home Emergency Preparedness and Response During Recent Hurricanes. August 2006. Department of Health and Human Services Office of Inspector General) (Gaps Continue To Exist In Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010. April 2012. Department of Health and Human Services Office of Inspector General).
(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

(iii) A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(iv) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

### Disclosure of ownership

1. The facility must comply with the disclosure requirements of §§420.206 and 455.104 of this chapter.

2. The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in—
   - Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter;
   - The officers, directors, agents, or managing employees;
   - The corporation, association, or other company responsible for the management of the facility; or
   - The facility's administrator or director of nursing.

3. The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.

4. All written notices shall be submitted to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:
   - At least 60 days prior to the date of closure; or
   - In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate.

5. Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

### Required training of feeding assistants

A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160 of this part.

### Facility closure - Administrator

Any individual who is the administrator of the facility must:

1. Submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:
   - At least 60 days prior to the date of closure; or
   - In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate.

2. Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

3. Given the risk of transfer trauma, residents need as much notice as possible in order to prepare for and adjust to any move.
Include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

Add the following language to (r) (ii) (3): The written notice shall include the information on transfer and discharge rights required by §483.12(a)(6).

Add the following subsections under (r) (ii) (3): (A) The plan shall include but not be limited to:

- Assessment of residents’ care needs and the provision of appropriate services.
- A plan for communicating with staff and/or unions.
- Continuation of appropriate staffing levels and paychecks at the facility.
- Provision of necessary supplies.
- Identification of available facilities to which residents could be transferred, along with an assessment of the quality of care provided by these facilities (for example, Minimum Data Set (MDS) data, OSCAR data and Nursing Home Compare) and information about contacting the long-term care ombudsman.
- Information about ADRCs and other organizations or agencies that can provide information about and referral to home and community-based services.
- A plan to ensure that other nursing homes, including those owned by the same company as the facility that is closing, do not have access to residents or resident records in order to “cherry pick” private pay residents or those with lighter care needs.
- Assurances that residents will be able to choose the nursing home or alternative setting they want and will have the right to appeal a transfer.
- A process for relocation of residents.
- Operation and management of the facility and oversight of those managing the facility.
- The roles and responsibilities of the facility’s Administrator or replacement.
- Sources of supplemental funding to assist in keeping a facility open until the residents are transferred.
- A plan for communicating with the Secretary, the State LTC ombudsman, residents and legal representatives of the residents and other responsible parties.

(B) Facilities should provide, orally and in writing, information to residents on how to obtain the assistance of the ombudsman and other resident representatives in understanding their rights and options in choosing an appropriate nursing home or home and community-based services option.

(C) Facilities are responsible for protecting residents and resident records when a relocation is being determined.

Nursing home closures have implications related to access to care, the quality of care, availability of services, and the overall health of residents. A move uproots a resident from a familiar environment, including a roommate and other residents, as well as assigned care providers. When a nursing home closes and residents have to move, the effect on residents can be devastating. The response to the stress caused by a transfer or relocation may include depression, manifesting as agitation, confusion, feelings of hopelessness and helplessness, sadness, increase in withdrawn behavior, self-care deficits, falls, and weight loss. In residents with cognitive impairment due to dementia or Alzheimer’s, the symptoms are more exaggerated and may include hallucinations and delusions. An organized process with specific procedures is needed to protect residents’ health and safety, and make the transition as smooth as possible for residents, as well as family members and facility staff. The facility must be required to develop a very detailed, thorough plan that gives enough time for residents, families and staff to make adjustments and new living arrangements.

(s) Facility closure. The facility must have in place policies and procedures to ensure that the administrator’s duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.