DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489

[CMS–3260–F]

RIN 0938–AR61

Medicare and Medicaid Programs;

Reform of Requirements for Long-Term Care Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule will revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These revisions are also an integral part of our efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

DATES: Effective date: These regulations are effective on November 28, 2016. Implementation date: The regulations included in Phase 1 must be implemented by November 28, 2016. The regulations included in Phase 2 must be implemented by November 28, 2017. The regulations included in Phase 3 must be implemented by November 28, 2019.

FOR FURTHER INFORMATION CONTACT: LTC Regulations Team, (410) 786–6633; Sheila Blackstock, Ronisha Blackstone, Diane Corning, Lisa Parker.

SUPPLEMENTARY INFORMATION:

Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

AAA Area Agencies on Aging
ACL Administration for Community Living
ADL Activities of Daily Living
AHCA American Health Care Association
AHLA American Health Lawyers Association
ANSI American National Standards Institute
ASPE Assistant Secretary for Planning and Evaluation
BPSD Behavioral and Psychological Symptoms of Dementia
CASPER Certification and Survey Provider Enhanced Reports
CIL Centers for Independent Living
CLIA Clinical Laboratory Improvement Amendment
CMS Centers for Medicare & Medicaid Services
CNS Clinical Nurse Specialist
CPR Cardiopulmonary Resuscitation
DoN Director of Nursing
EHR Electronic Health Records
FDA Food and Drug Administration
GAO Government Accountability Office
HACCP Hazard Analysis and Critical Control Point
HAI Healthcare-Associated Infection
HHS U.S. Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996
ICH International Council of Nurses
IDT Interdisciplinary Team
IG Interpretive Guidance
IP Infection Preventionist
IPCP Infection Prevention and Control Program
LSC Life Safety Code
LTC Long-Term Care
NATCEP Nurse Aide Training Competency Evaluation Program
MAR Medication Administration Record
MDS Minimum Data Set
NA Nurse Aide
NF Nursing Facility
NP Nurse Practitioner
OIG Office of the Inspector General
OMB Office of Management and Budget
ONC Office of the National Coordinator
PA Physician Assistant
PASARR Preadmission Screening and Resident Review
PIPs Performance Improvement Projects
PEU Protein-Energy under Nutrition
QA Quality Assurance
QAQuality Assessment and Assurance
QAPI Quality Assurance and Performance Improvement
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RN Registered Nurse
SNF Skilled Nursing Facility
WHO World Health Organization

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I. Background

A. Executive Summary

1. Purpose

Consolidated Medicare and Medicaid requirements for participation (requirements) for long term care (LTC) facilities (42 CFR part 483, subpart B) were first published in the Federal Register on February 2, 1989 (54 FR 5316). These regulations have been revised and added to since that time, principally as a result of legislation or a need to address a specific issue. However, they have not been comprehensively reviewed and updated since 1991 (56 FR 48826, September 26, 1991), despite substantial changes in service delivery in this setting.

Since the current requirements were developed, significant innovations in resident care and quality assessment practices have emerged. In addition, the population of LTC facilities has changed, and has become more diverse and more clinically complex. Over the last two to three decades, extensive, evidence-based research has been conducted and has enhanced our knowledge about resident safety, health outcomes, individual choice, and quality assurance and performance improvement. In light of these changes, we recognized the need to evaluate the regulations on a comprehensive basis, from both a structural and a content perspective. Therefore, we reviewed regulations in an effort to improve the quality of life, care, and services in LTC.
proposed QAPI requirements. Many commenters also indicated concern regarding the financial burden associated with this regulation and suggested that a delayed implementation would allow facilities the time needed to establish compliance with the new requirements.

Commenters provided varying suggestions for a implementation timeframe. Some commenters provided suggestions specific to certain requirements. For example, one commenter recommended a 12- to 18-month implementation timeframe for pharmacy services-related requirements. Other commenters recommended that the entire regulation be implemented by phasing in requirements over a certain time period. In addition, commenters provided varying suggestions for an implementation date of the entire regulation that ranged from 1 to 10 years in the future.

Response: We appreciate the feedback from commenters. Given the comprehensive nature of the regulatory revisions, we agree that a longer period of time is necessary to implement the changes outlined in this final rule. We acknowledge that LTC facilities may find the comprehensive revision to the LTC requirements overwhelming and want to avoid any unintended consequences or unanticipated risks to both facilities and residents. We believe that allowing for a longer implementation period will allow LTC facilities the time necessary to come into compliance with the new requirements. In addition, we anticipate that additional time will be needed to develop revised interpretive guidance and survey processes, conduct surveyor training on the changes, and implement the software changes in the Quality Indicator Survey (QIS) system.

While commenters provided varying suggestions for the appropriate implementation timeframe (ranging between 1 and 10 years), overall all commenters agreed that implementation will require more than a year and the majority of commenters suggested between 3 and 5 years. After considering these proposals, we are finalizing a phased-in implementation of the requirements over a 3 year time period. We believe that a phased-in approach over 3 years will sufficiently allow for LTC facilities to achieve compliance with the revised regulations without jeopardizing resident care. We note that these final regulations will be effective 60 days following the display of this final rule in the Federal Register, as discussed under the “Effective Date” section. Over the 3 year time period following the effective date of the final rule the requirements will be implemented in three phases. We have categorized the three phases based on the complexity of the revisions and the work necessary to revise the interpretive guidance and survey process based on the revisions. The first phase of implementation will occur upon the effective date of the final rule and include those requirements that were unchanged or received minor modification. We will provide updated training to surveyors on the new regulatory language.

The second phase of implementation will have a deadline of 1 year following the effective date of the final rule and in addition to those requirements implemented in phase one, this phase will also include those brand new requirements and those provisions that required more complex revisions. The additional time for implementation will allow for complete changes in our survey processes as well as updates to the survey guidance. We will provide updated guidance to facilities, update the traditional and QIS survey process, update the survey tags in accordance with the reorganization of the regulations, and provide training to surveyors on the new tags. The third and final phase of implementation will have a deadline of 3 years from the effective date of the final rule and include all the remaining requirements that were not implemented in phases 1 and 2. We expect that this final phase will allow for the complete set of revised requirements to be incorporated into the practices of LTC facilities and sufficiently enforced through the updated survey process.

Below we provide a detailed chart specifying the specific requirements that will be implemented in phases 1, 2, and 3 of the implementation time period for this final rule. We note that some regulatory sections may have certain requirements that are implemented in varying phases. In those instances we highlight the specific requirements in a regulatory section that will be implemented in a different phase.

### Implementation Timeframes

**Note:** These final regulations will be effective 60 days following the date of public inspection of this final rule in the Federal Register.

**Phase 1:** Upon the effective date of the final rule.

**Phase 2:** 1 year following the effective date of the final rule.

**Phase 3:** 3 years following the effective date of the final rule.

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This entire section will be implemented in Phase 1 with the following exceptions:

- (m) Trauma-informed care—implemented in Phase 3.

This section will be implemented in Phase 1 with the following exceptions:

- Specific usage of the Facility Assessment at § 483.70(e) in the determination of sufficient number and competencies for staff—implemented in Phase 2.

This section will be implemented in Phase 2 with the following exceptions:

- (a)(1) As related to residents with a history of trauma and/or post-traumatic stress disorder—implemented in Phase 3.
- (b)(1), (b)(2), and (d) Comprehensive assessment and medically related social services—implemented in Phase 1.

This section will be implemented in Phase 1 with the following exceptions:

- (c)(2) Medical chart review—implemented in Phase 2.
- (e) Psychotropic drugs—implemented in Phase 2.

This section will be implemented in Phase 1 with the following exceptions:

- (a)(3) and (a)(5) Loss or damage of dentures and policy for referrals—implemented in Phase 2.
- (b)(3) and (b)(4) Referral for dental services regarding loss or damaged dentures—implemented in Phase 2.

This section will be implemented in Phase 1 with the following exceptions:

- (a) As linked to Facility Assessment at § 483.70(e)—implemented in Phase 2.
- (a)(1)(iv) Dietitians hired or contracted with prior to effective date—Built in implementation date of 5 years following the effective date of the final rule.
- (a)(2)(i) Director of food & nutrition services designated to serve prior to effective—Built in implementation date of 5 years following the effective date of the final rule.
- (a)(2)(ii) Dietitians designated to after the effective date—Built in implementation date of 1 year following the effective date of the final rule.

This entire section will be implemented in Phase 1.

This section will be implemented in Phase 1 with the following exceptions:

- (d)(3) Governing body responsibility of QAPI program—implemented in Phase 3.
- (e) Facility assessment—implemented in Phase 2.

This section will be implemented in Phase 3 with the following exceptions:

- (a)(2) Initial QAPI Plan must be provided to State Agency Surveyor at annual survey—implemented in Phase 2.
- (g)(1) QAA committee All requirements of this section will be implemented in Phase 1 with the exception of subparagraph (iv), the addition of the ICPO, which will be implemented in Phase 3.
- (h) Disclosures of Information—implemented in Phase 1.
- (i) Sanctions Implemented in Phase 1.

This section will be implemented in Phase 1 with the following exceptions:

- (a) As linked to Facility Assessment at § 483.70(e) implemented in Phase 2.
- (b) Infection preventionist (IP)—implemented in Phase 3.
- (c) IP participation on QAA committee—implemented in Phase 3.

This section will be implemented in Phase 3.

This section will be implemented in Phase 1 with the following exceptions:

- (f)(1) Call system from each resident's bedside—implemented in Phase 3.
- (h)(3) Policies regarding smoking—implemented in Phase 2.
C. Basis and Scope (§ 483.1)  
We proposed to revise § 483.1 “Basis and Scope” to include references to sections 1819(f), 1919(f), 1128(b) and (c), and 1150B of the Act. Sections 1819(f) and 1919(f) of the Act require that the current mandatory on-going training for NAs include dementia management and resident abuse prevention training. New section 1128(b) of the Act requires the operating organizations for SNFs and NFs to have a compliance and ethics program and new section 1128(c) of the Act requires the Secretary to establish and implement a QAPI program for facilities. New section 1150B of the Act establishes requirements for reporting to law enforcement suspicion of crimes occurring in federally funded LTC facilities. In addition, we proposed to spell out the term “skilled nursing facility”.  

We did not receive any comments in response to our proposals in this section. Therefore, we are finalizing our proposal without modification.  

D. Definitions (§ 483.5)  
Current regulations at § 483.5 provide definitions for terms commonly used in the LTC requirements. We proposed to revise some of the existing terms for clarity and define new terms that we believe are widely used within the LTC setting, and that we believe will add value to the LTC requirements while promoting resident choice and safety.  

We retained the existing definitions for “facility” and “distinct part”. In addition, we retained the definition of “major modification”, which was added to the LTC regulations in the May 12, 2014 final rule, “Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II” (79 FR 27106). We also proposed minor revisions to the definition of “common area” to recognize that some facilities have living rooms or other areas where residents gather. We proposed to expand this section to include the following definitions: “abuse,” “adverse event,” “exploitation,” “misappropriation of resident property,” “neglect,” “person-centered care,” “resident representative,” and “sexual abuse”. In addition, we proposed to relocate the definitions for “licensed health professional” and “nurse aide” to this section from the “Administration” section at § 483.75(e)(1). In addition, we proposed to revise the definition of “nurse aide” in accordance with amendments to sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Act made by sections 6121(a)(2) and (b)(2) of the Affordable Care Act. “Nurse aide” is currently defined as any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. “Nurse aide” do not include those individuals who furnish services to residents only as paid feeding assistants, as defined in § 488.301. Section 6121 of the Affordable Care Act added the following clarification to the definition of “nurse aide”: “Such term includes an individual who provides such services through an agency or under a contract with the facility.” We proposed to amend the regulatory definition accordingly. We proposed to add the term “adverse event” to ensure clarity in our requirements relating to proposed requirements for QAPI. For purposes of this regulation, we also proposed to define the term “resident representative” broadly to include both an individual of the resident’s choice who has access to information and participates in healthcare discussions as well as personal representative with legal standing, such as a power of attorney for healthcare, legal guardian, or health care surrogate or proxy appointed in accordance with state law to act in whole or in part on the resident’s behalf. We also noted that the same-sex spouse of a resident would be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. In addition, we proposed to add a definition of “person-centered care” to be defined as focusing on the resident as the locus of control and supporting the resident in making their own choices and having control over their daily lives. For purposes of these regulations, we proposed that “abuse” would include actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. As used in this definition of “abuse”, “willful” means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. We proposed that “abuse” would also include the deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The term “sexual abuse” would extend the meaning of “abuse” to include non-consensual sexual contact of any type with a resident. We proposed to define the term “neglect” as “the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness.” We proposed to define “exploitation” as “the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats, or coercion.” We also proposed to add the term “misappropriation of resident property” and define the term as “the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.”  

Finally, we proposed to move the existing definition of “transfer and discharge” from § 483.12(a)(1) to § 483.5.  

Comment: Several commenters supported the addition of terms to the definitions section and indicated that the link between terms that are defined in regulation and guidance will support an increased response to elder abuse. Multiple commenters provided suggestions for additional terms to be included in the definitions sections. One commenter indicated that there is a need to define “behavioral health” given the addition of the regulatory section focused on behavioral health. Other commenters also suggested that
§ 483.5 Definitions.

As used in this subpart, the following definitions apply:

Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

Common area. Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas, and meeting rooms where residents are located on a regular basis.

Composite distinct part. The use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited.

Exploitation. Taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

Licensed health professional. A licensed health professional is 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; or registered respiratory therapist or certified respiratory therapy technician.

Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.

Mistreatment means inappropriate treatment or exploitation of a resident.

Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Nurse aide. Individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but 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.

Person-centered care. This subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Resident representative. For purposes of this subpart, the term resident representative means any of the following:

(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications.

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications.

(3) Legal representative, as used in section 712 of the Older Americans Act; or

(4) The court-appointed guardian or conservator of a resident.

(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Sexual abuse is non-consensual sexual contact of any type with a resident.

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.

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

(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. The facility must protect and promote the rights of the resident.

(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

(b) Exercise of rights. 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.

(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

(3) In the case of a resident who has not been adjudged incompetent by the State court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident’s rights to the extent provided by State law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(i) The right to exercise the resident’s rights to the extent those rights are delegated to the resident representative.

(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.

(7) 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 devolve to and are exercised by the resident representative appointed under State law to act on the resident’s behalf. The court-appointed resident representative exercises the resident’s rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative’s authority.

(ii) The resident’s wishes and preferences must be considered in the exercise of rights by the representative.

(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:

(1) 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.

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

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

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

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

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

(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident’s strengths and needs.

(iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.

(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

(7) The right to self-administer medications if the interdisciplinary team, as defined by § 483.21(b)(2)(ii), has determined that this practice is clinically appropriate.

(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(d) Choice of attending physician. The resident has the right to choose his or her attending physician.

(1) The physician must be licensed to practice, and

(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet
requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:

(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms, consistent with §483.12(u)(2).

(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

(4) 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.

(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.

(6) The right to receive written notice, including the reason for the change, before the resident’s room or roommate in the facility is changed.

(7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:

(i) To relocate 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) To relocate 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.

(iii) Solely for the convenience of staff.

(8) A resident’s exercise of the right to refuse transfer does not affect the resident’s eligibility or entitlement to Medicare or Medicaid benefits.

(i) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination with respect to resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section:

(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

(2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

(i) The facility must provide immediate access to any resident by—

(A) Any representative of the Secretary,

(B) Any representative of the State,

(C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.)),

(D) The resident’s individual physician,

(E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.),

(F) Any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.)), and

(G) The resident’s representative.

(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident’s right to deny or withdraw consent at any time;

(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident’s right to deny or withdraw consent at any time;

(iv) The facility must provide reasonable access to a resident by any entity 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; and

policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.

(vi) A facility must meet the following requirements:

(A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.

(B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.

(5) The resident has a right to organize and participate in resident groups in the facility.

(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.

(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group’s invitation.

(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.

(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and
recommendations of such groups concerning issues of resident care and life in the facility.

(A) The facility must be able to demonstrate their response and rationale for such response.

(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

(6) The resident has a right to participate in family groups.

(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.

The resident may perform services for the facility, if he or she chooses, when—

(A) In general: 

(i) The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. 

(ii) the facility must notify each resident that receives Medicaid benefits—

(A) The facility must maintain personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain a resident’s personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Mandatory: The facility must maintain an account for each resident in the facility. The resident may deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, the facility must follow the provisions set forth in this section. (f)(10)(ii)(B) of this section, the facility must deposit any residents’ personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain a resident’s personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. 

(vii) A The facility must notify each resident that receives Medicaid benefits—

(A) The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. 

(b) (i) The facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when—

(A) In general: 

(i) The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. 

(ii) the facility must notify each resident that receives Medicaid benefits—

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. 

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(c) The facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when—

(A) In general: 

(i) The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf. 

(ii) the facility must notify each resident that receives Medicaid benefits—

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Medicaid: The facility must deposit the residents’ personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. 

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.

(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under § 483.24(c).

(J) Non-covered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Except as provided in (e)(1)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by § 483.60.

(1) The facility may not charge for special foods and meals, including medicinally prescribed dietary supplements, ordered by the resident’s physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included in accordance with § 483.60.

(2) In accordance with § 483.60(c) through (l), when preparing foods and meals, a facility must take into consideration residents’ needs and preferences and the overall cultural and religious make-up of the facility’s population.

(iii) Requests for items and services.

(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.

(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.

(C) The facility must inform, orally and in writing, the resident 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.

(g) Information and communication.

(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(2) The resident has the right to access personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic format or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and

1. resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:

1. requested by the individual, whether in paper or electronic form;

1. copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

1. requested the copy be mailed.

1. described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.

1. receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) this section.

1. each resident a written description of legal rights which includes—

1. protecting personal funds, under paragraph (f)(10) of this section;

1. and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

1. and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

1. file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

1. information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.); and Medicaid eligibility and coverage; and Disability Resource Center.

1. 202(a)(20)(B)(iii) of the Older Americans Act; or other No Wrong Door Program.

1. information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

1. and manner accessible and understandable to residents, and resident representatives:

1. and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy
network, home and community based service programs, and the Medicaid Fraud Control Unit; and
(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, noncompliance with the advance directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident’s own expense.

(7) The facility must protect and facilitate that resident’s right to communicate with individuals and entities within and external to the facility, including reasonable access to:
(i) A telephone, including TTY and TDD services;
(ii) The internet, to the extent available to the facility; and
(iii) Stationery, postage, writing implements and the ability to send mail.

(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident’s own expense.

(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research.

(i) If the access is available to the facility
(ii) At the resident’s expense, if any
(iii) Such use must comply with state and federal law.

(j) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(i) Surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
(ii) Such reports in areas of the facility that are prominent and accessible to the public.

(k) Available identifying information about complainants or residents.

(l) The requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(m) 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 resident’s option, formulate an advance directive.

(n) Description of the facility’s policies to implement advance directives and applicable State law.

(o) Contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(p) Incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual’s resident representative in accordance with State law.

(q) Obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(r) 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.

(s) A facility must immediately inform the resident; consult with the resident’s physician; and notify, consistent with his or her authority, the resident representative(s), when there is—

(i) Which results in injury and has the potential for requiring physician intervention;

(ii) The resident’s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(t) Significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(u) The resident from the facility as specified in §483.15(c)(1)(ii).

(v) Paragraph (g)(1)(4)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(w) Notify the resident and the resident representative, if any, when there is—

(1) Assignment as specified in §483.10(e)(6); or

(x) Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(y) Periodically update the address (mailing and email) and phone number of the resident representative(s).

(z) Distinct part.

(aa) Composite distinct part (as defined in §483.5) 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 §483.15(c)(9).

(bb) Of rights and services to the resident prior to or upon admission and during the resident’s stay.

(cc) 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.

(dd) Resident with the State-developed notice of Medicaid rights and obligations, if any.

(ee) Any amendments to it, must be acknowledged in writing.

(ff) Resident, in writing, at the time of
admission to the nursing facility and 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;

(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 Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

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/Medicaid or by the facility’s per diem rate.

made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility’s per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

resident or resident representative any and all refunds due the resident within 30 days from the resident’s date of discharge from the facility.

by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

(h) resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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.

residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

(i) and confidential personal and medical records.

the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.

representatives of the Office of the State Long-Term Care Ombudsman to examine a resident’s medical, social, and administrative records in accordance with State law.

(i) The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide—

homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. . . . . .

reasonable care for the protection of the resident’s property from loss or theft. . . . .

services necessary to maintain a sanitary, orderly, and comfortable interior; . . . . .

in good condition; . . . . .

resident room, as specified in §483.90(d)(2)(iv); . . . . .

levels in all areas; . . . . .

levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 °

comfortable sound levels.

(j) Grievances. (1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay.

the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

information on how to file a grievance or complaint available to the resident.

grievance policy to ensure the prompt resolution of all grievances regarding the residents’ rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

action to prevent further potential violations of any resident right while the alleged violation is being investigated;

immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services


on behalf of the provider, to the
administrator of the provider; and as
required by State law:
(y) Ensuring that all written grievance
decisions include the date the grievance
was received, a summary statement of
the resident’s grievance, the steps taken
to investigate the grievance, a summary
of the pertinent findings or conclusions
regarding the resident’s concern(s), a
statement as to whether the grievance
was confirmed or not confirmed, any
corrective action taken or to be taken by
the facility as a result of the grievance,
and the date the written decision was
issued;
(vi) Taking appropriate corrective action in accordance with State law if
the alleged violation of the residents’
rights is confirmed by the facility or if
an outside entity having jurisdiction,
such as the State Survey Agency,
Quality Improvement Organization, or
local law enforcement agency confirms
a violation of any of these residents’
rights within its area of responsibility;
and
(vii) Maintaining evidence
demonstrating the results of all
grievances for a period of no less than
3 years from the issuance of the
grievance decision.
(k) Contact with external entities. A
facility must not prohibit or in any way
discourage a resident from
communicating with federal, state, or
local officials, including, but not limited
to, federal and state surveyors, other
federal or state health department
employees, including representatives of
the Office of the State Long-Term Care
Ombudsman, and any representative of
the agency responsible for the
protection and advocacy system for
individuals with mental disorder
(established under the Protection
and Advocacy for Mentally Ill Individuals
Act of 2000 (42 U.S.C. 10801 et al.),
regarding any matter, whether or not
subject to arbitration or any other type
of judicial or regulatory action.
- 14. Section 483.12 is revised to read
as follows:
§ 483.12 Freedom from abuse, neglect,
and exploitation.
The resident has the right to be free
from abuse, neglect, misappropriation
of resident property, and exploitation as
defined in this subpart. This includes
but is not limited to freedom from
corporal punishment, involuntary
seclusion and any physical or chemical
restraint not required to treat the
resident’s medical symptoms.
(a) The facility must—
(1) Not use verbal, mental, sexual, or
physical abuse, corporal punishment, or
involuntary seclusion;
(2) Ensure that the resident is free
from physical or chemical restraint
imposed for purposes of discipline or
convenience and that are not required to
treat the resident’s medical symptoms.
When the use of restraints is indicated,
the facility must use the least restrictive
alternative for the least amount of time
and document ongoing re-evaluation of
the need for restraints.
(3) Not employ or otherwise engage individuals who—
(i) Have been found guilty of abuse,
eglect, exploitation, misappropriation
of property, or mistreatment by a court
of law;
(ii) Have had a finding entered into
the State nurse aide registry concerning
abuse, neglect, exploitation,
mistreatment of residents or
misappropriation of their property;
or
(iii) Have a disciplinary action in
effect against his or her professional
license by a state licensure body as a
result of a finding of abuse, neglect,
exploitation, mistreatment of residents
or misappropriation of resident
property.
(4) Report to the State nurse aide
registry or licensing authorities 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.
(b) The facility must develop and
implement written policies and
procedures that:
(1) Prohibit and prevent abuse,
eglect, and exploitation of residents
and misappropriation of resident
property.
(2) Establish policies and procedures
to investigate any such allegations, and
(3) Include training as required at
paragraph § 483.95.
(4) Establish coordination with the
QAPI program required under § 483.75.
(5) Ensure reporting of crimes
occurring in federally-funded long-term
care facilities in accordance with
section 1150B of the Act. The policies
and procedures must include but are not
limited to the following elements:
(i) Annually notifying covered
individuals, as defined at section
1150B(a)(3) of the Act, of that
individual’s obligation to comply with
the following reporting requirements,
(A) Each covered individual shall
report to the State Agency and one or
more law enforcement entities for the
political subdivision in which the
facility is located any reasonable
suspicion of a crime against any
individual who is a resident of, or is
receiving care from, the facility.
(B) Each covered individual shall
report immediately, but not later than 2
hours after forming the suspicion, if the
events that cause the suspicion result in
serious bodily injury, or not later than 24
hours if the events that cause the
suspicion do not result in serious bodily
injury.
(ii) Posting a conspicuous notice of
employee rights, as defined at section
1150B(d)(3) of the Act.
(iii) Prohibiting and preventing
retaliation, as defined at section
1150B(d)(1) and (2) of the Act.
(c) In response to allegations of abuse,
eglect, exploitation, or mistreatment,
the facility must:
(1) Ensure that all alleged violations
involving abuse, neglect, exploitation
or mistreatment, including injuries of
unknown source and misappropriation
of resident property, are reported
immediately, but not later than 2 hours
after the allegation is made, if the events
that cause the allegation involve abuse
or result in serious bodily injury, or not
later than 24 hours if the events that
cause the allegation do not involve
abuse and do not result in serious
bodily injury, to the administrator of the
facility and to other officials (including
to the State Survey Agency and adult
protective services where state law
provides for jurisdiction in long-term
care facilities) in accordance with State
law through established procedures.
(2) Have evidence that all alleged
violations are thoroughly investigated.
(3) Prevent further potential abuse,
eglect, exploitation, or mistreatment
while the investigation is in progress.
(4) Report the results of all
investigations to the administrator or his
or her designated representative and to
other officials in accordance with State
law, including to the State Survey
Agency, within 5 working days of the
incident, and if the alleged violation is
verified appropriate corrective action
must be taken.
§ 483.13 [Removed]
16. Section 483.15 is revised to read
as follows:
§ 483.15 Admission, transfer, and
discharge rights.
(a) Admissions policy. (1) The facility
must establish and implement an
admissions policy.
(2) The facility must—
(i) Not request or require residents or
potential residents to waive their rights
as set forth in this subpart and in
applicable state, federal or local
licensing or certification laws, including
but not limited to their rights to
Medicare or Medicaid; and
(ii) Not request or require oral or
written assurance that residents or
potential residents are not eligible for,
or will not apply for, Medicare or Medicaid benefits.

(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

(3) The facility must not request or 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 request and require a resident representative 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.

(4) 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—

(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

(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.

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

(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

(7) A nursing facility that is a composite distinct part as defined in §483.5 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 paragraph (b)(10) of this section.

(1) A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, as defined in §483.5 and the provision of services for all individuals regardless of source of payment, consistent with §483.10(a)(2): (2) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement in §483.10(g)(3) and (g)(4)(i) describing the charges; and

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

(c) Transfer and discharge

Facility requirements—

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;

(B) 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;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) 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. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. 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

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(2) Documentation.

Transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident’s medical record must include—

(A) The basis for the transfer per paragraph (c)(1)(i)(A) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident’s physician when transfer or discharge is necessary under paragraph (c)(1)(i)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the residents discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident’s medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (b)(5) of this section.
(4) **Timing of the notice.** (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident’s health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(ii) Notice is required by the resident’s urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(iii) facility for 30 days.

(5) The written notice specified in paragraph (b)(3) of this section must include the following:

- discharge;
- discharge;

- resident is transferred or discharged;

- appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

- email) and telephone number of the Office of the State Long-Term Care Ombudsman;

- intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 ); and

- with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(6) *information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.*

(7) **discharge.** A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

(8) **closure.** the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

(9) **distinct part.** Room changes in a facility that is a composite distinct part (as defined in § 483.3) are subject to the requirements of § 483.10(e)(7) and 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.

(d) **return.** Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—

- policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

- the state plan, under § 447.40 of this chapter, if any;

- regarding bed-hold periods, which must be consistent with paragraph (c)(3) of this section, permitting a resident to return; and

- paragraph (c)(3) of this section.

(1) **Resident assessment instrument.** A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

* the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section.

(e)(1) **Permitting residents to return to facility.** A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following:

- nursing facility services or Medicaid nursing facility services.

- a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to

(2) **distinct part.** a resident returns is a composite distinct part (as defined in § 483.3), 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 return, the resident must be given the option to return to that location upon the first availability of a bed there.
well as communication with licensed and nonlicensed direct care staff members on all shifts.

* * * * *

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes—

1. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.

2. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

* * * * *

(k) individuals with a mental disorder and individuals with intellectual disability.

or after January 1, 1989, any new resident with—

paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

level of services, whether the individual requires specialized services; or

in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—

mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions.

program under paragraph (k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital—

the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual—

directly from a hospital after receiving acute inpatient care at the hospital, and

services for the condition for which the individual received care in the hospital, and

certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) section—

have a mental disorder if the individual has a serious mental disorder as defined in § 483.102(b)(1).

have an intellectual disability if the individual has an intellectual disability as defined in § 483.102(b)(3) or is a person with a related condition as

state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review.

§ 483.21 Comprehensive person-centered care planning.

(a) A facility must develop and implement a comprehensive baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident’s admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.

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

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

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

(iii) Meets the requirements set forth in paragraph (c) of this section.

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

(b) A facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at § 483.10(c)(2) and § 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

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

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

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

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

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

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

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).

is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident’s follow up care and any post-discharge medical and non-medical services.

19. Section 483.24 is added to read as follows:

§ 483.24 Quality of life.

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident’s comprehensive assessment and plan of care.

assessment of a resident and consistent with the resident’s needs and choices, the facility must provide the necessary care and services to ensure that a resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section,

out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and

support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident’s advance directives.
(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) of this section for the following activities of daily living:

(1) Hygiene—bathing, dressing, grooming, and oral care,
(2) Mobility—transfer and ambulation, including walking,
(3) Elimination—toileting,
(4) Dining—eating, including meals and snacks,
(5) Communication, including
   (i) Speech,
   (ii) Language,

provided by a qualified professional who—

applicable, by the State in which practicing; and

therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program;

therapist or occupational therapy assistant; or

approved by the State.

20. Section 483.25 is revised to read as follows:

§ 483.25 Quality of care.

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choices, including but not limited to the following:

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

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.

(b) Skin integrity—(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that—

with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and

receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must—

accordance with professional standards of practice, including to prevent complications from the resident’s medical condition(s) and

making appointments with a qualified person, and arranging for transportation to and from such appointments.

(1) The facility must ensure that a resident who enters the facility without 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

motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

(d) Accidents. that—

as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(e) Incontinence. (1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

incontinence, based on the resident’s comprehensive assessment, the facility must ensure that—

without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary;

with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is necessary, and

bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

incontinence, based on the resident’s comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

(f) residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.

(g) tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral feedings. Based on a resident’s comprehensive assessment, the facility must ensure that a resident—

of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

maintain proper hydration and health; and

there is a nutritional problem and the
health care provider orders a therapeutic diet. 

(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident’s clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and 

(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 

(b) Parenteral fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident’s goals and preferences. 

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents’ goals and preferences, and § 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences, to wear and be able to use the prosthetic device. 

(k) Pain management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences. 

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences. 

(m) Trauma-informed care. The facility must ensure that residents who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. 

(n) Bed rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. 

1. Assess the resident for risk of entrapment from bed rails prior to installation. 

2. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. 

3. Ensure that the bed’s dimensions are appropriate for the resident’s size and weight. 

4. Follow the manufacturers’ recommendations and specifications for installing and maintaining bed rails. 

21. In the table below, each section indicated in the first column is re-designated as the section indicated in the second column: 

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22. In newly redesignated § 483.30— 

a. Revise the introductory text. 

b. Revise paragraph (b)(3). 

c. Amend paragraph (e)(1) introductory text by removing the reference “paragraph (e)(2)” and adding in its place the reference “paragraph (e)(4)”. 

d. Designate paragraph (e)(2) as paragraph (e)(4). 

e. Add new paragraphs (e)(2) and (e)(3). 

The revisions and additions read as follows: 

§ 483.30 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. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident’s immediate care and needs. 

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

(2) A resident’s attending physician may delegate the task of writing dietary orders, consistent with § 483.60, to a qualified dietitian or other clinically qualified nutrition professional who— 

(i) Is acting within the scope of practice as defined by State law; and 

(ii) Is under the supervision of the physician. 

(3) A resident’s attending physician may delegate the task of writing therapy orders, consistent with § 483.65, to a qualified therapist who— 

(i) Is acting within the scope of practice as defined by State law; and 

(ii) Is under the supervision of the physician. 

* * * * * 

23. In newly redesignated § 483.35— 

a. Revise the introductory text. 

b. Amend paragraph (a)(1)(i) by removing the reference “paragraph (c)” and adding in its place the reference “paragraph (e)”. 

c. Revise paragraph (a)(1)(ii). 

d. Add paragraphs (a)(1)(ii) and (a)(2). 

e. Amend paragraphs (b)(1) and (b)(2) by removing the reference “paragraph (c) or (d)” and adding in its place the reference “paragraph (e) or (f)”. 

f. Designate paragraphs (e), (d) and (a) as paragraphs (e), (f) and (g), respectively. 

g. Add new paragraphs (c) and (d). 

h. Revise newly redesignated paragraphs (e)(6) and (7). 

i. Revise newly redesignated paragraphs (f)(1)(iv) and (v). 

The revisions and additions read as follows: 

§ 483.35 Nursing services. 

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population. In accordance with the facility assessment required at § 483.70(e). 

(a) * * * 

(1) * * * 

(2) Other nursing personnel, including but not limited to nurse aides. 

(3) The facility must ensure that licensed nurses have the specific
competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care;

(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs.

* * * * *

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

(d) Requirements for facility hiring and use of nursing aides—(1) 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) That individual has completed a training and competency evaluation program or, a competency evaluation program approved by the State meeting the requirements of §483.151 through §483.154; or

(2) Non-permanent employees. A facility must not use on a temporary, per diem, lease, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section;

(3) Minimum 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—

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).

(4) 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—

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(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.

(5) 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 that the facility believes will include information on the individual.

(6) 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.

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

* * * * *

(8) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders who are eligible for such services as provided by the protection and advocacy agency; and

(9) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.

* * * * *

I. The Secretary provides notice of the Secretary’s determination under paragraph (b)(2) to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders;

(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable physical, mental, and psychosocial well-being; and

(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder 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 development of such a pattern was unavoidable; and

(3) A resident who displays or is diagnosed with dementia, receives the
appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

(c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident’s comprehensive plan of care, the facility must—

(1) Provide the required services, including specialized rehabilitation services as required in § 483.65; or

(2) Obtain the required services from an outside resource (in accordance with § 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.

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

25. In newly redesignated § 483.45—

a. Amend the introductory text by removing the reference “§ 483.75(h) of this part” and add in its place the reference “§ 483.70(g)”.

b. Redesignate paragraph (c)(2) as paragraph (c)(4).

c. Add new paragraphs (c)(2) and (3).

d. Revise newly designated paragraph (c)(4).

e. Redesignate paragraphs (d) and (e) as paragraphs (g) and (h), respectively.

f. Add new paragraphs (d), (e), and (f).

The additions and revisions read as follows:

§ 483.45 Pharmacy services.

* * * * *

(2) This review must include a review of the resident’s medical chart.

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

(4) The pharmacist must report any irregularities to the attending physician and the facility’s medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

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

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

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

(d) Unnecessary drug—General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

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

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

(e) Psychotropic drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as documented and documented in the diagnosis and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in § 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.

(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

(f) The facility must ensure that its—

(1) Medication error rates are not 5 percent or greater; and

(2) Residents are free of any significant medication errors.

26. Add § 483.50 to read as follows:

§ 483.50 Laboratory, radiology, and other diagnostic services.

(a) Laboratory services. 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.

(ii) If the facility provides its own laboratory services, the services 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.

(b) Radiology services. The facility must provide or obtain radiology services only when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

(i) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or the ordering physician’s orders.

(ii) 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.

(b) 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 a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or the ordering physician’s orders.

(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.

§ 483.55 Dental services.

(a) * * *

(1) Those circumstances when the loss or damage of dentures is the facility’s responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility’s responsibility;

(4) Must if necessary or if requested, assist the resident—

(ii) By arranging for transportation to and from the dental services location; and

(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

(b) * * *

(ii) Must, if necessary or if requested, assist the resident—

(ii) By arranging for transportation to and from the dental services locations;

(3) Must promptly, within 3 days, refer residents with lost or damaged services, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e). This includes:

(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultative basis. A qualified dietitian or other clinically qualified nutrition professional is one who—

(i) Holds a bachelor’s or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who—

(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:

(A) A certified dietary manager; or

(B) A certified food service manager, or

(C) Has similar national certification for food service management and safety from a national certifying body; or

(D) Has an associate’s or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and

§ 483.60 Food and nutrition services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

(a) * * *

§ 483.60 Food and nutrition services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

(a) * * *

(b) * * *

(c) * * *

(d) * * *

(e) * * *

(f) * * *

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(h) * * *

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(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in §483.21(b)(2)(ii).

(c) Menus and nutritional adequacy. Menus must—

1. Meet the nutritional needs of residents in accordance with established national guidelines;
2. Be prepared in advance;
3. Be followed;
4. Reflect, based on a facility’s reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups;
5. Be updated periodically;
6. Be reviewed by the facility’s dietitian or other clinically qualified nutrition professional for nutritional adequacy; and
7. Nothing in this paragraph should be construed to limit the resident’s right to make personal dietary choices.

(d) Food and drink. Each resident receives and the facility provides—
1. Food prepared by methods that conserve nutritive value, flavor, and appearance;
2. Food and drink that is palatable, attractive, and at a safe and appetizing temperature;
3. Food prepared in a form designed to meet individual needs;
4. Food that accommodates resident allergies, intolerances, and preferences;
5. Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and
6. Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.

(e) Therapeutic diets. (1) Therapeutic diets must be prescribed by the attending physician. (2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by State law.

(f) Frequency of meals. (1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.

2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served 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.

3. Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

(g) Assistive devices. Provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.

(h) Use a paid feeding assistant, as defined in §488.301 of this chapter, if—

1. Successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and
2. Consistent with State law.

(2) Supervision. The feeding assistant must call a supervisory nurse or a RN or LPN licensed practical nurse.

(i) An assistant must call a supervisory nurse for help.

(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.

1. Include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

2. Selection on the interdisciplinary team’s assessment and the resident’s latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.

3. Facility must—

1. Approve or considered satisfactory by federal, state, or local authorities;
2. Obtain directly from local producers, subject to applicable State and local laws or regulations.

or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

serve food in accordance with professional standards for food service safety.

storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, and

properly.

29. In newly redesignated §483.65, revise paragraphs (a) introductory text and (a)(2) to read as follows:

§483.65 Specialized rehabilitative services.

(a) Specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident’s comprehensive plan of care, the facility must—

1. Obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

30. In newly redesignated §483.70—

(a) Revise paragraphs (d), (e), (f), (g), (h), (i), (k), (l), (m), (n), (p), (r), (s), (t), and (u) as paragraphs (i), (g), (h), (l), (j), (k), (l), (m), (n), (p), (r), (s), (t), and (u) as paragraphs (f)(1)(1) introductory text, and (i)(2), (3), (4), and (5).
The revisions and additions read as follows:

§ 483.70 Administration.

(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 disability (45 CFR part 455) and protection of those pertaining to nondiscrimination on the basis of race, color, or national origin, on the basis of race, color, or national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164).

Violations of such other provisions may result in a finding of non-compliance with this paragraph.

(d) **

(2) The governing body appoints the administrator who is—

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

(ii) Responsible for management of the facility; and

(iii) Reports to and is accountable to the governing body.

(3) The governing body is responsible and accountable for the QAPI program, in accordance with § 483.75(f).

(e) must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must analyze the data and update that assessment, as necessary, and at least annually. The facility must monitor and analyze this assessment whenever there is, or the facility plans for, any change that would result in a substantial modification to any part of this assessment. The facility must address or include:

(1) The facility's resident population, including, but not limited to,

[i] Both the number of residents and the facility's resident capacity;

(ii) The population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;

(iii) Whenever, or the resident representative where permitted by applicable law;

(iv) Required by law;

(v) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(vi) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

medical record information against loss, destruction, or unauthorized use;

for—

State law; or

discharge when there is no requirement in State law; or

residents and, when the transferring physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law; and

the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law; and

have in place policies and procedures to

(i) with accepted professional standards and practices, the facility must maintain medical records on each resident that are—

(ii) To the individual, or their resident representative where permitted by applicable law;

(iii) Required by law;

(iv) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(v) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

medical record information against loss, destruction, or unauthorized use;
(p) **Social worker.** Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

1. An individual with a minimum of a bachelor’s degree in social work or a bachelor’s degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and
2. One year of supervised social work experience in a health care setting working directly with individuals.

- 31. A new § 483.75 is added to read as follows:

**§ 483.75 Quality assurance and performance improvement.**

(a) **Quality assurance and performance improvement (QAPI) program.** Each LTC facility, including a facility that is part of a multunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must—

1. Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities.

2. Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation.

3. Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

4. Present documentation and evidence of its ongoing QAPI program’s implementation and the facility’s compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

(b) **Program design and scope.** A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

1. Address all systems of care and management practices;
2. Include clinical care, quality of life, and resident choice;
3. Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

4. Reflect the complexities, unique care, and services that the facility provides.

(c) **Program feedback, data systems and monitoring.** A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

1. Facility maintenance of effective systems to obtain and use feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

2. Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.

3. Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

4. Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

(d) **Program systematic analysis and systemic action.** (1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

2. The facility will develop and implement policies addressing:

   i. How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

   ii. How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

   iii. How they will assess the effectiveness of its performance...
improvement activities to ensure that improvements are sustained.

(e) Program activities. (1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

(3) As a part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility’s services and available resources, as reflected in the facility assessment required at §483.70(e).

Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas and improves the quality of care.

(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for:

(1) An ongoing QAPI program defined, implemented, and maintained.

(2) The QAPI program is sustained during transitions in leadership and staffing.

(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed.

(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to resident based on performance indicator data, and resident and staff input, and other information.

(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

(g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;

(ii) The Medical Director or his or her designee;

(iii) At least three other members of the facility’s staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and

(iv) The infection control and prevention officer.

(2) The quality assessment and assurance committee reports to the facility’s governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary; and

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; and

(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

(h) Disclosure of information. 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.

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

§483.80 Infection control.

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

(b) Infection preventionist. The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility’s IPCP. The IP must:

(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;

(2) Be qualified by education, training, experience or certification;

(3) Work at least part-time at the facility; and

(4) Have completed specialized training in infection prevention and control.

(c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility’s quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

(d) Influenza and pneumococcal immunizations—(1) Influenza. The
facility must develop policies and procedures to ensure that—
(i) Before offering the influenza immunization, each resident or the resident’s 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 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 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 to ensure that—
(i) Before offering the pneumococcal immunization, each resident or the resident’s 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 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 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.
(3) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
(4) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

§483.85 Compliance and ethics program.
(a) Definitions. For purposes of this section, the following definitions apply:
Compliance and ethics program means, with respect to a facility, a program of the operating organization that—
(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and
(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.
High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.
Operating organization means the individual(s) or entity that operates a facility.
(b) General rule. Beginning on November 28, 2017, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.
(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:
(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles.
(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization’s compliance and ethics program’s standards and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.
(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures.
(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.
(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization’s compliance and ethics program to the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program.
(6) The facility takes reasonable steps to achieve compliance with the program’s standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization’s staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.
(7) Consistent enforcement of the operating organization’s standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization’s compliance and ethics program.
operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization’s program to
prevent and detect criminal, civil, and administrative violations under the Act.
(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:

(1) A mandatory annual training program on the operating organization’s compliance and ethics program that meets the requirements set forth in § 483.95(f).

(2) A designated compliance officer for whom the operating organization’s compliance and ethics program is a major responsibility. This individual must report directly to the operating organization’s governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.

(3) Designated compliance liaisons located at each of the operating organization’s facilities.

(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.

§ 483.90 Physical environment.

(c) Space and equipment. The facility must—

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

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

§ 483.95 Training requirements.

(a) Communication. A facility must include effective communications as mandatory training for direct care staff.

(b) Resident’s rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10, respectively.

(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on—

(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.

(d) Dementia management and resident abuse prevention.

§ 483.95(f). Designated compliance liaisons must be responsible to ensure that the required training is provided.

(1) Each resident’s bedside; and

(2) Be well ventilated;

(i) A separate bed of proper size and height for the safety and convenience of the resident;

(f) Bathroom facilities. Each resident room must be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, each resident must accommodate no more than two residents.

(1) An effective way to communicate that program’s standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

(2) Annual training if the operating organization operates five or more facilities.

(g) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).

(h) Be well ventilated;

(i) A separate bed of proper size and height for the safety and convenience of the resident;

(j) Provide a bed rail, if rail is in use.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.

§ 483.95(f). A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10, respectively.

(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.

(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility’s QAPI program as set forth at § 483.75.

(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at § 483.80(a)(2).

(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at § 483.85—

(1) An effective way to communicate that program’s standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

(2) Annual training if the operating organization operates five or more facilities.

(g) Required in-service training for nurse aides. In-service training must—

(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(2) Include dementia management training and resident abuse prevention training.

(3) Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
§ 485.645 Special requirements for CAH providers of long-term care services (“swing-beds”)

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<tr>
<td>(1) Resident rights (§ 483.10(a)(4)(iv), (b), (c), (d)(1), (d)(3), (e)(8), (g), and (h)(3) of this chapter).</td>
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<td>(2) Facility responsibilities (§ 483.11(d)(1)(i), (d)(1)(iii), (d)(4), (e)(11), (e)(12), (e)(14)(iii), and (f)(1)(i) of this chapter).</td>
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<td>(3) Admission, transfer, and discharge rights (§ 483.5(n), § 483.15(b)(1), (b)(2), (b)(3)(i) through (iii), (b)(4), (b)(5)(i) through (vii), and (b)(7) of this chapter).</td>
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<td>(4) Freedom from abuse, neglect and exploitation (§ 483.12 of this chapter).</td>
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<td>(5) Patient activities (§ 483.25(c) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of § 483.25(c)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.</td>
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<td>(6) Social services (§ 483.40(d) and § 483.75(p) of this chapter).</td>
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<td>(7) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), and § 483.21(b) and (c) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under § 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b) of this chapter).</td>
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<td>(8) Specialized rehabilitative services (§ 483.65 of this chapter).</td>
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<td>(9) Dental services (§ 483.55 of this chapter).</td>
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<td>(10) Nutrition (§ 483.25(d)(8) of this chapter).</td>
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PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

§ 488.56 [Amended]

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<td>45.</td>
<td>The authority citation for part 488 continues to read as follows:</td>
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<td>Authority:</td>
<td>Secs. 1102, 1128I and 1871 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302 and 1305(hh)).</td>
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§ 488.301 Definitions.

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<td>Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</td>
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Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Nurse aide means an individual, as defined in § 483.35 of this chapter.

Paid feeding assistant means an individual who meets the requirements specified in § 483.60(h)(1) of this chapter and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization.

Substandard quality of care means one or more deficiencies related to participation requirements under § 483.10 “Resident rights”, paragraphs (a)(1) through (a)(2), (b)(1) through (b)(2), (e) except for (e)(2), (e)(7), and (e)(8), (f)(1) through (f)(3), (f)(5) through (f)(8), and (i) of this chapter; § 483.12 of this chapter “Freedom from abuse, neglect, and exploitation”; § 483.24 of this chapter “Quality of life”; § 483.25 of this chapter “Quality of care”; § 483.40 “Behavioral health services”, paragraphs (b) and (d) of this chapter; § 483.45 “Pharmacy services”, paragraphs (d), (e), and (f) of this chapter; § 483.70 “Administration”, paragraph (p) of this chapter, and § 483.80 “Infection control”, paragraph (d) of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or