National Consumer Voice for Quality Long-Term Care
Side-by-Side Comparison of
CMS Proposed and Current Federal Nursing Home Regulations

Key:

Black font = Proposed language is exactly the same as current language; OR the proposed language is exactly the same as the current language with the exception of the section number, which has been changed.

Red & italicized font = Proposed language is a revision of current language. Note that sometimes the only revision is a change in a citation referenced in the provision.

Blue & bold font = Proposed language is identified by CMS as new. Note that sometimes the language, although identified by CMS as new, is similar to current language. If this is the case, you will see a notation in column three.

Proposed		Current	
Section	**Regulation**	**Section**	**Regulation**
§ 483.1 BASIS AND SCOPE.		§ 483.1 BASIS AND SCOPE.	
	(a) Statutory Basis	§ 483.1	(a) Statutory basis.
	(1) Sections 1819(a), (b), (c), (d), and (f) of the Act provide that—	§ 483.1(a)	(1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—
	(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and		(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and
	(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.		(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.
	(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.	§ 483.1(a)	(2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.
	(3) Sections 1919(a), (b), (c), (d), and (f) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.	§ 483.1(a)	(3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.
	(4) Sections 1128I(b) and (c) require that--		

	(i) Skilled nursing facilities or nursing facility have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations.		
	(ii) The Secretary establish and implement a quality assurance and performance improvement program for facilities, including multi-unit chains of facilities		
	(5) Section 1150B establishes requirements for reporting to law enforcement crimes occurring in federally funded LTC facilities.		
	(b) Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a Skilled Nursing Facility in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.	§ 483.1	(b) Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.
§ 483.5 DEFINITIONS. As used in this subpart, the following definitions apply:		§483.5 DEFINITIONS.	

	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. This presumes that 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.	§483.5	(d) Common area. Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.
	Composite distinct part.	§483.5	(c) Composite distinct part —
	(1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.	§483.5(c)	(1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.

	(2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:	§483.5(c)	(2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:
	(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.		(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.
	(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care.		(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care.
	(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.		(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.
	(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.		(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.
	(v) Use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited.		

	Exploitation. Means 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		
	Fully sprinklered. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.	§483.5(e)	Fully sprinklered. A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.
	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.	§483.75(e)(1)	Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.
	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.		
	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 mental illness.		
	Nurse aide. A nurse aide is any 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 dietitian, 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.	§483.75(e)(1)	Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, 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. For purposes of 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 an individual of the resident's choice who has access to information and participates in healthcare discussions or a personal representative with legal standing, such as a power of attorney, legal guardian, or health care surrogate appointed or designated in accordance with state law. If selected as the resident representative, 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.		
	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.	§483.12(a)	(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
	(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States		

§483.10 Resident rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.		§483.10 Resident rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:	
	(a) Exercise of rights.		(a) Exercise of rights.
	(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.		(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
	(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart	§483.10(a)	(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.
	(3) A resident has the right to designate a representative, in accordance with State law.	§483.10(a)	(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.
	(i) The resident representative has 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) 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	§483.10(a)	(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.
	(i) The resident may exercise his or her rights to the extent not prohibited by court order.		
	(ii) 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.		
	(iii) The resident's wishes and preferences must be considered in the exercise of rights by the representative		
	(iv) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.	§483.10(d) *This language can also be found in the proposed regulations at §483.10(b)(5)	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.
	(5) In the case of a resident who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law. 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.		
	(b) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:	§483.10(d)	(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

	(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.	§483.10(b)	(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;
	(2) The right to be informed, in advance, of the care to be furnished and the disciplines that will furnish care.		
	(3) The right to be informed in advance 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.		
	(4) 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 as specified in §483.11(e)(6).	§483.10(b)	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and
	(5) The right to participate in the development and implementation of his or her personcentered plan of care, including but not limited to:	§483.10(d) *This language can also be found in the proposed regulations at §483.10(a)(4)(iv)	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.
	(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, and 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 changes to the plan of care.		
	(6) The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate in accordance with §483.11(b)(2).	§483.10	(n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.
	(7) 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.		
	(c) Choice of attending physician. The resident has the right to choose his or her attending physician.	§483.10	(d) Free choice. The resident has the right to— (1) Choose a personal attending physician;
	(1) The physician must be licensed to practice, and		
	(2) The physician must meet the professional credentialing requirements of the facility.		
	(3) 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 §483.11(c) to assure provision of appropriate and adequate care and treatment.		
	(d) Respect and dignity. The resident has a right to be treated with respect and dignity, including:	§483.15	(e) Accommodation of needs. A resident has the right to—
	(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.	§483.13 *This language can also be found in the proposed regulations at §483.12 and §483.25(d)(1)	(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
	(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.	§483.10	(l) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

	(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.	§483.15(e)	(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
	(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.	§483.10	(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
	(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 notice before the resident's room or roommate in the facility is changed.	§483.15(e)	(2) Receive notice 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 to relocate:	§483.10 CMS table says this is also re-designated to §483.11d(8), but there is no §483.11d(8)	(o) Refusal of certain transfers.
	(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or	§483.10(o) *This language can also be found in the proposed regulations at §483.11d(8)	(1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate— (i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
	(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF	§483.10(o)	(2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

	(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.	§483.10(o)	(1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate— (i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.
	(e) Self-determination. The resident has the right to self-determination, including but not limited to the right to —	§483.15 *This language can also be found in the proposed regulations at §483.11(d)	(b) Self-determination and participation. The resident has the right to—
	(1) Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care;	§483.15(b)	(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
	(2) Interact with members of the community and participate in community activities both inside and outside the facility;	§483.15(b)	(2) Interact with members of the community both inside and outside the facility; and
	(3) Receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation, and in a manner that does not impose on the rights of another resident, including the individuals specified in §483.11(d);	§483.10 *This language can also be found in the proposed regulations at §483.11(d)(1)	(j) Access and visitation rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following:
	(4) Organize and participate in resident groups in the facility;	§483.15	(c) Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the facility;
	(5) Participate in family groups;	§483.15(c)	(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;

	(6) 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;	§483.15(c)	(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;
	(7) Participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility;	§483.15	(d) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.
	(8) Choose to or refuse to perform services for the facility subject to the facility requirements in §483.11(d)(4);	§483.10 *(2) of this language can also be found in the proposed regulations at §483.11(d)(4)	(h) Work. The resident has the right to—(1) Refuse to perform services for the facility;(2) Perform services for the facility, if he or she chooses, when—
	(9) Manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds as specified in §483.11(d)(6)(ii);	§483.10 *This language can also be found in the proposed regulations at §483.11(d)(5)	(c) Protection of resident funds. (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.
	(10) Make choices about aspects of his or her life in the facility that are significant to the resident.		
	(f) Access to information.		
	(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.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(1)	
	(2) The resident has the right to receive notices verbally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including		
	(i) Required notices as specified in §483.11(e);		

	(ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2006 (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.);	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(7)(iii)	
	(iii) Information regarding Medicare and Medicaid eligibility and coverage;	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(10)	
	(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program		
	(v) Contact information for the Medicaid fraud control unit; and	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(7)(iii)	
	(vi) Information and contact information for filing grievances or complaints about abuse, neglect, misappropriation of resident property in the facility, and non-compliance with §489.102 of this chapter.		
	(3) The resident has the right to access medical records pertaining to him or herself,—	§483.10(b)	(2) . The resident or his or her legal representative has the right—

	(i) 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 form or format when such medical 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, including current medical records, within 24 hours (excluding weekends and holidays); and		(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and
	(ii) After receipt of his or her medical records for inspection, to purchase, a copy of the medical records or any portions thereof (including in an electronic form or format when such medical 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:		(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.
	(A) Labor for copying the medical records requested by the individual, whether in paper or electronic form;		
	(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and		
	(C) Postage, when the individual has requested the copy be mailed		
	(4) The resident has the right to—	§483.10	(g) Examination of survey results. A resident has the right to—
	(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and	§483.10(g) *This language can also be found in the proposed regulations at §483.11(e)(3)	(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

	(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	§483.10(g)	(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
	(g) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	§483.10	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
	(1) This includes the right to privacy in his or her verbal (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.	§483.10 *(1) of this language can also be found in the proposed regulations at §483.11(f)(1)(i) and (i) can be found in the proposed regulations at §483.10(h)(3)	(i) Mail. The resident has the right to privacy in written communications, including the right to— (1) Send and promptly receive mail that is unopened
	(2) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;	§483.10 (e)	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;
	(3) The resident has a right to a secure and confidential medical record	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.75(l)(4)	

	(4) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	§483.10(e)(2) & §483.10(e) 3)	(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.
	(h) Communication. (1) 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.	§483.10	(k) Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.
	(2) 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 additional expense is incurred by the facility to provide such access to the resident.		
	(3) 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:	§483.10 *This language can also be found in the proposed regulations at §483.10(g)(1)	(i) Mail. The resident has the right to privacy in written communications, including the right to—
	(i) Privacy of such communications consistent with paragraph (g)(1) of this section; and		
	(ii) Access to stationery, postage, and writing implements at the resident's own expense	§483.10(i) *This language can also be found in the proposed regulations at §483.11(e)(13)(iii)	(2) Have access to stationery, postage, and writing implements at the resident's own expense.

	(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment in accordance with §483.11(g), including but not limited to receiving treatment and supports for daily living safely.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.15(h)(1)	
	(j) Grievances.	§483.10	(f) Grievances. A resident has the right to—
	(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.	§483.10(f)	(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and
	(2) The resident has the right to prompt efforts by the facility to resolve grievances in accordance with §483.11(h).	§483.10(f)	(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

§483.11 Facility responsibilities. 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 as specified in §483.10, including, but not limited to the following obligations:	*(a) Exercise of rights.*	§ 483.15 Quality of Life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.	§483.15 (a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
	(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(a)(2)	
	(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	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.12(c)(1)	

	(3) 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.		
	(4) 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.		
	(5) 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 may report such concerns as permitted and shall report such concerns when and in the manner required under State law.		
	(b) Planning and implementing care.		
	(1) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right, consistent with §483.10(b). The planning process must:		
	i) Facilitate the inclusion of the resident 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.		
	(2) The interdisciplinary team, as defined by §483.21(b)(2)(ii), is responsible for determining if resident self-administration of medications is clinically appropriate.		
	(c) Attending physician.		
	(1) 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.	§483.10(b)	(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

	(2) 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.		
	(3) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice		
	(d) Self-determination. The facility must promote and facilitate resident selfdetermination through support of resident choice as specified in §483.10(e) and as follows:	§483.15 *This language can also be found in the proposed regulations at§483.10(e)	(b) Self-determination and participation. The resident has the right to—
	(1) The facility must:	§483.10 *This language can also be found in the proposed regulations at §483.10(e)(3)	(j) Access and visitation rights.
	(i) Provide immediate access to any resident by:	§483.10(j) *This language can also be found in the proposed regulations at §483.10(e)(3)	(1) The resident has the right and the facility must provide immediate access to any resident by the following:
	(A) Any representative of the Secretary,		(i) Any representative of the Secretary;
	(B) Any representative of the State,		(ii) 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 2006 (42 U.S.C. 3001 et seq);		(iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

	(D) The resident's individual physician,		(iii) 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.),		(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);
	(F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental illness (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10802); and		(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);
	(G) The resident representative.		
	(ii) 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;		(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
	(iii) 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;		(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.
	(iv) Provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	§483.10(j)	(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.
	(2) The facility must have written 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 that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. A facility must meet the following requirements:		

	(i) Inform each resident (or resident representative, where appropriate) of his or her visitation rights, including any clinical or safety restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.		
	(ii) 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		
	(iii) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability		
	(iv) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.		
	(3) The facility must provide a resident or family group, if one exists, with private space; and	§483.15(c)	(3) The facility must provide a resident or family group, if one exists, with private space;
	(i) Staff or visitors may attend meetings only at the group's invitation;	§483.15(c)	(4) Staff or visitors may attend meetings at the group's invitation;
	(ii) 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;	§483.15(c)	(5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;
	(iii) The facility must consider the views of a resident or family group and act upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	§483.15(c)	(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

	(A) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.		
	(B) The facility must be able to demonstrate their response and rationale for such response.		
	(4) 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—	§483.10 *This language can also be found in the proposed regulations at §483.10(e)(8)	(h) Work. The resident has the right to— 2) Perform services for the facility, if he or she chooses, when—
	(i) The facility has documented the resident's need or desire for work in the plan of care;		(i) The facility has documented the need or desire for work in the plan of care;
	(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;		(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
	(iii) Compensation for paid services is at or above prevailing rates; and		(iii) Compensation for paid services is at or above prevailing rates;
	(iv) The resident agrees to the work arrangement described in the plan of care.		(iv) The resident agrees to the work arrangement described in the plan of care.
	(5) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, the facility must adhere to the following requirements.	§483.10 *This language can also be found in the proposed regulations at §483.10(e)(9)	(c) Protection of resident funds. (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.
	(i) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.	§483.10(c)	(2) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)–(8) of this section.
	(ii) Deposit of funds.	§483.10(c)	(3) Deposit of funds.
	(A) In general:		

	(1) Except as set out in paragraph (d)(5)(ii)(B)(1) 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.)		(i) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)
	(2) 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.		(ii) Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.
	(B) Residents whose care is funded by Medicaid:		
	(1) 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.)	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(c)(3)(i)	
	(2) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(c)(3)(ii)	
	(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	§483.10(c)	(4) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.
	(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.		(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

	(C) The individual financial record must be available to the resident through quarterly statements and upon request.		(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.
	(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits—	§483.10(c)	(5) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits—
	(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and		(i) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and
	(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI		(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
	(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	§483.10(c)	(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.
	(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	§483.10(c)	(7) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

	(6) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)	§483.10(c)	(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or co-payment required by the plan to be paid by the individual.)
	(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:		(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:
	(A) Nursing services as required at §483.35.		(A) Nursing services as required at §483.30 of this subpart.
	(B) Food and Nutrition services as required at §483.60.		(B) Dietary services as required at §483.35 of this subpart.
	(C) An activities program as required at §483.25(c).		(C) An activities program as required at §483.15(f) of this subpart.
	(D) Room/bed maintenance services.		(D) Room/bed maintenance services.

	(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.		(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.
	(F) Medically-related social services as required at §483.40(d).		(F) Medically-related social services as required at §483.15(g) of this subpart.
	(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.		
	(ii) Items and services that may be charged to residents' funds. Listed below in paragraphs (d)(6)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:		(ii) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
	(A) Telephone, including a cellular phone.		(A) Telephone.
	(B) Television/radio, personal computer or other electronic device for personal use.		(B) Television/radio for personal use.
	(C) Personal comfort items, including smoking materials, notions and novelties, and confections.		(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.		(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
	(E) Personal clothing.		(E) Personal clothing.
	(F) Personal reading matter		(F) Personal reading matter.
	(G) Gifts purchased on behalf of a resident.		(G) Gifts purchased on behalf of a resident.
	(H) Flowers and plants.		(H) Flowers and plants.
	(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.25(c)		(I) Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.
	(J) Noncovered special care services such as privately hired nurses or aides.		(J) Noncovered special care services such as privately hired nurses or aides.
	(K) Private room, except when therapeutically required (for example, isolation for infection control)		(K) Private room, except when therapeutically required (for example, isolation for infection control).
	(L) Except as provided below, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.		(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.
	(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's health care provider, as these are included per §483.60.		
	(2) In accordance with §483.60(c) through (f), 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 noncovered item or service if such item or service is specifically requested by the resident.		(iii) Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.
	(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.		(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

	(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.		(C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
	(e) Information and communication		
	(1) With the exception of information described in paragraph (e)(2) 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 (e)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(1)	
	(2) The facility must		
	(i) Provide the resident with access to 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 form or format when such medical 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	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(2)(i)	
	(ii) Allow the resident to purchase, after receipt of his or her medical records for inspection, a copy of the medical records or any portions thereof (including in an electronic form or format when such medical records are maintained electronically) upon request and 2 working days advance notice to the facility.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(2)(ii)	
	(iii) The facility may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:		

	(A) Labor for copying the medical records requested by the individual, whether in paper or electronic form;		
	(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and		
	(C) Postage, when the individual has requested the copy be mailed		
	(3) The facility must make reports with respect to any surveys, certifications, and complaint investigations conducted by Federal or State surveyors during the 3 preceding years available for any individual to review upon request and any plan of correction in effect with respect to the facility available for examination in a place readily accessible to and in a form understandable by residents, and must post a notice of its availability.	§483.10(g) *This language can also be found in the proposed regulations at §483.10(f)(4)(i)	(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and
	(4) The facility must post, in a form and manner accessible and understandable to residents, resident representatives and support person:		
	(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State survey and certification 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	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(7)(iii)	

	(ii) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the requirements specified in 42 CFR part 489 subpart I (Advance Directives).	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(b)(7)(iv)	
	(5) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives)	§483.10(b)	(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

	(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.		
	(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.		
	(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.		
	(iv) If an adult individual is 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.		
	(v) The facility is not relieved of its 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.		
	(6) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits	§483.10(b)	(10) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
	(7) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify the resident representative(s) when there is—	§483.10(b)	(11) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;		(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
	(B) A significant change in 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);		(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
	(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or		(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
	(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(b)(1)(ii).		(D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).
	(ii) When making notification under paragraph (e)(7)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(b)(2) is available and provided upon request to the physician.		
	(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is—		(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is—
	(A) A change in room or roommate assignment as specified in §483.10(d)(6); or		(A) A change in room or roommate assignment as specified in §483.15(e)(2); or
	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section		(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).		(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

	(8) Admission to a composite distinct part. A 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 §483.15(b)(9).	§483.10(b)	(12) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.12(a)(8).
	(9) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.	§483.10	(b) Notice of rights and services.
	(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	§483.10 (b)	(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;
	(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any		
	(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;		
	(10) The facility must:	§483.10(b)	(5) The facility must—
	(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—		(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of—

	(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged		(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		(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 paragraphs (e)(10)(i)(A) and (B) of this section.		(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i) (A) and (B) of this section.
	(11) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.	§483.10 (b)	(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.
	(i) Where changes in coverage are 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;		
	(ii) Where changes are made to 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.		
	(iii) If a resident dies or is 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.		

	(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within thirty days from the resident's date of discharge from the facility		
	(v) Where the facility requires the execution of an admission contract by or on behalf of an individual seeking admission to the facility, the terms of the contract must not conflict with the requirements of these regulations.		
	(12) The facility must furnish to each resident a written description of legal rights which includes—	§483.10(b)	(7) The facility must furnish a written description of legal rights which includes—
	(i) A description of the manner of protecting personal funds, under paragraph (d)(5) of this section;		(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;
	(ii) A description of the requirements 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.		(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;
	(iii) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State survey and certification 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		(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

	(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.		(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.
	(13) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, consistent with §483.10(h), 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.	§483.10(i) *Incorrectly listed in CMS table as re-designated to §483.11(e)(14)(iii).	(2) Have access to stationery, postage, and writing implements at the resident's own expense.
	(f) Privacy and confidentiality.		
	(1) The facility must respect the resident's right to personal privacy, including privacy in his or her verbal (meaning spoken), written and electronic communications		
	(i) This includes ensuring that a resident can send and promptly receive mail that is unopened; as well as receive, unopened, letters, packages and other materials delivered to the facility for the resident through a means other than a postal service.	§483.10 *This language can also be found in the proposed regulations at §483.10(g)(1)	(i) Mail. The resident has the right to privacy in written communications, including the right to— (1) Send and promptly receive mail that is unopened; and

	(ii) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(e)(1)	
	(2) The facility must comply with the residents' rights in §483.10(g)(3) regarding his or her medical records.		
	(3) The facility must allow 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.	§483.10(j)	(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.
	(g) Safe environment. The facility must provide:	§483.15	(h) Environment. The facility must provide—
	(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring:	§483.15(h)	(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;
	(i) That the resident can receive care and services safely.		
	(ii) That the physical layout of the facility maximizes independence and does not pose a safety risk.		
	(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	§483.15(h)	(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
	(3) Clean bed and bath linens that are in good condition;	§483.15(h)	(3) Clean bed and bath linens that are in good condition;
	(4) Private closet space in each resident room, as specified in §483.90(d)(2)(iv);	§483.15(h)	(4) Private closet space in each resident room, as specified in §483.70(d)(2)(iv) of this part;
	(5) Adequate and comfortable lighting levels in all areas;	§483.15(h)	(5) Adequate and comfortable lighting levels in all areas;

	(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81°F; and	§483.15(h)	(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71–81°F; and
	(7) For the maintenance of comfortable sound levels.	§483.15(h)	(7) For the maintenance of comfortable sound levels.
	(h) Grievances		
	(1) The facility must make information on how to file a grievance or complaint available to the resident, including the information required under paragraph (f)(2) of this section.		
	(2) The facility must make prompt efforts to resolve grievances the resident may have, including those with respect to the behavior of other residents.	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.10(f)(2)	
	(3) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in §483.10. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:		

	(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances verbally (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;**		
	(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through 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;		
	(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;		

	(iv) 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		
	(v) 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 and certification 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 three years from the issuance of the grievance decision.		

	(i) 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 of the protection and advocacy system, regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.		
§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.		§ 483.13 Resident Behavior and Facility Practices. *This language can also be found in the proposed regulations at§483.10(d)(1) and §483.25(d)(1)	(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
	(a) The facility must— (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	§483.13(c)	(1) The facility must— (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
	(2) Not employ or otherwise engage individuals who—		(ii) Not employ individuals who have been—

	(i) Have been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law;		(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
	(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; or		(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
	(iii) Have had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of resident property		
	(3) 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.		(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.
	(b) The facility must develop and implement written policies and procedures that:	§483.13	(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
	(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.13(c)	
	(2) Establish policies and procedures to investigate any such allegations, and	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.13(c)	
	(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 Social Security 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 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, neglect, 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 to the administrator of the facility and to other officials (including to the State survey and certification agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	§483.13(c)	(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
	(2) Have evidence that all alleged violations are thoroughly investigated.	§483.13(c)	(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
	(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.		
	(4) Report the results of all investigations to the administrator or his resident representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken	§483.13(c)	(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
§483.13 [Removed]			
§483.15 Transitions of care. Transitions of care include admissions to and discharges or transfers to or from a SNF or NF. This section also addresses bed-hold policies and therapeutic leave.	(a) Admissions policy.	§483.12	(d) Admissions policy.
	(1) The facility must establish and implement an admissions policy.		

	(2) The facility must—	§483.12	(1) 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		(i) Not require residents or potential residents to waive 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.		(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.
	(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.	§483.12(d)	(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.
	(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,—	§483.12(d)	(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

	(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		(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		(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.
	(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	§483.12(d)	(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.
	(6) A nursing facility must disclose and provide to a resident or potential resident, at or 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(c) 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.		
	(b) Transfer and discharge		

	(1) Facility requirements—		
	(i) Equal access to quality care	§483.12	(c) Equal access to quality care.
	(A) A facility must establish, maintain and implement identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment;	§483.12(c)	(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;
	(B) 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 §483.11(e)(11)(i) and (e)(12) describing the charges; and	§483.12(c)	(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and
	(C) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan	§483.12(c)	(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.
	(ii) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—	§483.12 Admission, Transfer and Discharge Rights. (a) Transfer and discharge—	(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
	(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;		(i) 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;		(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
	(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;		(iii) The safety of individuals in the facility is endangered;
	(D) The health of individuals in the facility would otherwise be endangered;		(iv) 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 does not apply unless the resident does not submit the necessary paperwork for third party payment or until 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		(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
	(F) The facility ceases to operate.		(vi) The facility ceases to operate.
	(iii) 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.		
	(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (b)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's clinical record and appropriate information is communicated to the receiving health care institution or provider.	§483.12 (a)	(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—
	(i) Documentation in the resident's clinical record must include:		
	(A) The basis for the transfer per paragraph (b)(1)(ii).		
	(B) In the case of paragraph (b)(1)(ii)(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 must be made by		

	(A) The resident's physician when transfer or discharge is necessary under paragraph (b)(1)(i)(A) or (B) of this section; and	§483.12 (a)(3)	(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
	(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.		(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
	(iii) Information provided to the receiving provider must include a minimum of the following:		
	(A) Demographic information including but not limited to name, sex, date of birth, race, ethnicity, and preferred language,.		
	(B) Resident representative information including contact information.		
	(C) Advance Directive information.		
	(D) History of present illness/reason for transfer including primary care team contact information.		
	(E) Past medical/surgical history, including procedures		
	(F) Active diagnoses/Current problem list and status.		
	(G) Laboratory tests and the results of pertinent laboratory and other diagnostic testing.		
	(H) Functional status.		
	(I) Psychosocial assessment, including cognitive status.		
	(J) Social Supports		
	(K) Behavioral Health Issues		
	(L) Medications		
	(M) Allergies, including medication allergies.		
	(N) Immunizations.		
	(O) Smoking status		
	(P) Vital signs.		
	(Q) Unique device identifier(s) for a patient's implantable device(s), if any.		

	(R) Comprehensive Care plan goals, including health concerns, assessment and plan, resident preferences, interventions, including efforts to meet resident needs, and resident status.		
	(iv) This requirement may be satisfied by the discharge summary providing it meets the requirements of §483.21(c) and includes at a minimum the information specified in paragraph (b)(2)(iii) of this section		
	(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—	§483.12(a)	(4) 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. Subject to the resident's agreement, the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.		(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
	(ii) Record the reasons for the transfer or discharge in the resident's clinical record in accordance with paragraph (b)(2) of this section; and		(ii) Record the reasons in the resident's clinical record; and
	(iii) Include in the notice the items described in paragraph (b)(5) of this section		(iii) Include in the notice the items described in paragraph (a)(6) 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.	§483.12(a)	(5) Timing of the notice. (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
	(ii) Notice must be made as soon as practicable before transfer or discharge when—		(ii) Notice may 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;		(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

	(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;		(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) 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;		(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
	(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or		(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
	(E) A resident has not resided in the facility for 30 days		(E) A resident has not resided in the facility for 30 days.
	(5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:	§483.12(a)	(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
	(i) The reason for transfer or discharge;		(i) The reason for transfer or discharge;
	(ii) The effective date of transfer or discharge;		(ii) The effective date of transfer or discharge;
	(iii) The location to which the resident is expected to be transferred or discharged;		(iii) The location to which the resident is transferred or discharged;
	(iv) A statement that the resident has the right to appeal the action to the State, the name, address (mailing and email), and telephone number of the State 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;		(iv) A statement that the resident has the right to appeal the action to the State;
	(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;		(v) The name, address and telephone number of the State long term care ombudsman;
	(vi) For nursing facility residents with intellectual and developmental 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 (42 U.S.C. 10802); and		(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

	(vii) For nursing facility residents with mental illness, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act		(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
	(6) Changes to the notice. If the 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) Orientation for transfer or 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.	§483.12(a)	(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
	(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.70(l).	§483.12(a)	(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).
	(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5) are subject to the requirements of §483.10(d)(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.	§483.12(a)	(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.
	(c) Notice of bed-hold policy and readmission —	§483.12	(b) Notice of bed-hold policy and readmission —

	(1) Notice before transfer. 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—	§483.12(b)	(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—
	(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;		(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and
	(ii) The reserve bed payment policy in the state plan, under §447.40 of this chapter, if any;		
	(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(3) of this section, permitting a resident to return; and		(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.
	(iv) The information specified in paragraph (c)(3) of this section.		
	(2) Bed-hold notice upon transfer. At 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.	§483.12(b)	(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.
	(3) Permitting resident to return to facility. A nursing 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.	§483.12(b)	(3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

	(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.12(b)(3)	
	(A) Requires the services provided by the facility; and		(i) Requires the services provided by the facility; and
	(B) Is eligible for Medicaid nursing facility services.		(ii) Is eligible for Medicaid nursing facility services.
	(ii) A resident who is hospitalized or placed on therapeutic leave with an expectation of returning to the facility must be notified in writing by the facility when the facility determines that the resident cannot be readmitted to the facility, the reason the resident cannot be readmitted to the facility, and the information specified in paragraphs (b)(5)(iv) through (vii) of this section		
	(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in §483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.	§483.12(b)	(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in §483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

§483.20 Resident assessment	(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.	§ 483.20 Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.	(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.
	(b) Comprehensive assessments —	§ 483.20	(b) Comprehensive assessments —
	(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:	§ 483.20(b)	(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
	(i) Identification and demographic information.		(i) Identification and demographic information.
	(ii) Customary routine.		(ii) Customary routine.
	(iii) Cognitive patterns.		(iii) Cognitive patterns.
	(iv) Communication.		(iv) Communication.
	(v) Vision.		(v) Vision.
	(vi) Mood and behavior patterns.		(vi) Mood and behavior patterns.
	(vii) Psychosocial well-being.		(vii) Psychosocial well-being.
	(viii) Physical functioning and structural problems.		(viii) Physical functioning and structural problems.
	(ix) Continence.		(ix) Continence.
	(x) Disease diagnoses and health conditions.		(x) Disease diagnoses and health conditions.
	(xi) Dental and nutritional status.		(xi) Dental and nutritional status.
	(xii) Skin condition.		(xii) Skin condition.
	(xiii) Activity pursuit.		(xiii) Activity pursuit.
	(xiv) Medications.		(xiv) Medications.
	(xv) Special treatments and procedures.		(xv) Special treatments and procedures.

	(xvi) Discharge planning.		(xvi) Discharge potential.
	(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).		(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
	(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care/direct access staff members on all shifts.		(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
	(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.	§ 483.20(b)	(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
	(i) Within 14 calendar days after admission, excluding re-admissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)		(i) Within 14 calendar days after admission, excluding re-admissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

	(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)		(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
	(iii) Not less often than once every 12 months.		(iii) Not less often than once every 12 months.
	(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	§ 483.20	(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
	(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.	§ 483.20	(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.
	(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes—	§ 483.20	(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicate testing and effort.
	(1) 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 illness, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.		
	(f) Automated data processing requirement —	§ 483.20	(f) Automated data processing requirement —
	(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	§ 483.20(f)	(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
	(i) Admission assessment.		(i) Admission assessment.
	(ii) Annual assessment updates.		(ii) Annual assessment updates.
	(iii) Significant change in status assessments.		(iii) Significant change in status assessments.
	(iv) Quarterly review assessments.		(iv) Quarterly review assessments.
	(v) A subset of items upon a resident's transfer, reentry, discharge, and death.		(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
	(vi) Background (face-sheet) information, if there is no admission assessment.		(vi) Background (face-sheet) information, if there is no admission assessment.
	(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	§ 483.20(f)	(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.
	(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	§ 483.20(f)	(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
	(i) Admission assessment.		(i) Admission assessment.
	(ii) Annual assessment.		(ii) Annual assessment.
	(iii) Significant change in status assessment.		(iii) Significant change in status assessment.
	(iv) Significant correction of prior full assessment.		(iv) Significant correction of prior full assessment.

	(v) Significant correction of prior quarterly assessment.		(v) Significant correction of prior quarterly assessment.
	(vi) Quarterly review.		(vi) Quarterly review.
	(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.		(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
	(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.		(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.
	(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	§ 483.20(f)	(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
	(5) Resident-identifiable information.	§ 483.20(f)	(5) Resident-identifiable information.
	(i) A facility may not release information that is resident-identifiable to the public.		(i) A facility may not release information that is resident-identifiable to the public.
	(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.		(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.
	(g) Accuracy of assessments. The assessment must accurately reflect the resident's status.	§ 483.20	(g) Accuracy of assessments. The assessment must accurately reflect the resident's status.
	(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	§ 483.20	(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
	(i) Certification.		(i) Certification.
	(1) A registered nurse must sign and certify that the assessment is completed.	§ 483.20(h)	(1) A registered nurse must sign and certify that the assessment is completed.
	(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	§ 483.20(h)	(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
	(j) Penalty for falsification.	§ 483.20	(j) Penalty for falsification.

	(1) Under Medicare and Medicaid, an individual who willfully and knowingly—	§ 483.20(j)	(1) Under Medicare and Medicaid, an individual who willfully and knowingly—
	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or		(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
	(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.		(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.
	(2) Clinical disagreement does not constitute a material and false statement.	§ 483.20(j)	(2) Clinical disagreement does not constitute a material and false statement.
	(k) Preadmission screening for individuals with mental illness and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—	§483.20(m)	(m) Preadmission screening for mentally ill individuals and individuals with mental retardation. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—
	(i) Mental illness as defined in 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,		(i) Mental illness as defined in paragraph (f)(2)(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,
	(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and		(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
	(B) If the individual requires such level of services, whether the individual requires specialized services; or		(B) If the individual requires such level of services, whether the individual requires specialized services; or
	(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—		(ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission—

	(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and		(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
	(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability		(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
	(2) Exceptions. For purposes of this section—		
	(i) The preadmission screening 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.		
	(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,		
	(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and		
	(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.		
	(3) Definition. For purposes of this section—	§483.20 (m)	(2) Definition. For purposes of this section—
	(i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in §483.102(b)(1).		(i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in §483.102(b)(1).
	(ii) An individual is considered to 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 described in §435.1010 of this chapter		(ii) An individual is considered to be mentally retarded if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.

	(4) A nursing facility must notify the 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 mental illness or intellectual disability for resident review.		
§483.21 Comprehensive person-centered care planning.	**(a) Baseline care plans**		
	(1) The facility must develop a 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).		
	(b) Comprehensive care plans.	§483.20	(k) Comprehensive care plans.

	(1) The facility must develop a comprehensive personcentered care plan for each resident, consistent with §483.10(b)(1) and §483.11(b)(1), that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —	§483.20(k)	(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—
	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25 or §483.40; and		(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and
	(ii) Any services that would otherwise be required under §483.25 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(b)(4).		(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).
	(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.		
	(2) A comprehensive care plan must be—	§483.20(k)	(2) A comprehensive care plan must be—

	(i) Developed within 7 days after completion of the comprehensive assessment		(i) Developed within 7 days after completion of the comprehensive assessment;
	(ii) Prepared by an interdisciplinary team, that includes but is not limited to--		(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and
	(A) The attending physician.		
	(B) A registered nurse with responsibility for the resident.		
	(C) A nurse aide with responsibility for the resident		
	(D) A member of food and nutrition services staff.		
	(E) A social worker.		
	(F) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.		
	(G) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.		
	(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.
	(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—	§483.20(k)	(3) The services provided or arranged by the facility must—
	(i) Meet professional standards of quality.		(i) Meet professional standards of quality; and
	(ii) Be provided by qualified persons in accordance with each resident's written plan of care		(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
	(iii) Be culturally-competent and trauma –informed		

	(c) Discharge planning—		
	(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals and preparing residents to be active partners in post-discharge care, effective transition of the resident from SNF to post-SNF care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must—		
	(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.		
	(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.		
	(iii) Involve the interdisciplinary team, as defined by §483.20(b)(2)(ii), in the ongoing process of developing the discharge plan.		
	(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.		
	(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.		
	(vi) Address the resident's goals of care and treatment preferences.		
	(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community		

	(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.		
	(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.		
	(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.		
	(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.		
	(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer		

	(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:	§483.20	(l) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—
	(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	§483.20 (l)	(1) A recapitulation of the resident's stay;
	(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative	§483.20 (l)	(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and
	(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter)		
	(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, his or her family, 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.	§483.20 (l)	(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

§483.25 Quality of care and quality of life. 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.	*(a) Based on the comprehensive 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:*	§ 483.25 Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that— (1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—
	(1) A resident is given the appropriate 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,	§483.25(a)	(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and
	(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and	§483.25(a)	(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
	(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to the resident's advance directives.		
	(b) Activities of daily living.	§483.25(a)	(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—
	(1) Hygiene –bathing, dressing, grooming, and oral care		(i) Bathe, dress, and groom;
	(2) Mobility—transfer and ambulation		(ii) Transfer and ambulate;
	(3) Elimination-toileting,		(iii) Toilet;

	(4) Dining-eating, including meals and snacks,		(iv) Eat; and
	(5) Communication, including		(v) Use speech, language, or other functional communication systems.
	(i) Speech		
	(ii) Language,		
	(iii) Other functional communication systems.		
	(c) Activities	§483.15	(f) Activities.
	(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	§483.15(f)	(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.
	(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who	§483.15(f)	(2) The activities program must be directed by a qualified professional who— (i) Is a qualified therapeutic recreation specialist or an activities professional who—
	(i) Is licensed or registered, if applicable, by the State in which practicing; and		(A) Is licensed or registered, if applicable, by the State in which practicing; and
	(ii) Is:		
	(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or		(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
	(B) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a therapeutic activities program; or		(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or
	(C) Is a qualified occupational therapist or occupational therapy assistant; or		(iii) Is a qualified occupational therapist or occupational therapy assistant; or
	(D) Has completed a training course approved by the State.		(iv) Has completed a training course approved by the State.

	(d) Special care issues.	§483.25	(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:
	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 and the residents choices, related to the following special concerns—		
	(1) Restraints. The facility must ensure that the resident is free from physical or chemical restraints 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.	§ 483.13 Resident Behavior and Facility Practices. *This language can also be found in the proposed regulations at §483.10(d)(1) and §483.12	(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
	(2) Bed rails. The facility must ensure correct installation, use and maintenance of bed rails, including but not limited to the following elements.		
	(i) Attempt to use alternatives prior to installing a side or bed rail.		
	(ii) Assess resident for risk of entrapment from bed rails prior to installation.		
	(iii) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation		
	(iv) Ensure that the resident's size and weight are appropriate for the bed's dimensions		
	(v) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.		

	(3) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—	§483.25	(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—
	(i) In making appointments, and	§483.25 (b)	(1) In making appointments, and
	(ii) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices	§483.25(b)	(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.
	(4) Skin integrity—		
	(i) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that—	§483.25	(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—
	(A) A resident receives care, consistent 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	§483.25 (c)	(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
	(B) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	§483.25 (c)	(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
	(ii) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	§483.25(k)	(7) Foot care; and
	(A) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and		
	(B) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.		

	(5) Mobility	§483.25(e)	(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that—
	(i) 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	§483.25(e)	(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and
	(ii) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion	§483.25(e)	(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
	(iii) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable		
	(6) Incontinence.		
	(i) The facility must ensure that 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.		
	(ii) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—	§483.25	(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that—
	(A) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	§483.25(d)	(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
	(B) A resident who enters the facility 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		

	(C) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible	§483.25(d)	(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.
	(iii) For a resident with fecal 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.		
	(7) Colostomy, ureterostomy, or ileostomy care	§483.25(k)	(3) Colostomy, ureterostomy, or ileostomy care;
	(8) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—	§483.25	(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—
	(i) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and protein levels, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	§483.25(i)	(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
	(ii) Is offered sufficient fluid intake to maintain proper hydration and health; and	§483.25	(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.
	(iii) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	§483.25(i)	(2) Receives a therapeutic diet when there is a nutritional problem.
	(iv) 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	§483.25(g)	(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that— (1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

	(v) 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.	§483.25(g)	(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.
	(9) Parenteral fluids.	§483.25(k)	(2) Parenteral and enteral fluids;
	(10) Accidents. The facility must ensure that—	§483.25	(h) Accidents. The facility must ensure that—
	(i) The resident environment remains as free of accident hazards as is possible; and	§483.25(h)	(1) The resident environment remains as free of accident hazards as is possible; and
	(ii) Each resident receives adequate supervision and assistance devices to prevent accidents.	§483.25(h)	(2) Each resident receives adequate supervision and assistance devices to prevent accidents.
	(11) Respiratory care, including tracheostomy care and tracheal suctioning. See §483.65 re: specialized rehabilitative services	§483.25(k)(4) -(6)	(4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care;
	(12) Prostheses.	§483.25(k)(8)	(8) Prostheses.
	(13) Pain management		
	(14) Dialysis.		
	(15) 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		
	21. In the table below, each section and paragraph indicated in the first column is redesignated as the section and paragraph indicated in the second column:		

§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.	(a) Physician supervision. The facility must ensure that—	§483.40 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 supervision. The facility must ensure that—
	(1) The medical care of each resident is supervised by a physician; and	§483.40(a)	(1) The medical care of each resident is supervised by a physician; and
	(2) Another physician supervises the medical care of residents when their attending physician is unavailable.	§483.40(a)	(2) Another physician supervises the medical care of residents when their attending physician is unavailable.
	(b) Physician visits. The physician must—	§483.40	(b) Physician visits. The physician must—
	(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	§483.40(b)	(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;
	(2) Write, sign, and date progress notes at each visit; and	§483.40(b)	(2) Write, sign, and date progress notes at each visit; and
	(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.	§483.40(b)	(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
	(c) Frequency of physician visits.	§483.40	(c) Frequency of physician visits.
	(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	§483.40(c)	(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

	(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	§483.40(c)	(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
	(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	§483.40(c)	(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.
	(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.	§483.40(c)	(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.
	(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.	§483.40	(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.
	(e) Availability of a physician, physician assistant, nurse practitioner, or clinical nurse specialist to evaluate resident for non-emergent transfer to a hospital. The facility must provide or arrange for an in-person evaluation of a resident by a physician, a physician assistant, nurse practitioner, or clinical nurse specialist prior to transferring the resident to a hospital.		
	(1) The evaluation must occur expeditiously once the potential need for a transfer is identified		
	(2) This requirement does not apply in emergency situations where the health or safety of the individual would be endangered.		
	(f) Physician delegation of tasks in SNFs.	§483.40	(e) Physician delegation of tasks in SNFs.
	(1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—	§483.40(e)	(1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

	(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;		(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;
	(ii) Is acting within the scope of practice as defined by State law; and		(ii) Is acting within the scope of practice as defined by State law; and
	(iii) Is under the supervision of the physician.		(iii) Is under the supervision of the physician.
	(2) A 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 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.		
	(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	§483.40 (e)	(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.
	(g) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.	§483.40	(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

§483.35 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) Sufficient staff.	§ 483.30 Nursing Services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	(a) Sufficient staff.
	(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	§483.30(a)	(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
	(ii) Other nursing personnel, including but not limited to nurse aides.		(ii) Other nursing personnel.
	(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	§483.30(a)	(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

	(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.		
	(b) Registered nurse.	§483.30	(b) Registered nurse.
	(1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	§483.30(b)	(1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
	(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	§483.30(b)	(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.
	(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	§483.30(b)	(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
	(c) 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.	§483.75(f)	(f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
	(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:	§483.75(e)	(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:
	(i) That individual is competent to provide nursing and nursing related services; and		(i) That individual is competent to provide nursing and nursing related services; and

	(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151 through 483.154; or		(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151–483.154 of this part; or
	(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).		(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).
	(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1) (i) and (ii) of this section.	§483.75(e)	(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2) (i) and (ii) of this section.
	(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	§483.75(e)	(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—
	(i) Is a full-time employee in a State-approved training and competency evaluation program;		(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		(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).		(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—	§483.75(e)	(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—
	(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or		(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.		(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.	§483.75(e)	(6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act 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.	§483.75(e)	(7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

	(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)	§483.75(e) *This language can also be found in the proposed regulations at §483.95(g)	(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must— (i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; (ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and (iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
	(e) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—	§483.30	(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—
	(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;	§483.30 (c)	(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;
	(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;	§483.30 (c)	(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;
	(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;	§483.30 (c)	(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;
	(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;	§483.30 (c)	(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

	(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;	§483.30 (c)	(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;
	(6) The State agency granting a waiver of such requirements provides notice of the waiver to the 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 illnesses; and	§483.30(c)	(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and
	(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.	§483.30(c)	(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.
	(f) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.	§483.30	(d) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.
	(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—	§483.30(d)	(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—
	(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;		(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;
	(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and		(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
	(iii) The facility either—		(iii) The facility either—
	(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or		(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

	(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;		(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;
	(iv) The Secretary provides notice of the waiver to the 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 illnesses; and		(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and
	(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver		(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.
	(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.	§483.30(d)	(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.
	(g) Nurse staffing information —	§483.30	(e) Nurse staffing information —
	(1) Data requirements. The facility must post the following information on a daily basis:	§483.30(e)	(1) Data requirements. The facility must post the following information on a daily basis:
	(i) Facility name.		(i) Facility name.
	(ii) The current date.		(ii) The current date.
	(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:		(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
	(A) Registered nurses.		(A) Registered nurses.
	(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).		(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
	(C) Certified nurse aides.		(C) Certified nurse aides.
	(iv) Resident census.		(iv) Resident census.
	(2) Posting requirements.	§483.30(e)	(2) Posting requirements.

	(i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.		(i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.
	(ii) Data must be posted as follows:		(ii) Data must be posted as follows:
	(A) Clear and readable format.		(A) Clear and readable format.
	(B) In a prominent place readily accessible to residents and visitors.		(B) In a prominent place readily accessible to residents and visitors.
	(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	§483.30(e)	(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.
	(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	§483.30(e)	(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
§483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	**(a) The facility must have sufficient direct care/direct access 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 §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:**		
	(1) Caring for residents with mental illnesses and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and		

	(2) Implementing non-pharmacological interventions.		
	(b) Based on the comprehensive assessment of a resident, the facility must ensure that—	§483.25	(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—
	(1) A resident who displays or is diagnosed with mental 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	§483.25(f)	(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and
	(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or posttraumatic 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.	§483.25(f)	(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.
	(c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental illness 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 §483.45; or		
	(2) Obtain the required services from an outside resource (in accordance with § 483.75(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 mental and psychosocial well-being of each resident.	§483.15	(g) Social Services.(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

§ 483.45 PHARMACY SERVICES. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	§ 483.60 PHARMACY SERVICES. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
	(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—	§ 483.60	(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—
	(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;	§ 483.60 (b)	(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
	(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	§ 483.60 (b)	(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
	(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	§ 483.60 (b)	(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
	(c) Drug regimen review.	§ 483.60	(c) Drug regimen review.
	(2) This review must include a review of the resident's medical chart at least every 6 months and:		

	(i) When the resident is new, that is the individual has not previously been a resident in that facility; or		
	ii) When the resident returns or is transferred from a hospital or other facility; and		
	(iii) During each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug the QAA Committee has requested be included in the pharmacist's monthly drug review.		
	(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;		
	(iv) Hypnotic;		
	(v) Opioid analgesic; and		
	(vi) Any other drug that results in effects similar to the drugs listed in paragraphs (c)(3)(i) through (v) of this section.		
	(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	§483.60(c)	(2) The pharmacist must report any irregularities to the attending physician and the 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.		
	(d) Unnecessary drugs — General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	§483.25	(l) Unnecessary drugs — (1) 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	§483.25(l)	(i) In excessive dose (including duplicate drug therapy); or
	(2) For excessive duration; or		(ii) For excessive duration; or
	(3) Without adequate monitoring; or		(iii) Without adequate monitoring; or
	(4) Without adequate indications for its use; or		(iv) Without adequate indications for its use; or
	(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or		(v) 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.		(vi) Any combinations of the reasons above.
	(e) Psychotropic drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—	§483.25(l)	(2) Antipsychotic 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 diagnosed and documented in the clinical record;		(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
	(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;		(ii) Residents who use antipsychotic 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 48 hours and cannot be continued beyond that time unless the resident's physician or primary care provider documents the rationale for this continuation in the resident's clinical record.		
	(f) Medication errors. The facility must ensure that its-	§483.25	(m) Medication Errors. The facility must ensure that—
	(1) Medication error rates are not five percent or greater; and	§483.25(m)	(1) It is free of medication error rates of five percent or greater; and
	(2) Residents are free of any significant medication errors.	§483.25(m)	(2) Residents are free of any significant medication errors.
	(g) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	§483.60	(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
	(h) Storage of drugs and biologicals.	§483.60	(e) Storage of drugs and biologicals.

	(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	§483.60(e)	(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
	(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	§483.60(e)	(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
§483.50 Laboratory, radiology, and other diagnostic services.	(a) Laboratory services.	§483.75	(j) Laboratory services.
	(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	§483.75(j)	(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
	(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.		(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.
	(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.		(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.
	(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.		(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.		(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.
	(2) The facility must—	§483.75(j)	(2) The facility must—
	(i) Provide or obtain laboratory 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) Provide or obtain laboratory services only when ordered by the attending physician;
	(ii) 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 per the ordering physician's orders.		(ii) Promptly notify the attending physician of the findings;
	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and		(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and
	(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.		(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.	§483.75	(k) 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.	§483.75(k)	(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.		(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.		(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—	§483.75(k)	(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.		(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;
	(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 per the ordering physician's orders.		(ii) Promptly notify the attending physician of the findings;
	(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and		(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.		(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.
§483.55 DENTAL SERVICES. The facility must assist residents in obtaining routine and 24-hour emergency dental care.		§483.55 DENTAL SERVICES. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	
	(a) Skilled nursing facilities. A facility -	§483.55	(a) Skilled nursing facilities. A facility -

	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;	§483.55(a)	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;
	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	§483.55(a)	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;
	(3) 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—	§483.55(a)	(3) Must if necessary, assist the resident—
	(i) In making appointments; and		(i) In making appointments; and
	(ii) By arranging for transportation to and from the dental services location; and		(ii) By arranging for transportation to and from the dentist's office; and
	(5) Promptly, within three days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within three days, the facility must provide documentation of the extenuating circumstances that led to the delay.	§483.55(a)	(4) Promptly refer residents with lost or damaged dentures to a dentist.
	(b) Nursing facilities. The facility -	§483.55	(b) Nursing facilities. The facility -
	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident:	§483.55(b)	(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident:
	(i) Routine dental services (to the extent covered under the State plan); and		(i) Routine dental services (to the extent covered under the State plan); and
	(ii) Emergency dental services;		(ii) Emergency dental services;
	(2) Must, if necessary or if requested, assist the resident—	§483.55(b)	(2) Must, if necessary, assist the resident—
	(i) In making appointments; and		(i) In making appointments; and
	(ii) By arranging for transportation to and from the dental services locations;		(ii) By arranging for transportation to and from the dentist's office; and

	(3) Must promptly, within three days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within three days, the facility must provide documentation of the extenuating circumstances that led to the delay;	§483.55(b)	(3) Must promptly refer residents with lost or damaged dentures to a dentist.
	(4) May not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and		
	(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.		
§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.		§ 483.35 Dietary Services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	
	(a) Staffing. The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, 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:	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.35(b)	

	(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who is qualified based on:	§483.35(a)	(a) Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. (2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.
	(i) Meeting State requirements to practice dietetics, including licensure or certification, or		
	(ii) If the state does not have requirements, registration by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics, or	CMS considers this proposed language to be new. However, the language is drawn from current language; see §483.35(a)(2)	
	(iii) For dietitians hired or contracted with prior to [effective date of final rule], meets these requirements no later than 5 years after [effective date of final rule] 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:	§483.35(a)	(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.
	(i) For designations prior to [effective date of final rule], meets the following requirements no later than 5 years after [effective date of final rule], 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 hospitality from an accredited institution of higher learning; or		
	(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.	§483.35(b)	(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary 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—	§483.35	(c) Menus and nutritional adequacy. Menus must—
	(1) Meet the nutritional needs of residents in accordance with established national guidelines or industry standards.;	§483.35(c)	(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;
	(2) Be prepared in advance;	§483.35(c)	(2) Be prepared in advance; and
	(3) Be followed;	§483.35(c)	(3) Be followed.
	(4) Reflect the religious, cultural and ethnic needs of the residents, 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—	§483.35	(d) Food. Each resident receives and the facility provides—

	(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	§483.35(d)	(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;	§483.35(d)	(2) Food that is palatable, attractive, and at the proper temperature;
	(3) Food prepared in a form designed to meet individual needs;	§483.35(d)	(3) Food prepared in a form designed to meet individual needs; and
	(4) Food that accommodates resident allergies, intolerances, and preferences;		
	(5) Appealing substitutes of similar nutritive value to residents who choose not to eat food that is initially served or who request an alternative meal; and	§483.35(d)	(4) Substitutes offered of similar nutritive value to residents who refuse food served.
	(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.		
	(e) Therapeutic diets.	§483.35	(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.
	(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.	§483.35	(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.	§483.35(f)	(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. (2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.
	(2) Suitable, nourishing alternative meals and snacks must be available for residents who want to eat at non-traditional times or outside of scheduled meal service times and in accordance with the resident plan of care.		
	(3) The facility must offer snacks at bedtime daily.	§483.35(f)	(3) The facility must offer snacks at bedtime daily.

	(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.		(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.
	(g) Assistive devices. The facility must 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	§483.35	(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.
	(h) Paid feeding assistants —	§483.35	(h) Paid feeding assistants —
	(1) State-approved training course. A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if	§483.35(h)	(1) State-approved training course. A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if—
	(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and		(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and
	(ii) The use of feeding assistants is consistent with State law.		(ii) The use of feeding assistants is consistent with State law.
	(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).	§483.35(h)	(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
	(ii) In an emergency, a feeding assistant must call a supervisory nurse for help		(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.
	(3) Resident selection criteria.	§483.35(h)	(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.		(i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.
	(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.		(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

	(iii) The facility must base resident selection on the 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.		(iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.
	(i) Food safety requirements. The facility must—	§483.35	(i) Sanitary conditions. The facility must—
	(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;	§483.35(i)	(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;
	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.		
	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices		
	(iii) This provision does not preclude residents from consuming foods not procured by the facility.		
	(2) Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.	§483.35(i)	(2) Store, prepare, distribute, and serve food under sanitary conditions; and
	(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, and		
	(4) Dispose of garbage and refuse properly.	§483.35 (i)	(3) Dispose of garbage and refuse properly.
§483.65 Specialized rehabilitative services.	*(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness 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—*	§ 483.45 SPECIALIZED REHABILITATIVE SERVICES.	(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must—
	(1) Provide the required services; or	§483.45 (a)	(1) Provide the required services; or

	(2) Obtain the required services from an outside resource (in accordance with §483.70(g)) from a Medicare and/or Medicaid provider of specialized rehabilitative services.	§483.45 (a)	(2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.
	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	§483.45	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.
§483.67 Outpatient rehabilitation services. If the facility provides outpatient rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must meet the needs of the patients in accordance with acceptable standards of practice and the facility must meet the following requirements.	**(a) Organization and staffing**		
	(1) The organization of the service must be appropriate to the scope of the services offered.		
	(2) The facility must ensure the services are organized and staffed to ensure the health and safety of residents.		
	(b) Personnel.		
	(1) The facility must assign one or more individuals to be responsible for outpatient rehabilitative services. The individual responsible for the outpatient rehabilitative services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.		

	(2) The facility must have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services		
	(3) Physical therapy, occupational therapy, speech-language pathology or audiology services, if provided, must be provided by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists as defined in part 484 of this chapter.		
	(c) Delivery of services.		
	(1) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under state law		
	(2) All rehabilitation services orders and progress notes must be documented in the patient's clinical record in accordance with the requirements at §483.70(i).		
	(3) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice.		

§483.70 ADMINISTRATION. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	(a) Licensure. A facility must be licensed under applicable State and local law.	§ 483.75 ADMINISTRATION. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	(a) Licensure. A facility must be licensed under applicable State and local law.
	(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	§ 483.75	(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

	(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); 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. .	§483.75	(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.
	(d) Governing body.	§483.75	(d) Governing body.
	(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	§483.75(d)	(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
	(2) The governing body appoints the administrator who is—	§483.75(d)	(2) The governing body appoints the administrator who is—
	(i) Licensed by the State;		(i) Licensed by the State where licensing is required; and
	(ii) Responsible for management of the facility; and		(ii) Responsible for management of the facility.
	(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) Facility assessment. The LTC facility 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 review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment 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 care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;		
	(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;		
	(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and		
	(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services		
	(2) The facility's resources, including but not limited to,		
	(i) All buildings and/or other physical structures and vehicles;		
	(ii) Equipment (medical and non-medical);		

	(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;		
	(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;		
	(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and		
	(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.		
	(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.		
	(f) Staff qualifications.	§483.75	(g) Staff qualifications.
	(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.	§483.75(g)	(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.
	(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	§483.75(g)	(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.
	(g) Use of outside resources.	§483.75	(h) Use of outside resources.
	(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.	§483.75(h)	(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.

	(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for—	§483.75(h)	(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for—
	(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and		(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and
	(ii) The timeliness of the services.		(ii) The timeliness of the services.
	(h) Medical director.	§483.75	(i) Medical director.
	(1) The facility must designate a physician to serve as medical director.	§483.75(i)	(1) The facility must designate a physician to serve as medical director.
	(2) The medical director is responsible for—	§483.75(i)	(2) The medical director is responsible for—
	(i) Implementation of resident care policies; and		(i) Implementation of resident care policies; and
	(ii) The coordination of medical care in the facility.		(ii) The coordination of medical care in the facility.
	(i) Medical records.	§483.75	(l) Clinical records.
	(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are—	§483.75 (l)	(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—
	(i) Complete;		(i) Complete;
	(ii) Accurately documented;		(ii) Accurately documented;
	(iii) Readily accessible; and		(iii) Readily accessible; and
	(iv) Systematically organized.		(iv) Systematically organized.
	(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is—	§483.75(l)	(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by—
	(i) To the individual, or their resident representative where permitted by applicable law;		(iv) The resident.
	(ii) Required by Law;		(ii) Law;
	(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;		(iii) Third party payment contract; or

	(iv) 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.		(i) Transfer to another health care institution;
	(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use;	§483.75(l)	(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;
	(4) Medical records must be retained for—	§483.75(l)	(2) Clinical records must be retained for—
	(i) The period of time required by State law; or		(i) The period of time required by State law; or
	(ii) Five years from the date of discharge when there is no requirement in State law; or		(ii) Five years from the date of discharge when there is no requirement in State law; or
	(iii) For a minor, three years after a resident reaches legal age under State law.		(iii) For a minor, three years after a resident reaches legal age under State law.
	(5) The medical record must contain—	§483.75(l)	(5) The clinical record must contain—
	(i) Sufficient information to identify the resident;		(i) Sufficient information to identify the resident;
	(ii) A record of the resident's assessments;		(ii) A record of the resident's assessments;
	(iii) The comprehensive plan of care and services provided;		(iii) The plan of care and services provided;
	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;		(iv) The results of any preadmission screening conducted by the State; and
	(v) Physician's, nurse's, and other licensed professional's progress notes; and		(v) Progress notes.
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.		
	(j) Transfer agreement.	§483.75	(n) Transfer agreement.

	(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that—	§483.75(n)	(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that—
	(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and		(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and
	(ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community, will be exchanged between the providers, including but not limited to the information required under §483.15(b)(2)(iii).		(ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
	(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	§483.75(n)	(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
	(k) Disclosure of ownership.	§483.75	(p) Disclosure of ownership.
	(1) The facility must comply with the disclosure requirements of §§420.206 and 455.104 of this chapter.	§483.75(p)	(1) The facility must comply with the disclosure requirements of §§420.206 and 455.104 of this chapter.
	(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in—	§483.75(p)	(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in—

	(i) Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter;		(i) Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter;
	(ii) The officers, directors, agents, or managing employees;		(ii) The officers, directors, agents, or managing employees;
	(iii) The corporation, association, or other company responsible for the management of the facility; or		(iii) The corporation, association, or other company responsible for the management of the facility; or
	(iv) The facility's administrator or director of nursing.		(iv) The facility's administrator or director of nursing.
	(3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.	§483.75(p)	(3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.
	(l) Facility closure-Administrator. Any individual who is the administrator of the facility must:	§483.75	(r) Facility closure-Administrator. Any individual who is the administrator of the facility must:
	(1) Submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:	§483.75(r)	(1) Submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:
	(i) At least 60 days prior to the date of closure; or		(i) At least 60 days prior to the date of closure; or
	(ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;		(ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;
	(2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and	§483.75(r)	(2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

	(3) Include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.	§483.75(r)	(3) Include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.
	(m) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section.	§483.75	(s) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.
	(n) Binding arbitration agreements. If the facility enters into an agreement for binding arbitration with its residents:		
	(1) The facility must ensure that:		
	(i) The agreement is explained to the resident in a form and manner that he or she understands, including in a language the resident understands, and		
	(ii) The resident acknowledges that he or she understands the agreement.		
	(2) The agreement must:		
	(i) Be entered into by the resident voluntarily;		
	(ii) Provide for the selection of a neutral arbiter;		
	(iii) Provide for selection of a venue convenient to both parties.		
	(3) Admission to the facility must not be contingent upon the resident or the resident representative signing a binding arbitration agreement.		

	(4) The agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with Federal, State, or local officials, including but not limited to, Federal and State surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with §483.11(i).		
	(5) The agreement may be signed by another individual if		
	(i) Allowed by state law;		
	(ii) All of the requirements in this section are met; and		
	(iii) That individual has no interest in the facility.		
	(o) Hospice services.	§483.75	(t) Hospice services.
	(1) A long-term care (LTC) facility may do either of the following:	§483.75(t)	(1) A long-term care (LTC) facility may do either of the following:
	(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.		(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
	(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.		(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.
	(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (t)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	§483.75(t)	(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (t)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
	(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services		(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services

	(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:		(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
	(A) The services the hospice will provide		(A) The services the hospice will provide
	(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in § 418.112 (d) of this chapter.		(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in § 418.112 (d) of this chapter.
	(C) The services the LTC facility will continue to provide, based on each resident's plan of care		(C) The services the LTC facility will continue to provide, based on each resident's plan of care
	(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.		(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
	(E) A provision that the LTC facility immediately notifies the hospice about the following:		(E) A provision that the LTC facility immediately notifies the hospice about the following:
	(1) A significant change in the resident's physical, mental, social, or emotional status		(1) A significant change in the resident's physical, mental, social, or emotional status
	(2) Clinical complications that suggest a need to alter the plan of care.		(2) Clinical complications that suggest a need to alter the plan of care.
	(3) A need to transfer the resident from the facility for any condition.		(3) A need to transfer the resident from the facility for any condition.
	(4) The resident's death.		(4) The resident's death.
	(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.		(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

	(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.		(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
	(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.		(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
	(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.		(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
	(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.		(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

	(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.		(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.
	(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:	§483.75(t)	(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:
	(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.		(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
	(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.		(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
	(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.		(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
	(iv) Obtaining the following information from the hospice:		(iv) Obtaining the following information from the hospice:

	(A) The most recent hospice plan of care specific to each patient.		(A) The most recent hospice plan of care specific to each patient.
	(B) Hospice election form.		(B) Hospice election form.
	(C) Physician certification and recertification of the terminal illness specific to each patient.		(C) Physician certification and recertification of the terminal illness specific to each patient.
	(D) Names and contact information for hospice personnel involved in hospice care of each patient.		(D) Names and contact information for hospice personnel involved in hospice care of each patient.
	(E) Instructions on how to access the hospice's 24-hour on-call system.		(E) Instructions on how to access the hospice's 24-hour on-call system.
	(F) Hospice medication information specific to each patient.		(F) Hospice medication information specific to each patient.
	(G) Hospice physician and attending physician (if any) orders specific to each patient.		(G) Hospice physician and attending physician (if any) orders specific to each patient.
	(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.		(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.
	(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.	§483.75(t)	(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.
	(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:	§483.15(g)	(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

	(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	§483.15(g)	(3) Qualifications of social worker. A qualified social worker is an individual with— (i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
	(2) One year of supervised social work experience in a health care setting working directly with individuals.		(ii) One year of supervised social work experience in a health care setting working directly with individuals.
§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 multiunit 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;		
	(2) Present its QAPI plan to the State Agency Surveyor at the first annual recertification survey that occurs after [the effective date of this regulation];		
	(3) Present its QAPI plan to a State 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 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 of feedback and input from direct care/direct access workers, 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 from all departments, including but not limited to the facility assessment required at §483.75(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 (such as root cause analysis, reverse tracer methodology, or health care failure and effects analysis) to determine underlying causes of problems impacting larger systems;		
	(ii) Development of 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 the facility will monitor 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) 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 identified through the data collection and analysis described in paragraphs (c) and (d) of this section.		
	(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 ensuring that:		
	(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.		
	(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 based on performance indicator data, and resident and staff input that reflects organizational processes, functions, and services provided to residents.		
	(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and		

	(6) Clear expectations are set around safety, quality, rights, choice, and respect.		
	(g) Quality assessment and assurance.	§483.75(o)	(o) Quality assessment and assurance.
	(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:		(1) A facility must maintain a quality assessment and assurance committee consisting of—
	(i) The director of nursing services;		(i) The director of nursing services;
	(ii) The Medical Director or his/her designee;		(ii) A physician designated by the facility; and
	(iii) At least 3 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		(iii) At least 3 other members of the facility's staff.
	(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:	§483.75(o)	(2) The quality assessment and assurance committee—
	(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		(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; and		(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.
	(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.		

	(1) 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.	§483.75(o)	(3) 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.
	(2) Demonstration of compliance with the requirements of this section may require State or Federal surveyor access to:		
	(i) Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events;		
	(ii) Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; and		
	(iii) Other documentation considered necessary by a State or Federal surveyor in assessing compliance.		
	(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	§483.75(o)	(4) 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:*	§ 483.65 INFECTION CONTROL. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	(a) Infection control program. The facility must establish an infection control program under which it—
	(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 §483.75(e) and following accepted national standards;	§ 483.65 (a)	(1) Investigates, controls, and prevents infections in the facility; (3) Maintains a record of incidents and corrective actions related to infections.
	(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	§ 483.65 (a)	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
	(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 isolation should be used for a resident;	§483.65	(b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
	(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	§483.65(b)	(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
	(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact,	§483.65(b)	(3) The facility must require staff to wash their hands after each direct resident contact for which hand-washing is indicated by accepted professional practice.
	(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.	§ 483.65(a)	(3) Maintains a record of incidents and corrective actions related to infections.
	(b) Infection prevention and control officer. The facility must designate one individual as the infection prevention and control officer (IPCO) for whom the IPCP at that facility is a major responsibility. The IPCO must:		
	(1) Be a clinician who works at least part-time at the facility, and		
	(2) Have specialized training in infection prevention and control beyond their initial professional degree.		
	(c) IPCO participation on quality assessment and assurance committee. The person designated as the IPCO 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—	§483.25	(n) Influenza and pneumococcal immunizations — (1) Influenza. The facility must develop policies and procedures that ensure that—
	(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;		(i) Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
	(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;		(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		(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
	(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:		(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		(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
	(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.		(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—	§483.25(n)	(2) Pneumococcal disease. The facility must develop policies and procedures that ensure that—
	(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;		(i) Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;		(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		(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
	(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:		(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		(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
	(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal		(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
	(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	§483.65	(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
	(f) 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--		
	(i) 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		
	(ii) 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 [1 year after the effective date of the final rule], 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, policies, 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 Social Security 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.		
	(8) After a violation is detected, the 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 Act and in promoting quality of care.		

§ 483.90 PHYSICAL ENVIRONMENT. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	(a) Life safety from fire.	§ 483.70 PHYSICAL ENVIRONMENT. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	(a) Life safety from fire.
	(1) Except as otherwise provided in this section—	§483.70(a)	(1) Except as otherwise provided in this section—
	(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.		(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

	(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.		(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.
	(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.	§483.70(a)	(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.
	(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.	§483.70(a)	(3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.
	(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.	§483.70(a)	(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.
	(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.	§483.70(a)	(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.
	(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—	§483.70(a)	(6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if—
	(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;		(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;
	(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;		(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

	(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;		(iii) The dispensers are installed in a manner that adequately protects against inappropriate access;
	(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and		(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and
	(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.		(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.
	(7) A long term care facility must:	§483.70(a)	(7) A long term care facility must:
	(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.		(i) Install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.
	(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.		(ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.
	(iii) Exception:		(iii) Exception:

	(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or		(A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or
	(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems .		(B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems .
	(8) A long term care facility must:	§483.70(a)	(8) A long term care facility must:
	(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html . Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.		(i) Install an approved, supervised automatic sprinkler system in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html . Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

	(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html . Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.		(ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html . Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.
	(b) Emergency power.	§483.70(b)	(b) Emergency power.
	(1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.	§483.70(b)	(1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.
	(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.	§483.70(b)	(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

	(c) Space and equipment. The facility must—	§483.70	(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	§483.70(c)	(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and
	(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	§483.70(c)	(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.
	(3) Conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.		
	(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.	§483.70	(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.
	(1) Bedrooms must—	§483.70(d)	(1) Bedrooms must—
	(i) Accommodate no more than four residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after [effective date of final rule], bedrooms must accommodate no more than two residents.		(i) Accommodate no more than four residents;
	(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;		(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;
	(iii) Have direct access to an exit corridor;		(iii) Have direct access to an exit corridor;
	(iv) Be designed or equipped to assure full visual privacy for each resident;		(iv) Be designed or equipped to assure full visual privacy for each resident;

	(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;		(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;
	(vi) Have at least one window to the outside; and		(vi) Have at least one window to the outside; and
	(vii) Have a floor at or above grade level.		(vii) Have a floor at or above grade level.
	(2) The facility must provide each resident with—	§483.70(d)	(2) The facility must provide each resident with—
	(i) A separate bed of proper size and height for the safety and convenience of the resident;		(i) A separate bed of proper size and height for the convenience of the resident;
	(ii) A clean, comfortable mattress;		(ii) A clean, comfortable mattress;
	(iii) Bedding appropriate to the weather and climate; and		(iii) Bedding appropriate to the weather and climate; and
	(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.		(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.
	(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations—	§483.70(d)	(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations—
	(i) Are in accordance with the special needs of the residents; and		(i) Are in accordance with the special needs of the residents; and
	(ii) Will not adversely affect residents' health and safety.		(ii) Will not adversely affect residents' health and safety.

	(e) Toilet 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 from State and local authorities or are newly certified after [effective date of the final rule], each resident room must have its own bathroom equipped with at least a toilet, sink and shower.	§483.70(e)	(e) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities.
	(f) Resident call system. The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from—	§483.70	(f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from—
	(1) Each resident's bedside; and	§483.70(f)	(1) Resident rooms; and
	(2) Toilet and bathing facilities.	§483.70(f)	(2) Toilet and bathing facilities.
	(g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must—	§483.70	(g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must—
	(1) Be well lighted;	§483.70(g)	(1) Be well lighted;
	(2) Be well ventilated;	§483.70(g)	(2) Be well ventilated, with nonsmoking areas identified;
	(3) Be adequately furnished; and	§483.70(g)	(3) Be adequately furnished; and
	(4) Have sufficient space to accommodate all activities.	§483.70(g)	(4) Have sufficient space to accommodate all activities.
	(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—	§483.70	(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—
	(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	§483.70(h)	(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;
	(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	§483.70(h)	(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

	(3) Equip corridors with firmly secured handrails on each side; and	§483.70(h)	(3) Equip corridors with firmly secured handrails on each side; and
	(4) Maintain an effective pest control program so that the facility is free of pests and rodents.	§483.70(h)	(4) Maintain an effective pest control program so that the facility is free of pests and rodents.
	(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety, including but not limited to non-smoking residents.		
§483.95 Training requirements. A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at §483.70(e). Training topics must include but are not limited to--	**(a) Communication. A facility must include effective communications as mandatory training for direct care/direct access personnel**		
	(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 and §483.11, 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) 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--	§483.75 (8) *This language can also be found in the proposed regulations at§483.35(d)(7)	(e) Required training of nursing aides —(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—
	(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year	§483.75(e)(8) *This language can also be found in the proposed regulations at §483.35(d)(7)	(i) 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.	§483.75(e)(8) *This language can also be found in the proposed regulations at §483.35(d)(7)	(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and
	(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	§483.75(e)(8) *This language can also be found in the proposed regulations at §483.35(d)(7)	(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
	(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.	§483.75	(q) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160 of this part.
	(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).		

§483.118 [Amended]	**In §483.118, amend paragraphs (b)(1) and (c)(2)(i) by removing the reference "§483.12(a)" and adding in its place the reference "§483.15(b)".**		
§483.130 [Amended]	**In §483.130, amend paragraphs (m)(5) and (m)(6) by removing the reference "§483.12(a)" and adding in its place the reference §483.15(b)".**		
§483.138 [Amended]	**In §483.138, amend paragraphs (a) introductory text and (b)(1) by removing the reference "§483.12(a)" and adding in its place the reference "§483.15(b)".**		
§483.151 [Amended]	**In §483.151, amend paragraph (a)(3) by removing the reference "§483.75(e)" and adding in its place the reference "§483.35(c) and (d) and §483.95(g)".**		
§483.204 [Amended]	**In §483.204, amend paragraph (b) by removing the reference "§483.12 of this part" and adding in its place the reference "§483.15(h)".**		
§483.206 [Amended]	**In §483.206, amend paragraph (a) by removing the reference "(See §§483.5 and 483.12(a)(1))" and adding in its place the reference "(See §483.5)".**		