



CMS Training Requirements for Long-Term Care (LTC) Facilities



A Division of



Foreword

The Centers for Medicare and Medicaid Service (CMS) have issued the final rule that updates the requirements that Long-Term Care facilities must meet to participate in their programs. These regulations are being implemented in three phases – Phase 1: November 28, 2016; Phase 2: November 28, 2017 and Phase 3: November 28, 2019.

Our purpose in preparing this document is to identify those specific changes that will have an impact on staff training. Specifically, we are interested in what in-service and continuing education will be required to maintain and enhance nurses' competence to provide quality health care to CMS-funded residents.

In addition, we have developed a comprehensive Competency Profile for LTC nurses using the compiled information in this document. We are identifying which existing Learning Nurse educational resources can be used to provide this training, and what other resources need to be identified and/or developed.

Both these documents are available in the Learning Nurse Library, in the Reports section. Questions and comments should be directed to the contact listed below.

Russell Sawchuk

LearningNurse.org / Steppingstones.ca
May 25, 2017

Phone: 1-800-267-9997 (Toll-free USA and Canada)

E-mail: russ@steppingstones.ca

Webs: <http://www.learningnurse.org> and <http://www.steppingstones.ca>

Disclaimer: The information in this document was extracted directly from the on-line Federal Register (*Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations, pages 68688 – 68872*) for our own and our clients' use. Any interpretations or opinions expressed herein are solely our own, and do not necessarily reflect the view of CMS or any other organization. We assume no responsibility or liability whatsoever for use of this document.

If you need more information on the CMS final rule, please contact the Centers for Medicare & Medicaid Services, HHS, LTC Regulations Team at 410-786-6633.

Table of Contents

Foreword	i
Assessment (§ 483.70)	1
Training requirements (§ 483.95)	1
(a) Communication	1
(b) Resident’s rights and facility responsibilities	1
(c) Abuse, neglect and exploitation	1
(d) Quality assurance and performance improvement	2
(e) Infection control	2
(f) Compliance and ethics	2
(g) Required in-service training for nurse aides	2
(h) Required training of feeding assistants	2
(i) Behavioural health	2
Implications for additional training	3
Resident assessment ((§ 483.20)	3
Comprehensive person-centered care planning (§ 483.21)	3
Quality of care (§ 483.25)	4
Nursing services (§ 483.35)	4
Pharmacy services (§ 483.45)	5
Food and nutrition services (§ 483.60)	6
Resident rights (§ 483.10)	7
(a) Resident rights	7
(b) Exercise of rights	7
(c) Planning and implementing care	8
(d) Choice of attending physician	9
(e) Respect and dignity	10
(f) Self-determination	11
(g) Information and communication	18
(h) Privacy and confidentiality	24
(i) Safe environment	25
(j) Grievances	25
(k) Contact with external entities	27
Freedom from abuse, neglect and exploitation (§ 483.12)	28

Table of Contents

Quality assurance and performance improvement (§ 483.75)	30
(a) Quality assurance & performance improvement program	30
(b) Program design and scope	30
(c) Program feedback, data systems and monitoring	30
(d) Program systematic analysis and systemic action	31
(e) Program activities	31
(f) Governance and leadership	32
(g) Quality assessment and assurance	32
(h) Disclosure of information	33
(i) Sanctions	33
Infection Control (§ 483.80)	34
(a) Infection prevention and control program	34
(b) Infection preventionist (IP)	35
(c) IP participation on quality assessment and assurance committee	35
(d) Influenza and pneumococcal immunizations	35
(e) Linens	36
(f) Annual review	36
Compliance and ethics program (§ 483.85)	37
(a) Definitions	37
(b) General rule	37
(c) Required components for all facilities	37
(d) Additional required components for five or more facilities	39
(e) Annual review	39
Behavioural health services (§ 483.40)	40
Definitions (§ 483.5)	42

Assessment (§ 483.70)

The 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:

- (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
- (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;

Training requirements (§ 483.95)

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 staff.
- (b) **Resident's rights and facility responsibilities.** A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at § 483.10, respectively. (*See page 7 below*).
- (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. (*See page 28 below*).
 - (2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.
 - (3) Dementia management and resident abuse prevention.

- (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. (See page 30 below).
- (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). (See page 34 below).
- (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— (See page 37 below).
 - (1) An effective way to communicate that program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.
 - (2) Annual training if the operating organization operates five or more facilities.
- (g) **Required in-service training for nurse aides.** In-service training must—
 - (1) Be sufficient to ensure the continuing competence of *nurse aides*, but must be no less than 12 hours per year.
 - (2) Include dementia management training and resident abuse prevention training.
 - (3) Address areas of weakness as determined in *nurse aides'* performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.
 - (4) For *nurse aides* providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
- (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 § 483.60.
- (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). (See page 40 below).

Implications for additional training

A review of the detailed requirements of the CMS final rule identified these additional possible nursing competencies for which training may be required.

Resident assessment (§ 483.20)

(b) (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:

(xvi) Discharge planning.

(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.

[Implication: knowledge and ability to conduct a thorough health assessment of older adults.]

Comprehensive person-centered care planning (§ 483.21)

(a) Baseline care plans.

(1) The facility must develop and implement 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.

(b) Comprehensive care plans.

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

(2) A comprehensive care plan must be—

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

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—

(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) To the extent practicable, the participation of the resident and the resident's representative(s).

[Implication: competencies to develop basic and comprehensive person-centered care plans.]

Quality of care (§ 483.25)

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.

(b) Skin integrity—(1) Pressure ulcers.

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

- (i) 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
- (ii) 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.

[Implication: competencies to prevent and treat pressure ulcers in residents.]

Nursing Services (§ 483.35)

We are finalizing our proposal to require facilities to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments and care plans. This will require facilities to identify, document, and maintain any training, certification, and similar records in an existing personnel file or training record for direct care personnel. This specifically includes nursing services and food and nutrition services but may apply to any direct care provider. We anticipate that any initial competency requirements will be identified by the facility assessment with documentation of individual accomplishments managed by an administrative position, likely an office assistant, as an addition to existing documentation.

[Implication: learning management system (LMS) to track, record, verify and report training and educational activities.]

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).

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

- (4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.
- (c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
 - (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.

[Implication: learning management system (LMS) to assess, manage, record and report on continuing competence activities and status of nurses and nurse aides.]

Pharmacy services (§ 483.45)

- (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
 - (i) Anti-psychotic;
 - (ii) Anti-depressant;
 - (iii) Anti-anxiety; and
 - (iv) Hypnotic.
- (d) Unnecessary drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—
 - (1) In excessive dose (including duplicate drug therapy); or
 - (2) For excessive duration; or
 - (3) Without adequate monitoring; or
 - (4) Without adequate indications for its use; or
 - (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
 - (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
- (e) Psychotropic drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—
 - (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
 - (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

- (f) Medication errors. The facility must ensure that its—
 - (1) Medication error rates are not 5 percent or greater; and
 - (2) Residents are free of any significant medication errors.

[Implication: knowledge of psychotropic drugs and medication administration procedures including competencies to minimize and/or eliminate medication errors].

Food and nutrition services (§ 483.60)

- (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.

[Implication: knowledge of appropriate feeding procedures and ability to supervise feeding assistants].

Resident Rights (§ 483.10)

(a) Residents rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

- (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
- (2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

(b) Exercise of rights.

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

- (1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility
- (2) The resident has the right to be free of interference, coercion, discrimination, 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.
- (3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
 - (i) The 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) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
- (5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.
- (6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.
- (7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law
 - (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.
 - (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
 - (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

(c) **Planning and implementing care.**

The resident has the right to be informed of, and participate in, his or her treatment, including:

- (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
- (2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
 - (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

- (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, 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 significant changes to the plan of care.
- (3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—
- (i) Facilitate the inclusion of the resident and/or resident representative.
 - (ii) Include an assessment of the resident’s strengths and needs.
 - (iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.
- (4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
- (5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
- (6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.
- (7) The right to self-administer medications if the interdisciplinary team, as defined by § 483.21(b)(2)(ii), has determined that this practice is clinically appropriate.
- (8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.
- (d) **Choice of attending physician.**
The resident has the right to choose his or her attending physician.
- (1) The physician must be licensed to practice, and

- (2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.
- (3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.
- (4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.
- (5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

(e) **Respect and dignity.**

The resident has a right to be treated with respect and dignity, including:

- (1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with § 483.12(a)(2).
- (2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
- (3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
- (4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
- (5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
- (6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

- (7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
 - (i) To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
 - (ii) To relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
 - (iii) Solely for the convenience of staff.
- (8) A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

(f) **Self-determination.**

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

- (1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.
- (2) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.
- (3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
- (4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.
 - (i) The facility must provide immediate access to any resident by—
 - (A) Any representative of the Secretary,
 - (B) Any representative of the State,
 - (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.),
 - (D) The resident's individual physician,

- (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.),
 - (F) Any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and
 - (G) The resident representative.
- (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;
 - (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;
 - (iv) The facility must provide reasonable access to a resident by any entity 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
 - (v) 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, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.
 - (vi) A facility must meet the following requirements:
 - (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.
 - (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a

same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

- (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
 - (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.
- (5) The resident has a right to organize and participate in resident groups in the facility.
- (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
 - (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
 - (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
 - (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
 - (A) The facility must be able to demonstrate their response and rationale for such response.
 - (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.
- (6) The resident has a right to participate in family groups.
- (7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
- (8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

- (9) The resident has a right to choose to or refuse to perform services for the facility and 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—
- (i) The facility has documented the resident’s need or desire for work in the plan of care;
 - (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
 - (iii) Compensation for paid services is at or above prevailing rates; and
 - (iv) The resident agrees to the work arrangement described in the plan of care.
- (10) The resident has a right to 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.
- (i) 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, upon written authorization of a resident, the facility must act as a fiduciary of the resident’s funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.
 - (ii) Deposit of funds.
 - (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents’ personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain a resident’s personal funds that do not exceed \$100 in a noninterest bearing account, interest-bearing account, or petty cash fund.
 - (B) Residents whose care is funded by Medicaid: The facility must deposit the residents’ personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The facility must maintain personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

- (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.
 - (B) 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.
 - (iv) 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
 - (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.
 - (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.
 - (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.
- (11) 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.)

- (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:
 - (A) Nursing services as required at § 483.35.
 - (B) Food and Nutrition services as required at § 483.60.
 - (C) An activities program as required at § 483.24(c).
 - (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.
 - (F) Medically-related social services as required at § 483.40(d).
 - (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. Paragraphs (f)(11)(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:
 - (A) Telephone, including a cellular phone.
 - (B) Television/radio, personal computer or other electronic device for personal use.
 - (C) Personal comfort items, including smoking materials, notions and novelties, and confections.
 - (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

- (E) Personal clothing.
 - (F) Personal reading matter.
 - (G) Gifts purchased on behalf of a resident.
 - (H) Flowers and plants.
 - (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under § 483.24(c).
 - (J) Non-covered special care services such as privately hired nurses or aides.
 - (K) Private room, except when therapeutically required (for example, isolation for infection control).
 - (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, especially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by § 483.60.
- (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included in accordance with § 483.60.
- (2) In accordance with § 483.60(c) through (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 non-covered item or service if such item or service is specifically requested by the resident.
 - (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.
 - (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(g) Information and communication.

- (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
- (2) The resident has the right to access personal and medical records pertaining to him or herself.
 - (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and
 - (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:
 - (A) Labor for copying the 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) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.
- (4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including;
 - (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes—
 - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

- (B) 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.
 - (C) 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 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
 - (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, noncompliance with the advance directives requirements and requests for information regarding returning to the community.
- (ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.);
 - (iii) Information regarding Medicare and Medicaid eligibility and coverage;
 - (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
 - (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, noncompliance with the advance directives requirements and requests for information regarding returning to the community.

- (5) The facility must post, in a form and manner accessible and understandable to residents, and resident representatives:
 - (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 Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and
 - (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, noncompliance with the advance directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.
- (6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.
- (7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:
 - (i) A telephone, including TTY and TDD services;
 - (ii) The internet, to the extent available to the facility; and
 - (iii) Stationery, postage, writing implements and the ability to send mail.
- (8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
 - (i) Privacy of such communications consistent with this section; and
 - (ii) Access to stationery, postage, and writing implements at the resident's own expense.

- (9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research.
- (i) If the access is available to the facility
 - (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
 - (iii) Such use must comply with state and federal law.
- (10) The 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
 - (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
- (11) The facility must—
- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.
 - (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
 - (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
 - (iv) The facility shall not make available identifying information about complainants or residents.
- (12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
- (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.
- (13) 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.
- (14) Notification of changes.
- (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s), when there is—
 - (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);
 - (C) A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
 - (D) A decision to transfer or discharge the resident from the facility as specified in § 483.15(c)(1)(ii).
 - (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in § 483.15(c)(2) is available and provided upon request to the physician.

- (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is—
 - (A) A change in room or roommate assignment as specified in § 483.10(e)(6); or
 - (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
- (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
- (15) 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(c)(9).
- (16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident’s stay.
 - (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.
 - (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;
- (17) 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—
 - (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
 - (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
 - (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in § 483.10(g)(17)(i)(A) and (B) of this section.

- (18) 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.
- (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 30 days from the resident's date of discharge from the facility.
 - (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

(h) **Privacy and confidentiality.**

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

- (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.
- (2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.
- (3) The resident has a right to secure and confidential personal and medical records.

- (i) 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.
- (ii) 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.

(i) **Safe environment.**

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

- (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
 - (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
 - (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
- (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;
- (4) Private closet space in each resident room, as specified in § 483.90(d)(2)(iv);
- (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 to 81 °F; and
- (7) For the maintenance of comfortable sound levels.

(j) **Grievances.**

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

- (2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.
- (3) The facility must make information on how to file a grievance or complaint available to the resident.
- (4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
 - (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
 - (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
 - (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
 - (iv) Consistent with § 483.12(c)(1), 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 Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation of any of these residents' rights within its area of responsibility; and
- (vii) Maintaining evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

(k) **Contact with external entities.**

A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman, and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.)), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.

Freedom from abuse, neglect and exploitation (§ 483.12)

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

(a) The facility must—

- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
- (2) Ensure that the resident is free from physical or chemical 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.
- (3) Not employ or otherwise engage individuals who—
 - (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
 - (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
 - (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
- (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(b) The facility must develop and implement written policies and procedures that:

- (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
- (2) Establish policies and procedures to investigate any such allegations, and
- (3) Include training as required at paragraph § 483.95.
- (4) Establish coordination with the QAPI program required under § 483.75.

- (5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.
 - (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.
 - (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.
 - (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.
 - (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.
 - (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
- (c) In response to allegations of abuse, 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, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
 - (2) Have evidence that all alleged violations are thoroughly investigated.
 - (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
 - (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Quality assurance and performance improvement (§ 483.75)

(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. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;
- (2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;
- (3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and
- (4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

(b) **Program design and scope.**

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

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

(c) **Program feedback, data systems and monitoring.**

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

- (1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.
- (2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at § 483.70(e) and including how such information will be used to develop and monitor performance indicators.
- (3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.
- (4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

(d) **Program systematic analysis and systemic action.**

- (1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.
- (2) The facility will develop and implement policies addressing:
 - (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
 - (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems ; and
 - (iii) How 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) As a part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at § 483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas 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 that reflect organizational process, functions, and services provided to resident based on performance indicator data, and resident and staff input, and other information.
- (5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and
- (6) Clear expectations are set around safety, quality, rights, choice, and respect.

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

- (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:
 - (i) The director of nursing services;
 - (ii) The Medical Director or his or her designee;
 - (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and
 - (iv) The infection control and prevention officer.

- (2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
- (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary; and
 - (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; and
 - (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

(h) **Disclosure of information.**

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

(i) **Sanctions.**

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

Infection control (§ 483.80)

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

(a) Infection prevention and control program.

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

- (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to § 483.70(e) and following accepted national standards;
- (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
 - (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
 - (ii) When and to whom possible incidents of communicable disease or infections should be reported;
 - (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
 - (iv) When and how isolation should be used for a resident; including but not limited to:
 - (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
 - (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
 - (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
 - (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

- (3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.
- (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(b) **Infection preventionist (IP).**

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

- (1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;
- (2) Be qualified by education, training, experience or certification;
- (3) Work at least part-time at the facility; and
- (4) Have completed specialized training in infection prevention and control.

(c) **IP participation on quality assessment and assurance committee.**

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

(d) **Influenza and pneumococcal immunizations—**

- (1) **Influenza.** The facility must develop policies and procedures to ensure that—
 - (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
 - (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
 - (iii) The resident or the resident's representative has the opportunity to refuse immunization; and
 - (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

- (A) That the resident or resident’s representative was provided education regarding the benefits and potential side effects of influenza immunization; and
 - (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.
- (2) **Pneumococcal disease.** The facility must develop policies and procedures to ensure that—
 - (i) Before offering the pneumococcal immunization, each resident or the resident’s representative receives education regarding the benefits and potential side effects of the immunization;
 - (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
 - (iii) The resident or the resident’s representative has the opportunity to refuse immunization; and
 - (iv) The resident’s medical record includes documentation that indicates, at a minimum, the following:
 - (A) That the resident or resident’s representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
 - (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
- (e) **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.

Compliance and ethics program (§ 483.85)

(a) **Definitions.**

For purposes of this section, the following definitions apply:

Compliance and ethics program means, with respect to a facility, a program of the operating organization that—

- (1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the *Act* and in promoting quality of care; and
- (2) Includes, at a minimum, the required components specified in paragraph (c) of this section. High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization. Operating organization means the individual(s) or entity that operates a facility.

(b) **General rule.**

Beginning on November 28, 2017, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.

(c) **Required components for all facilities.**

The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:

- (1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the *Act* and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.
- (2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, 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 *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 the *Act* and in promoting quality of care.

Behavioural health services (§ 483.40)

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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

- (a) The facility must have sufficient staff who provide direct services to residents 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 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—
 - (1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or posttraumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;
 - (2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and
 - (3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
- (c) If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—

- (1) Provide the required services, including specialized rehabilitation services as required in § 483.65; or
 - (2) Obtain the required services from an outside resource (in accordance with § 483.70(g) of this part) from a Medicare and/or Medicaid provider of specialized rehabilitative services.
- (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

Definitions (§ 483.5)

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

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

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

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

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

Licensed health professional. A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.

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

Mistreatment means inappropriate treatment or exploitation of a resident.

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

Nurse aide. 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.

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 any of the following:

- (1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (3) Legal representative, as used in section 712 of the Older Americans Act; or,
- (4) The court-appointed guardian or conservator of a resident.
- (5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

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

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

NOTES