

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9310 HOUSE LABOR & COMMERCE

ANALYSIS CONTINUATION:

that workers' compensation coverage is provided only to those who are involved in a wage earning activity.

Passage of this legislation would have no fiscal impact on the Department of Law.

FISCAL NOTE

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STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 214

Revision Date: _____
Title: An Act relating to an employer's knowledge
of an employee's physical condition...
Sponsor: Rules Committee
Requestor: House Labor and Commerce

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: ATAP
COMPONENT SERIAL NO. 220
See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
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FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

This legislation provides includes ATAP participants, except for those engaged in subsidized and unsubsidized employment or on-the-job training, in the list of persons who are not covered by worker's compensation. It has no fiscal impact.

5/4/97

Prepared by: Jim Nordlund
Division: Public Assistance

Phone: 465-2680
Date: 04/03/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Date: 4-3-97

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SPONSOR STATEMENT AND SECTIONAL ANALYSIS HB 214

HB 214, which is supported by the Department of Labor, makes two important adjustments to Title 23 pertaining to workers' compensation. Sections 1 and 2 amend AS 23.30 to comport with federal law. Sections 3 and 4 amend Alaska workers' compensation law to reflect changes made to public assistance eligibility.

Section 1:

This section aligns Alaska's Second Injury Fund with 42 U.S.C. 12101-12213 (Americans with Disabilities Act). It amends AS 23.30.022 to provide that an employee who, following a conditional offer of employment, makes a false representation during a medical inquiry or examination regarding the employee's physical condition may be barred from receiving workers' compensation for an injury causally connected to the false representation. Currently, AS 23.30022 refers to false representations of physical condition in an "employment application or preemployment questionnaire".

The ADA prohibits many employers from making inquiries designed to obtain information regarding disabilities prior to a conditional offer of employment, including inquiries made in the employment application and preemployment questionnaire. An employer subject to the ADA could not comply with the ADA and benefit from AS 23.30.022, while an employer who did not comply with the ADA might benefit at the expense of an employee's rights under the ADA. Section 1 of HB 214 replaces the employment application or preemployment questionnaire of the current statute with the ADA permitted examinations or inquires after a conditional offer of employment. The employer who complies with the ADA will be able to benefit from AS 23.30.022, and employment candidates will not be asked to chose between exercising their rights under the ADA and potentially losing their workers' compensation benefits.



Representative Pete Kott

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Section 2:

This section deletes the requirement that an employer acquire written knowledge of a qualifying impairment before hiring an employee who later suffers a second injury whose resulting compensation payments are reimbursable by the Second Injury Fund. In order to obtain Second Injury Fund reimbursement, an employer will be able to continue to show that the employee was "retained" in the employment after the employer acquired written knowledge of the employee's impairment.

Section 3:

The Alaska temporary assistance program, AS 47.27, was enacted in 1996 as part of welfare reform. One of its provisions, AS 47.27.035, requires that, unless exempt under that statute, participants in the Alaska temporary assistance program must participate in "work activities" in order to receive assistance or services under the program. "Work activities," as defined in AS 47.27.900, includes paid employment and paid on-the-job training, as well as unpaid activities such as community work service and job search and preparation activities. Section 3 of HB 214 would amend AS 23.30.230(a), which contains the current list of persons excluded from workers' compensation coverage, to add Alaska temporary assistance participants who are engaged in an unpaid work activity. This amendment ensures that workers' compensation coverage is provided only to those who are involved in a wage earning activity.

Section 4:

Defines "on-the-job training", as that phrase is used in Section 3 of this bill.

Section 5:

Because the amendments contained in sections 3 and 4 are linked to the new AS 47.27.035, Section 5 of this bill ties the effective date of Sections 3 and 4 to the effective date of AS 47.27.035.

Section 6:

Establishes an immediate effective date, except as provided in Section 5.

HB 214 will make Alaska law consistent with Federal ADA law and will clarify an area of legal uncertainty created with the passage of welfare reform. I urge your support.

A

MEMORANDUM

STATE OF ALASKA DEPARTMENT OF LABOR Office of the Commissioner

TO: The Honorable Bruce Botelho
Attorney General
Department of Law

THRU: David Ramseur
Acting Chief of Staff
Office of the Governor

FROM: *Tom Cashen*
Tom Cashen
Commissioner

DATE: May 12, 1995

FILE: OM 1-3 B

PHONE: 465-2700

SUBJECT: Request for
Attorney General
Opinion Regarding
AS 23.30.022 and
AS 23.30.205(c) as
Related to ADA

X AG Opinion Binder

The Department of Labor's Workers' Compensation Division is requesting a formal Attorney General's opinion concerning AS 23.30.022 and AS 23.30.205 (c). It is alleged that AS 23.30.022 and AS 23.30.205 (c) are in direct conflict with the Americans with Disabilities Act (ADA). If that is the case, are these statutes preempted under the Supremacy Clause Act of the United States Constitution?

The Workers' Compensation Division provides every injured worker in Alaska an informative pamphlet regarding the workers' compensation system and process. AS 23.30.022 is referenced in the current pamphlet. An insert advising injured workers to contact the Equal Employment Opportunity Commission with any questions regarding their injury as related to ADA is included with the pamphlet. The insert is a temporary measure until language acknowledging the potential conflict is published in a new pamphlet. Is the language found in the insert sufficient?

Attached is a copy of a letter from Representative Kott requesting an Attorney General opinion, the current Workers' Compensation pamphlet, and a pamphlet insert.

Attachments (3)

cc: Representative Pete Kott
Dwight Perkins, Legislative Liaison, DOL
Paul Grossi, Director, WC
Jakob Sanders, Admin Officer, WC

The purpose of a second injury fund is to encourage employers to hire persons with certain permanent pre-existing physical impairments by ameliorating the employer's cost of potential work-related injury. See, Sea-Land Services v. Second Injury Fund, 737 P.2d 793, 795 (Alaska 1987); Employers Commercial Union Ins. Group v. Christ, 513 P.2d 1090, 1093 (Alaska 1973). While this is the primary purpose of second injury funds, they are designed to achieve this purpose without reducing the benefits available to the employee whose disability is greater because of pre-existing impairment.³ The Fund reimburses employers for compensation payments exceeding 104 weeks if, because of the pre-existing condition, the employee's disability is substantially greater than would result from the injury alone (AS 23.30.205(a)) or, if the employee dies, the employee would not have died except for the pre-existing impairment (AS 23.30.205(b)).

In order to be eligible for Fund reimbursement, the employer must:

...establish by written records that the employer had knowledge of the permanent physical impairment before the subsequent injury and that the employee was hired or retained in employment after the employer acquired that knowledge.

AS 23.30.205(c). The written record requirement:

helps ensure that Fund reimbursement furthers the statutory purpose by providing evidence that the employer actually knew of the employee's pre-existing impairment; it

are unrelated to industrial injuries. An employee need not have a prior work-related injury for an employer to be entitled to use the fund. The class intended to be benefitted is broader than workers who have suffered industrial injuries.

³Professor Larson argues that if the sole purpose of second injury fund statutes was to encourage employers to hire those with preexisting impairments by limiting exposure to liability, pure apportionment statutes achieve this with greater fairness to employers, albeit greater hardship to employees. If the purpose was only to ameliorate the impact of an employee's prior impairments upon his employer, there would be no need for prior knowledge, since the cost of prior impairment, not having arisen from the employment, should not be borne by the employer. 2 A. Larson, Workmen's Compensation Law, § 59.33(e), at 10-518 (1992).

protects the Fund against spurious or collusive claims.

Sea-Land Services, 737 P.2d at 795, citing U.S. Pipe & Foundry Co. v. Caraway, 546 S.W.2d 215, 219 (Tenn. 1977). The written record requirement also serves to reduce litigation on the question of whether the employer had knowledge of the pre-existing impairment. Sea-Land Services, supra; Ketchikan Gateway Borough v. Saling, 604 P.2d 590 (Alaska 1979); A. Larson, Workmen's Compensation Law, Sec. 59.33(f), Vol.2, p. 10-523 (1992).

2. False Statement Exclusion

As part of a general reconstruction of the workers' compensation laws in 1988, AS 23.30.022 was adopted. § 5 ch 79 SLA 1988. It provides:

An employee who knowingly makes a false statement as to the employee's physical condition on an employment application or preemployment questionnaire may not receive benefits under this chapter if

(1) the employer relied upon the false representation and this reliance was a substantial factor in the hiring; and

(2) there was a causal connection between the false representation and the injury to the employee.

This provision protects the employer from compensation liability where the employee misrepresents his physical condition, the employer relies on the false representation to the extent that it was a substantial factor in hiring, and the employee incurs an injury which is causally connected to the false representation. Unlike AS 23.30.250, which imposes a criminal penalty for willful misrepresentation in the workers' compensation process, this provision addresses knowing misrepresentation prior to the injury and protects the employer as well as excludes the employee. It complements the Second Injury Fund mechanism. If the employee divulged the information, the employer had a "written record" and could file a claim for Fund protection if an injury resulted in significant disability. On the other hand, if the employee knowingly concealed the information, the employer would not have access to Fund reimbursement in the event of injury, but in certain cases the employer would be able to avoid liability altogether.

'The misrepresentation exclusion applies only where the employee's misrepresentation is causally related to the injury; e.g., in those cases where the employer could have provided

3. The Americans with Disabilities Act (ADA)

The ADA is designed to:

provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life; to provide enforcement standards addressing discrimination against individuals with disabilities, and to ensure that the federal government plays a central role in enforcing these standards on behalf of individuals with disabilities.

Senate Rep. No. 116, 101st Cong., 1st Sess. 9 (1989). In order to accomplish these purposes, the ADA prohibits discrimination against a qualified individual with a disability in job application procedures, hiring, compensation, and other terms and conditions of employment. ADA 42 U.S.C. §12112(a). This prohibition applies to all employers of 15 or more employees, except Indian tribes, certain religious organizations and the federal government. 29 CFR § 1630.2(e). Through regulations enforcing 42 U.S.C. § 12132, these provisions also apply to state and local governments. 28 CFR 35.140.

In particular, the ADA explicitly prohibits pre-employment medical examinations or inquiries of job applicants as to the existence of a disability or the severity or nature of the disability. 42 U.S.C. § 12112(c)(2). On the other hand, the ADA permits employers to require medical examinations after an offer of employment and prior to the commencement of job duties. The information obtained regarding the medical condition or history of the applicant must be collected and maintained on separate forms, placed in separate medical files, and treated as a confidential medical record. 42 U.S.C. § 12112(c)(3)(B). For current employees, no examination may be required or inquiries made as to disability "unless such examination or inquiry is shown to be job-related and consistent with business necessity." 42 U.S.C. § 12112(c)(4)(A).

injury-preventing accommodation for an impairment, had it been known, or the employee was not qualified to perform the work without significant risk of substantial harm to himself. In many cases there is no causal relationship between the injury and the impairment, although the two may combine to result in greater disability.

The reasoning behind these restrictions was set forth at length in the House Education and Labor Committee:

Historically, employment application forms and employment interviews requested information concerning an applicant's physical or mental condition. This information was often used to exclude applicants with disabilities -- particularly those with so-called hidden disabilities such as epilepsy, diabetes, emotional illness, heart disease and cancer -- before their ability to perform the job was even evaluated.

In order to assure that misconceptions do not bias the employment selection process, the legislation sets forth a process which begins with a prohibition on pre-offer medical examinations or inquiries. . . . This prohibition against inquiries regarding disability is critical to assure that bias does not enter the selection process.

H.R. Rep. No. 485, 101 Cong., 2d Sess., pt. 2, at 72-73 (1990).

The ADA provides that state and local governments may not exclude a qualified person with a disability from participation in government services, benefits or programs, nor deny benefits of government services, benefits or programs by reason of such disability. 42 U.S.C. § 12132. Such programs include services of the workers' compensation division and eligibility for workers' compensation benefits.

While concern was expressed in Congress regarding ADA conflicts with OSHA workplace safety standards or other state health regulations, no explicit discussion of conflicts with second injury funds or workers' compensation laws is contained in committee reports.⁵ Regarding potential conflict with workplace safety laws, the United States Attorney General was directed to "exercise coordinating authority to avoid and eliminate such conflicts." H.R. Rep. No. 485, 101st Cong. 2d Sess., pt.2, at 136 (1990).

4. Federal Preemption

Article VI of the Constitution of the United States

⁵There was testimony relating "myths about job performance, safety, insurance costs" as a barrier to employment. H.R. Rep. No. 485, 101st Cong., 2d Sess., pt 2 at 33 (1990).

provides that the laws of the United States "shall be the supreme Law of the Land; . . . any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." Art. VI, cl.2. Thus, since M'Culloch v. Maryland, 17 U.S. 3136, 427, (1819), state law that conflicts with federal law is without effect.

In general, the courts are reluctant to infer preemption of state law. Cipollone v. Liggett Group, Inc., 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407 (1992); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152 (1947). "Consideration under the Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law." Building Trades Council v. Associated Builders, 507 U.S. 218, 113 S.Ct. 1190, 1194 122 L.Ed 2d 565 (1993) quoting Maryland v. Louisiana, 451 U.S. 725, 746, 101 S.Ct. 2114, 2129 (1981). Workers' compensation is traditionally reserved to the states, and is presumed not superseded unless Congress expresses a clear and manifest intent to preempt state law. Pacific Merchant Shipping Ass'n v. Aubry, 918 F.2d 1409, 1416 (9th Cir. 1990), cert. denied, 502 U.S. 1002, 112 S.Ct. 2956 (1992).

Federal preemption may be either express or implied, and "is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." Jones v. Rath Packing Co., 430 U.S. 519, 525, 97 S.Ct. 1305, 1309 (1977),; Shaw v. Delta Airlines, Inc., 463 U.S. 85, 95, 103 S.Ct. 2890, 2899 (1983); Fidelity Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 152-153, 102 S.Ct. 3014, 3022 (1982). Where there is no explicit preemptive language in the statute, the U.S. Supreme Court has recognized at least two forms of implied preemption: field preemption and conflict preemption. Gade v. National Solid Wastes Management Ass'n, 505 U.S. 88, 98, 112 S.Ct. 2374, 2383 (1992).

Field preemption occurs when Congress intends that federal law occupy a given field, California v. ARC Am. Corp., 490 U.S. 93, 100 (1989), as demonstrated by a scheme of federal regulation "so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it." Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152 (1947).

Conflict preemption is found where (1) compliance with both federal and state law is a physical impossibility, Federal Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142-3 (1963), or (2) where the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress, Hines v. Davidowitz, 312 U.S. 52, 67 (1941); Felder v. Casey, 487 U.S. 131, 138, 108 S.Ct. 2302, 2306 (1988).

While courts are not to seek out conflicts between state and federal regulation where none clearly exist, Huron Portland Cement Co. v. Detroit, 362 U.S. 440, 446 (1960), "under the Supremacy Clause, from which our pre-emption doctrine is derived, any state law, however clearly within a State's acknowledged power, which interferes with or is contrary to federal law, must yield." Gade v. National Solid Wastes Management Ass'n, 505 U.S. at 108, 112 S.Ct. 2388; quoting in part Felder v. Casey, 487 U.S. at 138; 108 S.Ct., at 2307.

Congress did not express a clear and manifest intent to preempt state workers' compensation laws in enacting the ADA. The ADA is designed to prevent discrimination on the basis of disability; not to compensate those who suffer disability as a result of work-related injury. Congress disclaimed any intent to occupy the field of disability law, stating that the ADA is not to be construed to "invalidate or limit the remedies, rights, and procedures of any Federal law or law of any State . . . that provides greater or equal protection for the rights of individuals with disabilities than are afforded by this Act." Sec. 501(b). Moreover, the EEOC's interpretive guidance to the federal regulations enforcing the ADA's restrictions on employer medical inquiries provide that state workers' compensation laws are not preempted by the ADA. 29 CFR 1630, App. 1630.14(b). However, the EEOC also states that "ADA requirements supersede any conflicting state workers' compensation laws." EEOC Technical Assistance Manual, Sec. 9.6(b), Part IX, p.6 (1992). In this instance, federal preemption by the ADA of the state's workers' compensation laws must rest on the existence of a conflict between the ADA and the state law.

5. Preemption of Second Injury Fund Written Record Requirement

AS 23.30.205(c) requires an employer to have written knowledge of a permanent physical impairment before the injury and that "the employee was hired or retained in employment after the employer acquired that knowledge". The ADA, on the other hand, strictly prohibits any pre-employment inquiries into the existence of a "disability or the nature or severity of a disability". 42 U.S.C. § 12112(c)(2)(A). The ADA definition of disability is sufficiently broad⁶ to encompass many of the Second Injury Fund's

⁶The ADA defines "disability" as

- (a) a physical or mental impairment that substantially limits one or more of the major life functions of such individual;
- (b) a record of such impairment; or
- (c) being regarded as having such an impairment.

42 U.S.C. 12102(2). Not all of the listed conditions would

listed impairments. An ADA covered employer may not ask an employee if he has such a condition before hire⁷ and still comply with the ADA. If an employee discloses the existence of a disability, the employer may not make further inquiry about it prior to employment. 29 CFR 1630.13, App.1630.13.

The ADA does permit pre-employment inquiry into the ability to perform essential functions of a position. However, the Alaska Supreme Court interpreted AS 23.30.205(c) to require the employer to have a written record, from which "its prior knowledge of the employee's qualifying disability can be fairly and reasonably inferred," Sea-Land Services, 737 P.2d at 795, (emphasis added). In other words, the record must disclose knowledge of the listed condition, not simply notation of inability to perform certain job functions.

To the extent then, that AS 23.30.205(c) requires an employer to have a written record showing that an employee "was hired . . . after the employer acquired" knowledge of a listed impairment, it is preempted by the ADA.

However, the ADA does not bar post-offer employment entrance examinations or inquiries, provided that the information is used in a permitted manner not inconsistent with the ADA. 42 U.S.C. § 12112(c)(3). Results must be kept confidential, ADA U.S.C. § 12112(c)(3)(B), but this requirement has been interpreted to allow an employer to "submit information to state workers' compensation offices or second injury funds" without violating the confidentiality provisions. 29 CFR 1630, App. 1630.14(b). All entering employees in a job class must be given the same examination and/or inquiry, 42 U.S.C. § 12112(c)(3)(A); 29 CFR

necessarily substantially limit one or more major life functions in a particular worker. However, including the worker's condition in a list defined as permanent physical impairments "of such seriousness as to constitute a hindrance or obstacle to obtaining employment", AS 23.30.205(d), for Fund purposes probably at a minimum means the worker is "regarded as having such an impairment" under the ADA.

⁷The ADA creates a two-step process of hire: a first stage leading to an offer of employment, and, in some circumstances, a post-offer stage, during which the employment offer may be conditioned upon results of medical examination. In some situations, before hire arguably could be interpreted to mean "before completion of a post-offer medical examination". However, AS 23.30.205(c) states that the employee must be "hired . . . after the employer acquired [the] knowledge". In this context, "before hire" means "before an offer of employment".

Tom Cashen
Department of Labor
AGO 661-95-0748

September 3, 1996
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1630.14(b), and inquiries to current employees are limited to those "job-related and consistent with business necessity." 42 U.S.C. § 12112(c)(4)(A).⁸ With regard to entrance examinations, the EEOC cautions that, although inquiries that are not job-related are permitted:

employers may, as a practical matter, find it desirable to avoid requiring such examination/inquiries. This is so because an employer's obtaining information unrelated to the job can be probative of an employer's knowledge of an individual's disability if discrimination is alleged at a later time.

EEOC Guidance on Pre-Employment Disability-Related Inquiries and Medical Examinations under the ADA (No. 915.002, May 19, 1994) at n.59. Thus, while an ADA covered employer has a window of opportunity to make broad inquiry into the existence of listed conditions, and the EEOC acknowledges the role of second injury funds in limiting the cost of injury to an employer, the EEOC cautions that the employer may find it more advantageous not to make such inquiries.

It is the position of the EEOC that: the ADA does not prohibit employers from obtaining information about pre-existing injuries and providing needed information to second injury funds. . . . [A]n employer may make such medical inquiries and require a medical examination after a conditional offer of employment and before a person starts work, so long as the examination or inquiry is made of all applicants in the same job category.

EEOC Technical Assistance Manual, Sec. 9.5, Part IX, p.6, (1992). The Manual makes no statement about information acquired after hire. After the employment entrance inquiries, inquiries must be "job related and consistent with business necessity". It could be argued that broad inquiries after the employment entrance window are "consistent with business necessity", but it is more difficult to tie such inquiries to the specific employee's job, even solely for Second Injury Fund purposes.

⁸It could be argued that it is consistent with business necessity for an employer to make sufficient record to claim Fund protection in the event of a future serious work-related injury, particularly as the existence of the record is necessary for Fund reimbursement.

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The ADA restricts an employer's opportunity to acquire knowledge of listed impairments. If an employer acquires written knowledge of a listed impairment in a lawful post-offer entrance examination, or in the course of an examination which is job-related and consistent with business necessity, and the employer retains an employee in employment after acquisition of the knowledge, the employer may obtain Fund reimbursement in the event of a later qualifying injury to the employee. Therefore it is not impossible to comply with the ADA and AS 23.30.205(c) to the extent the employee is "retained . . . after the employer acquires knowledge" of the listed impairment.

The employer, whose compliance with the ADA results in an absence of prior knowledge of a listed impairment and denial of Second Injury Fund reimbursement may argue that the employer who has knowledge gained prior to the ADA, or in violation of the ADA, or to whom the ADA does not apply, has unfair advantage in obtaining Second Injury Fund reimbursement. The perceived inequity⁹ of application, and the financial incentives of Second Injury Fund reimbursement in a permanent total disability or death case, may be at cross-purposes with the ADA's purpose in limiting employer opportunity to obtain knowledge of pre-existing disabilities. Insurers of employers to whom the ADA applies may argue that the written record requirement encourages (other) employers to acquire knowledge which the ADA prohibits or limits.

Even where compliance is not impossible, a state law may be subject to conflict preemption if it is "an obstacle to the accomplishment and execution of the purposes and objectives of Congress," Felder v. Casey, 487 U.S. at 138, in enacting the ADA. In order to rise to the level of preemption, a state law must have a "direct and substantial effect" on the federal statutory scheme. Gade v. National Solid Wastes Management Ass'n, 505 U.S. at 107, 112 S.Ct. at 2387; quoting English v. General Electric Co., 496 U.S. 72, 85, 110 S.Ct. 2270, 2278 (1990). See also, State Dept. of Public Safety v. Brown, 794 P.2d 108, 110-11 (Alaska 1990) (state workers' compensation exclusive remedy rule cannot be applied to conflict with maritime policy and undermine uniformity of substantive maritime law).

⁹The Fund is designed to benefit employers who knowingly choose to employ a worker with a listed impairment, and not to benefit those who employ a worker without knowing about a listed impairment. The latter result is encouraged, when not mandated, by the ADA. In view of the shift in public policy represented by the ADA, Professor Larson advocates elimination of the knowledge requirement. 2 A. Larson, Workmen's Compensation Law, § 59.33(g), at 10-528 (1992).

The federal agency charged with enforcement of the ADA has approved transmission of information properly obtained to second injury funds, 28 C.F.R. 1630, App. 1630.14(b). Since the employer must obtain the knowledge and record it to send to a second injury fund, the EEOC evidently does not view a requirement that an employer establish by written record that the employee was retained in employment after the employer had knowledge of the listed impairment as having direct and substantial effect on implementation of the ADA. Such a written record requirement may or may not induce some employers to evade the ADA. However, speculation that an employer may be tempted to violate the ADA to obtain a state benefit does not render the state statute invalid. An otherwise valid state statute will not be struck down "merely because the public reacts to it in a manner inconsistent with federal law." Kosikowski v. Bourne 659 F.2d 100, 105 (9th Cir. 1981) (dismissing argument that local ordinance was preempted because it induced unsafe practices and caused pilots to attempt to violate federal regulations). Compare, Tellis v. United States Fidelity and Guar. Co., 625 F. Supp. 92, 95 (N.D.Ill. 1985) (in claim against employer based on scheme to defraud worker of benefits by false statement that he would be returned to work, RICO does not preempt state workers' compensation exclusive remedy rule), aff'd, 805 F.2d 741 (7th Cir. 1986), cert. granted and vacated on other grounds, 483 U.S. 1015, 107 S.Ct. 3255 (1987), aff'd on other grounds, 826 F.2d 477 (7th Cir. 1986).

6. False Statement Exclusion

AS 23.30.022 provides that an employee who "knowingly makes a false statement as to the employee's physical condition on an employment application or preemployment questionnaire" may not receive workers' compensation benefits if the employer substantially relies on the false statement "in hiring" and the employee's injury is causally related to the false statement.

The ADA prohibits preemployment inquiries as to physical condition prior to a job offer. Therefore, an employer with more than 15 employees cannot comply with the ADA and obtain relief from liability under this statute. Since the statute does not exclude employees from coverage based on post-offer misrepresentations, as in an entrance examination or a legitimate job-related inquiry, the employer cannot obtain relief under this statute in other circumstances when the information is obtained in compliance with the ADA.¹⁰ The statute also requires the employer to demonstrate

¹⁰If the "pre-employment questionnaire" in A23.30.022 is defined as a "post-offer entrance questionnaire" which complies with the ADA, an employer could avoid conflict. However, a preemployment questionnaire is not generally meant as being completed after an offer of employment. Also, taken in

that the employee's statement was a "substantial factor in hiring". While reliance on a statement of physical ability to perform job duties may be acceptable under the ADA, an employer who substantially relied on a statement that certain conditions (having no bearing on ability to perform the work) are absent in deciding to offer a job would not be in compliance with the ADA. It is precisely the "screening out" of persons with disabilities unrelated to qualification to perform the employment duties that the ADA is intended to prohibit. Finally, if an employee exercises his right not to answer improper preemployment inquiries, the employer may contest a later claim of injury.

These results are prohibited under the ADA, 42 U.S.C. § 12132, as they condition participation in a state program (workers' compensation) upon violation of the right of persons with disabilities not to be subjected to preemployment medical examinations or inquiries, 42 U.S.C. § 12112(d)(2)(A). See, Nash v. Florida Industrial Comm'n, 389 U.S. 235, 239, 88 S.Ct. 362, 366 (1967) (invalidating Florida ban on payment of state unemployment benefits to person filing unfair labor practice charge under NRLA). The ADA itself provides that a person may not discriminate against an individual because he or she "opposed any act or practice made unlawful" by the ADA, 42 U.S.C. § 122203. AS 23.30.022 also acts as an "eligibility criteri[on] that screen[s] out or tend[s] to screen out an individual with a disability . . . from fully and equally enjoying" the services of workers' compensation. 28 C.F.R. 35.130(b)(8). Therefore, to the extent that AS 22.30.022 refers to "employment application or preemployment" questionnaires and requires that "this reliance was a substantial factor in the hiring" it would be preempted by the ADA.

However, the ADA does not conflict with the principle underlying statutes like AS 23.30.022. The EEOC advises that an employer may refuse benefits to a person who knowingly makes false answers to a lawful inquiry and is later injured because of it.

The ADA does not prevent use of this defense to a workers' compensation claim. The ADA requires only that information requests about health or workers' compensation history are made as part of a post-offer examination or inquiry. (emphasis added)

EEOC Technical Assistance Manual Sec. 9.8, Part IX, p.7 (1992). As one noted commentator stated, "Fraud is not a disability".

conjunction with the requirement that the information be relied on in hiring, the text of AS 23.30.022 does not support this interpretation.

Christopher G. Bell, "Integrating the Americans with Disabilities Act into the Workers' Compensation System", Disability Law Reporter, Vol.2, No.6, p.3, 13 (June 1993). The EEOC takes the position that under the ADA an employer may withdraw an offer to, or fire, a person who knowingly provides a false answer to a lawful inquiry about their physical condition or workers' compensation history. EEOC Technical Assistance Manual, supra.

7. Effect of Federal Preemption.

A state statute that actually conflicts with federal law is void to the extent that the conflict exists. Edgar v. MITE Corp., 457 U.S. 624, 102 S.Ct. 2629 (1982). In those cases where Congress did not intend to occupy the whole field, the state statute is invalid or void only to the extent of the actual conflict; Planned Parenthood of Billings v. State of Montana, 648 F. Supp. 47 (D.C. Mont. 1986); Consolidated Rail Corp. v. City of Bayonne, 724 F. Supp. 320 (D.C. N.J. 1989); and inconsistent provisions only of state law may be preempted. Matter of Baby K., 16 F.3d 590 (4th Cir. 1994). The extent of the preemption depends on the extent of the conflict. Boyle v. United Tech Corp., 487 U.S. 500, 512, 108 S.Ct. 2510, 2518 (1988).

Federal preemption may invalidate otherwise valid state law "as it is applied", Hankin v. Finnel, 964 F.2d 853 (8th Cir. 1992) (invalidating application of state's incarceration reimbursement lien against judgment paid by state in inmate's 1983 action against state prison guard); Texas Employers' Ins. Ass'n v. U.S., 569 F.2d 874, 875 (5th Cir. 1978) (application of state workmen's compensation anti-assignment statute against V.A. hospital invalid); or specific provisions of state law, Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 101 S.Ct. 1895 (1981) (invalidating state law prohibiting pension benefit offsets of workmen's compensation benefits); or specific operation of state law. Employee Benefits Committee, Etc. v. Pascoe, 679 F.2d 1319, 1322-23, (9th Cir. 1982) (invalidating operation of Hawaii workers' compensation law barring any rule to relieve the employer from liability). Thus while specific operation or provision of state law may be invalid, the remaining applications or provisions are not preempted. District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 113 S.Ct. 580 121 L.Ed.2d 513 (1992).

A finding of federal preemption in this instance would invalidate only those specific offending parts of the state workers' compensation law, since neither the operation of second injury funds in general nor false statement exclusions are barred by the ADA. Specifically, in AS 23.30.205(c), the words "hired or" and, in AS 23.30.022, the words "on an employment application or preemployment questionnaire" and "this reliance was a substantial factor in the hiring" are the portions of the statutes that present

conflicts with the ADA.

42 U.S.C. § 12132, which prohibits exclusion of workers' compensation program "by reason of . . . disability" places an obligation upon states to ensure that their workers' compensation laws do not violate the ADA and imposes penalties if they do, 42 U.S.C. § 12202. While it is the opinion of this Commission that the specific portions of AS 23.30.022 and AS 23.30.205 above conflict with federal law, and that State agencies have an obligation to comply with the ADA, there have been no decisions dealing with a similar statute or "specifically declaring the [Alaska] statute unconstitutional". O'Callaghan v. Cogh 888 P.2d 1302, 1304 (Alaska 1995). Should the Alaska Supreme Court determine conflict preemption is not sufficiently clear, it should determine that the executive branch should have continued to enforce the above portions of AS 23.30.022 and AS 23.30.205 until the courts determined otherwise.

8. Notice to the Public.

The informational brochure supplied to injured employees by the Workers' Compensation Division sets out the employee's rights and obligations under the Alaska Workers' Compensation Act. The supplemental insert (attached Ex. A) refers to AS 23.30.022 only. It cautions the employee that "a federal law . . . may limit your employer's right to ask you about your physical condition (health)" and gives reference to the ADA and the EEOC's telephone number and address. While this is helpful, it does not place the employee on notice of the possible effects of pre-emption nor does it assist the employer who may believe that AS 23.30.022 grants it authority to do what the ADA prohibits. The supplemental insert also does not address the issue of the Second Injury Fund's written record requirements. For these reasons, the insert is insufficient to put employers and employees on notice of possible effects of preemption by the ADA relating to employer acquisition of knowledge of an employee disability.

CONCLUSION

The ADA bars inquiry into the existence of an employment candidate's disability in preemployment questionnaires, job applications, or interviews. The ADA also bars discrimination in hiring on the basis of disability. It is not possible for an employer to comply with the ADA and meet, through employer pre-hire inquiry, the Second Injury Fund requirement of AS 23.30.205(c) for a written record showing the employee was hired after the employer acquired knowledge of a listed impairment. It is possible for an employer to acquire subsequent knowledge of such impairment in accord with the ADA and the employer who retains an employee in employment thereafter may qualify for reimbursement by the Fund.

Tom Cashen
Department of Labor
AGO 661-95-0748

September 3, 1996
Page 15

Since the ADA bars inquiry into physical conditions in employment applications or pre-employment questionnaires, an employer may not require an employee to divulge such conditions at the risk of losing future workers' compensation under AS 23.30.022.

Because it is impossible to comply with conflicting provisions of the ADA (federal law) and the specific offending provisions of AS 23.30.205(c) and AS 23.30.022, identified more specifically above, the federal law (the ADA) would preempt the state law provisions regarding the Second Injury Fund (reimbursement based on hire after acquiring written knowledge of impairment) and the false statement exclusion (concealment of conditions on employment applications or pre-employment questionnaires). These provisions could be deemed void.¹¹ The insert provided does not give notice of the effect of preemption by the ADA.

We hope this memorandum answers your questions.

KSK:lea

Attachment

¹¹There has been no published ruling from any court on this precise issue to date.

NOTICE

At page 3, the following is added to the section "WHAT IF YOU DON'T TELL THE TRUTH."
Alaska Statute 23.30.022 states:

An employee who knowingly makes a false statement as to the employee's physical condition on an employment application or preemployment questionnaire may not receive benefits under this chapter if

- (1) the employer relied upon the false representation and this reliance was a substantial factor in the hiring; and
- (2) there was a causal connection between the false representation and the injury.

A federal law, the Americans with Disabilities Act (ADA), may limit your employer's right to ask you about your physical condition (health). You can get information about the ADA as it relates to employment by calling the federal Equal Employment Opportunity Commission at 1-800-669-4000, or writing the Commission at 907 First Avenue, Suite 400, Seattle, Washington 98104-1061.

(See Reverse for More Information)

Alaska State Legislature
House of Representatives

COL-95
JUNEAU

MAY 08 1995

COMMITTEE ASSIGNMENTS:

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EAGLE RIVER, AK 99577
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FAX 894-3949
SESSION:
STATE CAPITOL
JUNEAU, AK 99801-1162
PHONE (907) 465-3777
FAX (907) 465-3819

May 5, 1995

Mr. Paul Grossi

Director

Division of Workers' Compensation

PO Box 25512

Juneau, Alaska 99811-5512

Re: Draft Workers Compensation Pamphlet

Dear Mr. Grossi:

Thank you for providing me a draft copy of the Workers' Compensation pamphlet. I have had an opportunity to review it and have a few comments for your consideration.

I urge you to request an opinion from the Attorney General concerning the current viability of AS 23.30.022. It has been alleged that this statute conflicts with the Americans With Disabilities Act. If so, I would suspect that it is preempted under the Supremacy Clause of the United States Constitution. Should that prove to be the case, I request that you delete references to it in the pamphlet.

I note that the draft contains language that does not reflect the Gilmore decision. I recommend that you await the final status of HB 237 and if it becomes law incorporate its changes into the pamphlet. Should it not become law, the pamphlet should reflect the Gilmore decision.

Should you have any questions, or if I may be of any assistance, please do not hesitate to contact me.

Sincerely,

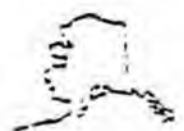

Pete Kott

District 24

cc House Labor and Commerce Committee members
Representative Bette Davis



Representative Pete Kott



HB

217

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 217

Revision Date: _____
 Title: "An Act relating to certified nurse aides;
 and providing for an effective date."
 Sponsor: Representative Ryan
 Requestor: _____

Dept. Affected: Health and Social Services
 BRU: Medical Assistance Admin
 Component: Certification & Licensing
 COMPONENT SERIAL NO. 245
 See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGES IN REVENUES ()						
-------------------------	--	--	--	--	--	--

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

Federal monies are already provided to fund this program, and no additional funding needs are anticipated.

Prepared by: Ronald A. Cowan *RC*
 Division: Medical Assistance

Phone: 561-8081
 Date: 04/04/97

RP Approved by Commissioner: Karen Perdue, Commissioner *KP*
 Agency: Department of Health & Social Services

Date: 4-7-97

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FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 217

Revision Date: _____
Title: An Act relating to certified nurse aides.

Department: Commerce and Economic Development
BRU: Occupational Licensing
Component: Operations

Sponsor: Representative Ryan
Requestor: House Labor & Commerce

COMPONENT SERIAL NO. 1844

Expenditures/Revenues

(Thousands of Dollars)

OPERATING EXPENDITURES	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
PERSONAL SERVICES	59.6	59.6	59.6	59.6	59.6	59.6
TRAVEL	2.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	15.7	15.7	15.7	15.7	15.7	15.7
SUPPLIES	1.0	1.0	1.0	1.0	1.0	1.0
EQUIPMENT	8.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	86.3	78.3	78.3	78.3	78.3	78.3

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES	86.3	78.3	78.3	78.3	78.3	78.3
---------------------------	------	------	------	------	------	------

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other 1091 Designated PR	86.3	78.3	78.3	78.3	78.3	78.3
TOTAL	86.3	78.3	78.3	78.3	78.3	78.3

Estimate of any current year (FY 97) cost: \$ 0.0

POSITIONS

FULL-TIME	1	1	1	1	1	1
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

The bill places certification of nurse aides under the Board of Nursing and grants disciplinary authority of certified nurse aides to the board. Certification of nurse aides is currently administered by the Department of Commerce and Economic Development under Administrative Order #115 signed on 8/4/89. However, current administration of the program does not include enforcement of unacceptable or inappropriate conduct. Since the bill assigns enforcement responsibility to the Board of Nursing, this fiscal note provides a full-time Investigator to work certified nurse aide cases and provides funding for legal services. See attached for further explanation.

Prepared by: Jennifer Strickler, Administrative Officer
Division: Occupational Licensing
Approved by Commissioner: William L. Hensley
Agency: Commerce and Economic Development

Phone: 465-2144
Date: 4/3/97
Date: 4-3-97

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FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO.: HB 217

ANALYSIS: (Continued)

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT FISCAL NOTE CALCULATIONS

PERSONAL SERVICES 59.6

1 - Permanent Full-Time Investigator III, Range 18, GGU

TRAVEL 2.0

- Travel and Per Diem for the Investigator III to conduct field work throughout the State: \$2.0

CONTRACTUAL 15.7

- Contractual-related costs for the Investigator III position, such as communications (phones, postage, etc.), misc. case related costs (copies of records), expert witnesses, depositions, etc.: \$3.0
- Office space costs for the Investigator III position: \$2.5
- Legal services in preparing cases for litigation. The funding provides 120 hours of legal services (10 hours per month x 12) at \$85 per hour. There are 1,929 certified nurse aides. At the rate of \$85 per hour, each individual would be responsible to contribute \$5.29 of their licensing fees toward enforcement, for a total of: \$10.2

SUPPLIES 1.0

Provides daily operating desk top supplies for the Investigator III.

EQUIPMENT (One-time costs only) 8.0

Workstation	3.0
Phone/Install	2.0
Computer	2.0
File Cabinet	1.0

TOTAL FY 98 Costs: \$ 86.3

REVENUE:

Certified Nurse Aides currently pay biennial fees of \$30 (\$15 per year). Fees will be adjusted to cover its program costs.

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO.: HB 217

ANALYSIS: (Continued)

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT FISCAL NOTE CALCULATIONS

PERSONAL SERVICES 59.6

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04/14/97 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
5:29:40 PARTICIPANT LIST (TESTIFIERS ONLY) BY:JNU
TCN:70608 SCHEDULED FOR:04/14/97 15:15 TO 17:15 FOR:ALL

PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION:ANCHORAGE

HB 217	RON	COWAN	DHSS/AFL&C	TESTIFY
HB 217	PAT	DOOLEY		TESTIFY
HB 237	THERESA	PEREZ		TESTIFY
HB 237	ROBERT	GILL		TESTIFY
HB 237	ANGELINA	CHRISTIANSEN		TESTIFY
HB 237	FRED	ROSENBERG	RED ROBIN	TESTIFY

LOCATION:KENAI LIO

HB 217	MS.	PATRICIA	SENNER <i>Hold</i>	AK NURSES ASSOC	TESTIFY
HB 217	MS.	CAROL	CLAUSSON	SELF	TESTIFY
HB 217	MS.	CONNIE	SMITH <i>Hold</i>	PENHOMEHEALTH	TESTIFY

04/14/97 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
16:02:37 PARTICIPANT LIST (ALL PARTICIPANTS) BY:ANC
TCN:70608 SCHEDULED FOR:04/14/97 15:15 TO 17:15 FOR:ANC

PUBLIC HEARING HOUSE LABOR & COMMERCE

LOCATION:ANCHORAGE

HB 217	RON	COWAN	DHSS/AFL&C	TESTIFY
HB 217	PAT	DOOLEY		TESTIFY
HB 217	MARY	WEISS		TESTIFY
HB 217	JACKIE	PFLUM		OBSERVE
HB 217	DOROTHY	FULTON		OBSERVE
HB 217	LOUISE	DEAN		TESTIFY
HB 237	THERESA	PEREZ		TESTIFY
HB 237	ROBERT	GILL		TESTIFY
HB 237	ANGELINA	CHRISTIANSEN		TESTIFY
HB 237	FRED	ROSENBERG	RED ROBIN	TESTIFY
ALL ITEMS	TO	OBSERVE		OBSERVE



ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272-0292

Certified Nurse Aide Bill HB 217 and SB 152

PURPOSE

The purpose of these bills is to give legislative authority to the Nurse Aide Certification program which has been in existence in Alaska since 1989 through the Board of Nursing. This program establishes minimum requirements for Nurse Aide training, approves Nurse Aide training programs in Alaska, and keeps a registry of Certified Nurse Aides.

The current Nurse Aide Certification program was established by Executive Order and so there is no legislative authority to take disciplinary action against CNA's. These bills will allow the Board of Nursing to deny, suspend or revoke a nurse aide's certification for reasons such as a conviction of a crime related to the nurse aide's function, negligence that has resulted in an injury or a risk to the health or safety of a client, and addiction to illegal drugs or alcohol. In addition, they will continue to allow the Department of Health and Social Services to maintain a list of CNA's who have worked in state licensed long-term care facilities and home health agencies, and who have committed abuse, neglect, or misappropriation of property.

The ultimate purpose of these bills is to protect Alaska's most vulnerable population by helping to insure that the people who care for them are properly trained and disciplined as needed.

HISTORY

The Omnibus Budget Reconciliation Act of 1987 required that states establish Nurse Aide Certification programs for nurses aides who worked in long-term care and home health agencies receiving Medicare and Medicaid funding. In Alaska the Board of Nursing has been the agency responsible for approving Nurse Aide Certification training programs, and for maintaining the list of Alaska Certified Nurses Aides. At present, the Board of Nursing has no authority to discipline CNA's or remove an individual from their list of CNA's for any reasons.

Per Federal Regulations, the Division of Medical Assistance, Section of Health Facilities Licensing and Certification, investigates complaints brought against CNA's who work in long-term care facilities and home health agencies licensed by the Division. This authority does not extend to CNA's working in other facilities, such as hospitals. This is why the present legislation

HB 217 & SB 152

Page two

gives disciplinary authority to the Board of Nursing, who already has this responsibility for Registered Nurses and Licensed Practical Nurses.

WHY LEGISLATION NOW

The Alaska Board of Nursing has been trying to get legislative authority for their CNA program for the last seven years. With the great increase in elder Alaskans needing assistance, there has been a tremendous growth in the need for CNA's. As the number of CNA's has grown (there are now 2500 CNA's in Alaska) the need for formal authority to operate the existing program, and to take disciplinary action, has increased.

FUNDING

The present CNA program is funded in part by Federal dollars connected to Medicaid funds, and through certification fees. It is the Board of Nursing's intent that should the Federal subsidy decrease, that the program would operate on certification fees, as the program for Registered Nurses and Licensed Practical Nurses presently operates off licensing fees.

SUPPORT

The current legislation was based on a bill drafted by a coalition that included representatives from the Alaska Board of Nursing, the Division of Medical Assistance, the Attorney General's office, the Division of Senior Services, and the Alaska Hospital and Nursing Home Association. **The present piece of legislation has been deemed a top priority by the Alaska Nurses Association.** CNA's work under the supervision of licensed nurses. We feel these people are important members of the health care team, and so require adequate preparation for the responsibilities given to them.

STEVE COWPER
GOVERNORSTATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAUADMINISTRATIVE ORDER NO. 115

Under the authority of Article III, Sections 1 and 24 of the Constitution of Alaska and AS 44.17.060, I hereby designate the Alaska Department of Commerce and Economic Development, Division of Occupational Licensing, as the state agency responsible for the implementation of nurse aide training and competency evaluation programs and registration requirements for nurse aides employed in Alaskan long-term care nursing facilities participating in the medicare or medicaid programs. These requirements are contained in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), as it may be amended from time to time.

WHEREAS, the Alaska Department of Commerce and Economic Development, Division of Occupational Licensing, serves as the central state agency with expertise in the licensure of businesses and professions and the Board of Nursing, within that division, is responsible for establishing standards for nurse aide competency;

WHEREAS, the performance of these functions by this division would be cost-effective and efficient to avoid the creation of an additional administrative structure to perform them;

WHEREAS, the registration of nurse aides is essential to allow Alaska's nursing facilities to continue to participate in the federally funded medicare and medicaid programs;

WHEREAS, the loss of these federal monies could mean a reduction in access and quality of nursing care for needy and elderly institutionalized Alaskans;

WHEREAS, the implementation of standards for training and the registration of nurse aides may promote and enhance the quality of care provided to these Alaskans;

I, therefore, designate the Alaska Department of Commerce and Economic Development, Division of Occupational Licensing, as the state agency responsible for implementation of the training, certification, and registration requirements of nurse aides under the Omnibus Budget

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

PROCARE Professional Training Systems, Inc. Suite 1525 1201 Peachtree Street, NE Atlanta, GA 30361	#1*
St. Ann's Nursing Home 415 6th Street Juneau, AK 99801 Contact: Renee O'Keefe, RN Telephone: 586-3883	#2
University of Alaska Southeast 1332 Seward Avenue Sitka, AK 99835-9498 Contact: Brenda Sturm, RN Telephone: 443-3384	#3
Kotzebue Senior Citizens Cultural Center P.O. Box 1073 Kotzebue, AK 99901 Contact: Director of Nursing Services	#4*
Quyaana Care Center P.O. Box 966 Nome, AK 99762 Contact: Director of Nursing Contact: Sue Buchanan, RN Telephone: 443-3311 Ext.-384	#5
Providence Extended Care Center 4900 Eagle Street Anchorage, AK 99503 Contact: Belle Cunningham, LPN Telephone: 562-2281	#6
Kenai Peninsula College 34820 College Drive Soldotna, AK 99669 Contact: Forrest Tressler/Carol Twait, RN	#7
Heritage Place 232 Rockwell Soldotna, AK 99669 Contact: Carol Twait, RN Telephone: 262-2545	#8

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STEVE COWPER
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

ADMINISTRATIVE ORDER NO. 115

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WHEREAS, the registration of nurse aides is essential to allow Alaska's nursing facilities to continue to participate in the federally funded medicare and medicaid programs;

WHEREAS, the loss of these federal monies could mean a reduction in access and quality of nursing care for needy and elderly institutionalized Alaskans;

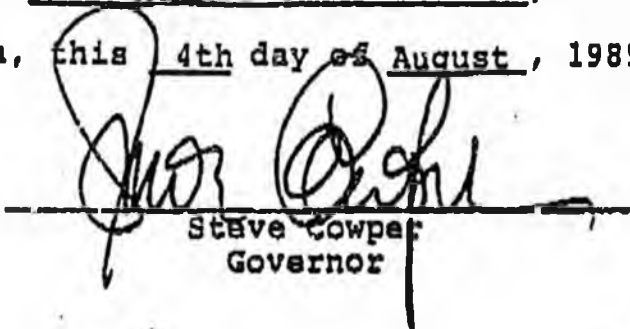
WHEREAS, the implementation of standards for training and the registration of nurse aides may promote and enhance the quality of care provided to these Alaskans;

I, therefore, designate the Alaska Department of Commerce and Economic Development, Division of Occupational Licensing, as the state agency responsible for implementation of the training, certification, and registration requirements of nurse aides under the Omnibus Budget

Reconciliation Act of 1987 (P.L. 100-203), as it may be amended from time to time. I find that this designation will promote the continued access and availability of quality nursing care services in the state and allow the state to remain compliant with federal law to assure Alaskans continued access to nursing care services funded by the medicare and medicaid programs.

This order takes effect on August 4, 1989.

DATED at Fairbanks, Alaska, this 4th day of August, 1989.



Steve Cowper
Governor

ADMINISTRATIVE ORDER NO. 115

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

PROCARE Professional Training Systems, Inc. Suite 1525 1201 Peachtree Street, NE Atlanta, GA 30361	#1*
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Heritage Place 232 Rockwell Soldotna, AK 99669 Contact: Carol Twait, RN Telephone: 262-2545	#8

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

South Peninsula Hospital, LTC 4300 Bartlett Homer, AK 99603 Contact: Sue Brooks, LPN Telephone: 235-8101	#9
Denali Center 1949 Gilliam Way Fairbanks, AK 99701 Contact: Kathleen Roberts, RN Telephone: 458-5100	#10
Alaska Home Health Care Agency Kodiak Branch Office 305 Center Avenue P.O. Box 4010 Kodiak, AK 99615 Contact: Joan Minks, RN	#11*
University of Alaska Fairbanks Northwest Campus Pouch 400 Nome, AK 99762 Telephone: 443-3282	#12
University of Alaska Southeast Juneau Campus 11120 Glacier Campus Juneau, AK 99801-8675	#13*
Wesley Rehabilitation Care Center P.O. Box 430 431 First Avenue Seward, AK 99664 Contact: B. J. Blackwell, RN Telephone: 224-5241	#14
Older Persons Action Group American Red Cross 325 East 3rd Avenue Anchorage, AK 99501 Contact: Lillian Tish, RN Telephone: 276-1059	#15

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

PWSCC & Harborview Development Center P.O. Box 487 Valdez, AK Contact: Sue Artz, RN Telephone: 835-4344	#16
Alaska Technical Center P.O. Box 51 Kotzebue, AK 99752 Contact: Cindy Lincoln, RN Telephone: 442-3733	#17
Anvil Mountain Correctional Center P.O. Box 730 Nome, AK 99762 Contact: Penny Dawson, RN Telephone: 443-3205	#18
Alaska Regional Hospital P.O. Box 143889 2801 DeBarr Road Anchorage, AK 99514 Contact: Elizabeth Blair, RN Telephone: 276-1131	#19*
Petersburg General Hospital and Long Term Care Center P.O. Box 589 Petersburg, AK 99833 Contact: Sandra Tackett, RN, DON Telephone: 772-4291	#20
PWSCC and Cordova Community Hospital LTC P.O. Box 160 Cordova, AK 99574 Contact: Director of Nursing	#21*
Southeast Regional Resource Center P.O. Box 3277 2030 Sealevel Drive, #310 Ketchikan, AK 99901 Contact: Judy Helmrich, RN Telephone: 225-6177	#22

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

- University of Alaska Anchorage** #23
College of Technical and Community Education
Diplomacy Building
3211 Providence Drive
Anchorage, Alaska 99508
Contact: Kathy Murtiashaw, RN
Telephone: 786-6753
- Hospice and Home Care of Juneau** #24*
Nurse Aide/Home Health Training Program
3200 Hospital Drive, Suite 100
Juneau, AK 99801
Contact: Natalie Powers or Sue Benhart, RN
Telephone: 563-3113
- Yukon-Kuskokwim Regional Hospital** #25
PO. Box 3000
Bethel, AK 99559
Contact: Linda Curda, RN
Telephone: 543-6300
- North Slope Borough** #26
P.O. Box 69
Barrow, AK 99723
Contact: Doral Vial, RN
Telephone: 852-0260
- University of Alaska Fairbanks** #27
Tanana Valley Campus
510 Second Avenue
Fairbanks, AK 99701
Contact: Cathy Winfrcc, RN
Telephone: 451-7223
- Alaska Psychiatric Hospital** #28*
2900 Providence Drive
Anchorage, AK 99508
Contact: Heather McCracken, RN
Telephone: 561-1633
- Peninsula Home Health Care, Inc.** #29
44539 Sterling Highway
Soldotna, AK 99669
Contact: Susan Shoemaker, RN
Telephone: 262-4750

**STATE OF ALASKA
APPROVED NURSE AIDE PROGRAMS**

Soldotna and Skyview High Schools 232 Rockwell Soldotna, AK 99669 Contact: Traci Davis, RN	#30
Fairbanks North Star Borough School District 520 5th Avenue Fairbanks, AK Contact: Cathy Winfree, RN Telephone: 452-2000	#31*
Alaska Job Corp Center 750 Cope Industrial Way Palmer, AK 99645 Contact: Lorraine Fullbright, RN Telephone: 746-8000	#32
Wrangell General Hospital P.O. Box 1081 Wrangell, AK 99929 Contact: Sue Nikodym, RN Telephone: 874-3356	#33
Kodiak Island Hospital & Care Center 1915 Rezanof Kodiak, AK 99615 Contact: Patricia A. Thorn, RN Telephone: 846-3050	#34

*Inactive Programs

APR 03 1997

Alaska State Legislature

House of Representatives

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Representative Joe Ryan

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Sponsor Statement

HB 217 gives the Board of Nursing the authority to oversee the training, supervision, utilization, and registration of Certified Nurse Aides.

There are some 2,800 Certified Nurse Aides (CNAs) working in Alaska's long-term care facilities and home health agencies. These Aides provide care to Alaskans most unable to care for themselves, the aged and the infirm.

These Certified Nurse Aides works under the supervision of a nurse licensed by the Board of Nursing, performing only those duties specifically delegated by that nurse.

The Omnibus Budget Reconciliation Act of 1987 (Federal) required that states establish Nurse Aide Certification programs for aides working in long-term care and home health agencies receiving Medicare and Medicaid funding. Since 1989, the responsibility for the Certified Nurse Aide program has been divided between DHSS, Division of Medical Assistance, Health Facilities and Licensing, and DCED, Occupational Licensing, Board of Nursing.

This legislation delineates responsibility for oversight of Certified Nurse Aides clearly to the Board of Nursing. The Board of Nursing has been responsible for establishing minimum training standards, approval of training programs, and maintenance of the registry of Certified Nurse Aides.

However, the Board of Nursing has not had the authority to conduct investigations, order corrective measures, or remove someone from

the Certified Nurse Aide registry when allegations of wrong-doing are made against a Certified Nurse Aide. This legislation will authorize the Board of Nursing to take appropriate action.

HB 217 protects Alaska's most vulnerable population by insuring that the people who care for them are properly trained and that oversight of that care is provided.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101


130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 3, 1997

SUBJECT: Sectional Summary of HB 217. (Certified Nurse Aides)

TO: Representative Joe Ryan
Attn: Mark Rosen

FROM: Terri Lauterbach
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, let me know.

Section 1 amends AS 08.01.087 to allow the Department of Commerce (the investigative agency for the Board of Nursing) to designate other state or local agencies (with their consent) to conduct investigations into reports of abuse by CNAs.

Section 2 is a cross-reference to the exemption from the requirements of the Administrative Procedure Act created in AS 08.68.333.

Section 3 amends AS 08.68.100(a) to give the Board of Nursing authority to adopt regulations regarding certified nurse aides.

Section 4 amends AS 08.68.140 to exempt procedures related to the registry of certified nurse aides from the requirements of the Administrative Procedure Act.

Section 5 creates a new article in AS 08.68. It contains several new sections that give the Board of Nursing authority to regulate and certify nurse aides. Under new AS 08.68.332, it would be a class B misdemeanor crime for a person to use the title "certified nurse aide" unless the person is certified by the Board. The Board is required to establish and maintain a registry of certified nurse aides. New AS 08.68.333 establishes the procedures for including findings of abuse and neglect in the registry. New AS 08.68.334 establishes the grounds for the denial or suspension of a nurse aide's certificate. AS 08.68.335 provides immunity for

good faith reports to the Board, and AS 08.68.336 allows the Department of Commerce to set and collect fees for CNAs as shown.

Section 6 adds a definition for "certified nurse aide" in AS 08.68.

Section 7 amends AS 44.62.330(a)(10) to exempt functions related to the nurse aide registry from the requirements of the Administrative Procedure Act (APA).

Section 8 amends AS 47.05.010 to add to the duties of the Department of Health and Social Services (DHSS) the investigation of reports of abuse, neglect, or misappropriation of property by certified nurse aides in facilities licensed by DHSS under AS 18.20.

Section 9 requires the DHSS to adopt procedures to report to the Board of Nursing suspected abuse, neglect, or misappropriation of property by CNAs who work as home care providers.

Section 10 is a new section in the DHSS administrative statutes. It gives DHSS the authority to investigate reports of abuse or neglect by CNAs in facilities licensed by DHSS under AS 18.20. The department would be required to hold hearings under regulations it adopts; these need not comply with the APA. Reports of findings of abuse or neglect by a CNA must be reported to the Board of Nursing. If the facility is a long-term care facility, only the designated state survey and certification agency may make the report to the registry. This provision is included to comply with federal law.

Section 11 amends AS 47.17.030, regarding investigation by state and local agencies of reports of harm to children, to require that suspected abuse or neglect by CNAs be reported to the Board of Nursing.

Section 12 amends AS 47.17.290(13) to include "certified nurse aides" among the "practitioners of the healing arts" required to report the suspected abuse or neglect of children under their care.

Section 13 amends AS 47.24.010(a) to add CNAs to the list of those required to report the suspected exploitation or abuse of vulnerable adults under their care.

Section 14 amends existing AS 47.24.013, regarding the investigation of abuse of elderly persons, to require that suspected abuse, neglect, or misappropriation of property by CNAs be reported to the Board.

Section 15 amends existing AS 47.24.015, which requires DHSS to investigate reports of harm to elderly that are not addressed under AS 47.24.013. The proposed new subsection requires DHSS to report suspected abuse, neglect, or misappropriation of property by CNAs to the Board.

Representative Joe Ryan

April 3, 1997

Page 3

Section 16 amends existing AS 47.33.500(c), regarding assisted living facilities, to allow information about a complainant or resident to be released to appropriate investigative agencies if the complaint involved a certified nurse aide.

Section 17 amends AS 47.33.520 to require that suspected abuse, neglect or misappropriation of property by CNAs in assisted living homes be reported to the Board of Nursing.

Section 18 is a transition section, allowing the Board and other affected state agencies, before the effective date of the new laws, to begin drafting the regulations necessary to implement the bill.

Section 19 is a transition section providing that persons who are certified as nurse aides immediately before the effective date of the Act retain their certifications, subject to continued eligibility. CNAs whose certifications have expired within two years before the Act takes effect may apply to renew them if they apply by September 1, 2000.

Section 20. Immediate effective date for sec. 18.

TML:jdr

97-230.jdr

9:25 a.m.
APR 09 1997

ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272-0292

Representative Norm Rokeberg
Juneau, Alaska

Dear Representative Rokeberg:

On behalf of the Alaska Nurses Association, I'd like to take this opportunity to comment on HB 217, "An Act relating to certified nurse aides. The Alaska Nurses Association supports this bill and its greater purpose to protect the health, safety, and welfare of the public served by nurses aides as well as to ensure competency in the performance of nurses aide tasks.

The Alaska Nurses Association believes that this act is a positive first step toward the goal to mandate certification for all nurse aides. The Alaska Nurses Association passed a resolution in support of requiring certification for all nurse aides at the annual convention in 1995. The Alaska Nurses Association continues to be committed to certification of all unlicensed assistive personnel not just those individuals who are already mandated to be certified.

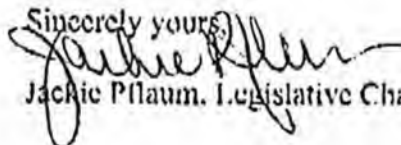
The nursing profession is accountable for the quality of service it provides to the consumer. This includes responsibility for developing nursing policies and procedures and setting the standards of practice for the nursing care of populations served. Provision of any care which constitutes nursing or any activity represented as nursing is a regulatory responsibility of Boards of Nursing. This Act rightly assigns the oversight for the practice of certified nurse aides and the protection of the public to the Alaska Board of Nursing.

The Alaska Nurses Association supports the sections of the HB which provide the following:

- Definitions of covered individuals,
- Authorization for the Board to Nursing to certify nurse aides and maintain a registry,
- Authorization for the Board to discipline certified nurse aides,
- Enforcement authorization,
- Authorization for the Board of Nursing to approve curricula and adopt standards for educational programs and to adopt regulations.

The Alaska Nurses Association thanks you for the opportunity to give input on this piece of legislation.

Sincerely yours,


Jackie Pflaum, Legislative Chairperson

Alaska State Legislature
House of Representatives

APR 03 1997

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Representative Joe Ryan

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PHONE (907) 465-3875

MEMORANDUM

TO: Representative Norman Rokeberg
FROM: Rep. Joe Ryan
DATE: April 3, 1997
SUBJECT: HB 217

Please schedule this for hearing at the earliest possible moment. Thank you for your consideration

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(8) Dental services (§ 483.55).

[51 FR 22042, June 17, 1986; 51 FR 27848, Aug. 4, 1986, as amended at 51 FR 34833, Sept. 30, 1986; 54 FR 37275, Sept. 7, 1989; 56 FR 54546, Oct. 22, 1991; 59 FR 45403, Sept. 1, 1994]

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di-**PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES****Subpart A—(Reserved)****Subpart B—Requirements for Long Term Care Facilities**Jan
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- Sec.
483.1 Basis and scope.
483.5 Definitions.
483.10 Resident rights.
483.12 Admission, transfer and discharge rights.
483.13 Resident behavior and facility practices.
483.15 Quality of life.
483.20 Resident assessment.
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483.30 Nursing services.
483.35 Dietary services.
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483.45 Specialized rehabilitative services.
483.55 Dental services.
483.60 Pharmacy services.
483.65 Infection control.
483.70 Physical environment.
483.75 Level A requirement: Administration.

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- 483.100 Basis.
483.102 Applicability and definitions.
483.104 State plan requirement.
483.106 Basic rule.
483.108 Relationship of PASARR to other Medicaid processes.
483.110 Out-of-State arrangements.
483.112 Preadmission screening of applicants for admission to NFs.
483.114 Annual review of NF residents.
483.118 Residents and applicants determined to require NF level of services.
483.118 Residents and applicants determined not to require NF level of services.
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483.122 FFP for NF services.
483.124 FFP for specialized services.
483.126 Appropriate placement.
483.128 PASARR evaluation criteria.
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483.132 Evaluating the need for NF services and NF level of care (PASARR/NF).
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483.136 Evaluating whether an individual with mental retardation requires specialized services (PASARR/MR).

483.138 Maintenance of services and availability of FFP.

Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation

483.150 Deemed meeting of requirements, waiver of requirements.

483.151 State review and approval of nurse aide training and competency evaluation programs and competency evaluation programs.

483.152 Requirements for approval of a nurse aide training and competency evaluation program.

483.154 Nurse aide competency evaluation.

483.156 Registry of nurse aides.

483.158 FFP for nurse aide training and competency evaluation.

Subpart E—Appeals of Discharges, Transfers, and Preadmission Screening and Annual Resident Review (PASARR) Determinations

483.200 Basis.

483.202 Definitions.

483.204 Provision of a hearing and appeal system.

483.206 Transfers, discharges and relocations subject to appeal.

Subparts F-H—(Reserved)**Subpart I—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded**

483.400 Basis and purpose.

483.405 Relationship to other HHS regulations.

483.410 Condition of participation: Governing body and management.

483.420 Condition of participation: Client protections.

483.430 Condition of participation: Facility staffing.

483.440 Condition of participation: Active treatment services.

483.450 Condition of participation: Client behavior and facility practices.

483.460 Condition of participation: Health care services.

483.470 Condition of participation: Physical environment.

483.480 Condition of participation: Dietetic services.

AUTHORITY: Secs. 1102, 1819(a)-(f), 1861 (j) and (l), 1863, 1871, 1902(a)(28), 1905 (a), (c) and (d), and 1919 (a)-(f) of the Social Security Act (42 U.S.C. 1302, 13351-3(a)-(f), 1395x (j) and (l),



42 CFR Ch. IV (10-1-94 Edition)

1395z, 1395hh, 1396a(a)(28), and 1396d (a), (c) and (d), and 1396r(a)-(f), unless otherwise noted.

Subpart A—(Reserved)**Subpart B—Requirements for Long Term Care Facilities**

SOURCE: 54 FR 5359, Feb. 2, 1989, unless otherwise noted

§ 483.1 Basis and scope.

(a) *Basis in legislation.* (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—

(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.

(2) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.

(b) *Scope.* The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.5 Definitions.

For purposes of this subpart—

Facility means, a skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of sections 1819 or 1919 (a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution specified in § 440.40 of this chapter, but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which partici-

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The reside nified exist and commur persons and the facility. and promoti dent, includ rights:

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(b) *Notice of*

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483.136 Evaluating whether an individual with mental retardation requires specialized services (PASARR/MR).

483.138 Maintenance of services and availability of FFP.

Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation

483.150 Deemed meeting of requirements, waiver of requirements.

483.151 State review and approval of nurse aide training and competency evaluation programs and competency evaluation programs.

483.152 Requirements for approval of a nurse aide training and competency evaluation program.

483.154 Nurse aide competency evaluation.

483.156 Registry of nurse aides.

483.158 FFP for nurse aide training and competency evaluation.

Subpart E—Appeals of Discharges, Transfers, and Preadmission Screening and Annual Resident Review (FASARR) Determinations

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483.202 Definitions.

483.204 Provision of a hearing and appeal system.

483.206 Transfers, discharges and relocations subject to appeal.

Subparts F—(Reserved)

Subpart I—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

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AUTHORITY: Secs. 1102, 1819(a)-(f), 1861 (j) and (l), 1863, 1871, 1902(a)(28), 1905 (a), (c) and (d), and 1919 (a)-(f) of the Social Security Act (42 U.S.C. 1302, 1395i-3(a)-(f), 1395x (j) and (l),

42 CFR Ch. IV (10-1-94 Edition)

1395x, 1395hh, 1396a(a)(28), and 1396d (a), (c) and (d), and 1396r(a)-(f), unless otherwise noted.

Subpart A—(Reserved)

Subpart B—Requirements for Long Term Care Facilities

SOURCE: 54 FR 5359, Feb. 2, 1989, unless otherwise noted

§ 483.1 Basis and scope.

(a) *Basis in legislation.* (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—

(i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.

(2) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.

(b) *Scope.* The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

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Health Care Financing Administration, HHS

§ 483.10

pates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution. For Medicare, a SNF (see section 1819(a)(1)), and for Medicaid, a NF (see section 1919(a)(1)) may not be an institution for mental diseases as defined in § 435.1009.

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.10 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) *Exercise of rights.*

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

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

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

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

(b) *Notice of rights and services.*

(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing:

(2) The resident or his or her legal representative has the right—

(1) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(2) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must—

(1) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of—

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(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

(2) Inform each resident when changes are made to the items and services specified in paragraphs (5)(1)(A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility must furnish a written description of legal rights which includes—

(1) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(2) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section

1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

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

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

(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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

(11) *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(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 (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).

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

(A) A change in room or roommate assignment as specified in § 483.15(e)(2); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

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

(c) *Protection of Resident Funds.* (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(2) *Management of personal funds.* Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

(3) *Deposit of funds.* (i) *Funds in excess of \$50.* The facility must deposit any residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) *Funds less than \$50.* The facility must maintain a resident's personal funds that do not exceed \$50 in a non-

interest bearing account, interest-bearing account, or petty cash fund.

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

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) *Notice of certain balances.* The facility must notify each resident that receives Medicaid benefits—

(i) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) *Conveyance upon death.* Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) *Assurance of financial security.* The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) *Limitation on charges to personal funds.* The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid

has paid. See § 417.15, 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 may not charge a resident for the following categories of items and services:

(A) Nursing services as required at § 483.30 of this subpart.

(B) Dietary services as required at § 483.35 of this subpart.

(C) An activities program as required at § 483.15(f) of this subpart.

(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, and basic personal laundry.

(F) Medically-related social services as required at § 483.15(g) of this subpart.

(ii) *Items and services that may be charged to residents' funds.* Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone.

(B) Television/radio 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) Social events and entertainment offered outside the scope of the activities program, provided under § 483.15(f) of this subpart.

(J) Noncovered special care services such as privately hired nurses or aides.

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

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by § 483.35 of this subpart.

(iii) *Requests for items and services.* (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

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

(C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(d) *Free choice.* The resident has the right to—

(1) Choose a personal attending physician;

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(e) *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of his or her personal and clinical 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) Except as provided in paragraph (e)(3) of this section, the resident may

approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident's right to refuse release of personal and clinical records does not apply when—

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

(f) *Grievances.* A resident has the right to—

(i) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(g) *Examination of survey results.* A resident has the right to—

(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(h) *Work.* The resident has the right to—

(1) Refuse to perform services for the facility;

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

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

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

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

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

(i) *Mail.* The resident has the right to privacy in written communications, including the right to—

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

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

(j) *Access and visitation rights.* (1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;

(iii) The resident's individual physician;

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

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

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

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

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

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

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(i)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(k) *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

(l) *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space

permits, unless to do so would infringe upon the rights or health and safety of other residents.

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

(n) *Self-Administration of Drugs.* An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(d)(2)(ii), has determined that this practice is safe.

(o) *Refusal of certain transfers.* (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—

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

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

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

[56 FR 48667, Sept. 26, 1991, as amended at 57 FR 8202, Mar. 6, 1992; 57 FR 43924, Sept. 23, 1992; 57 FR 53587, Nov. 12, 1992]

§ 483.12 Admission, transfer and discharge rights.

(a) *Transfer and discharge—*

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

(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

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

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the res-

dent no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

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

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

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

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) *Timing of the notice.* (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

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

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

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

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

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

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

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to re-

turn and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

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

(3) *Permitting resident to return to facility.* A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

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

(ii) Is eligible for Medicaid nursing facility services.

(c) *Equal access to quality care.*

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

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

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

(d) *Admissions policy.*

(1) The facility must—

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

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued

stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

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

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

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

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

[56 FR 48590, Sept. 26, 1991, as amended at 5 FR 43924, Sept. 23, 1992]

§ 483.13 Resident behavior and facility practices.

(a) *Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) *Abuse.* The resident has the right to be free from verbal, sexual, physical,

and mental abuse, corporal punishment, and involuntary seclusion.

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

(1) The facility must—

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

(ii) Not employ individuals who have been—

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

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

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

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

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

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

[56 FR 48870, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.15 Quality of life.

A facility must care for its residents in a manner and in an environment

that promotes maintenance or enhancement of each resident's quality of life.

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

(b) *Self-determination and participation.* The resident has the right to—

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

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

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

(c) *Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility;

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;

(3) The facility must provide a resident or family group, if one exists, with private space;

(4) Staff or visitors may attend meetings at the group's invitation;

(5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

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

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

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident's room or roommate in the facility is changed.

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

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

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

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

(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

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

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

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

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

(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(3) *Qualifications of social worker.* A qualified social worker is an individual with—

(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(ii) One year of supervised social work experience in a health care setting working directly with individuals.

(h) *Environment.* The facility must provide—

(i) A safe, clean, comfortable, and homelike environment, allowing the

resident to use his or her personal belongings to the extent possible;

(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 § 483.70(d)(2)(iv) of this part;

(5) Adequate and comfortable lighting levels in all areas;

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain temperature range of 71–81°F; and

(7) For the maintenance of comfortable sound levels.

[56 FR 48871, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.20 Resident assessment.

The facility must conduct initial and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

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

(b) *Comprehensive assessments.*

(1) The facility must make a comprehensive assessment of a resident's needs, which—

(i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary and

(ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The comprehensive assessment must include at least the following information:

(i) Medically defined conditions and prior medical history;

(ii) Medical status measurement;

(iii) Physical and mental functional status;

(iv) Sensory and physical impairments;

(v) Nutritional status and requirements;

(vi) Special treatments or procedures;

(vii) Mental and psychosocial status.

- (viii) Discharge potential;
- (ix) Dental condition;
- (x) Activities potential;
- (xi) Rehabilitation potential;
- (xii) Cognitive status; and
- (xiii) Drug therapy.

(3) [Reserved]

(4) *Frequency.* Assessments must be conducted—

(i) No later than 14 days after the date of admission;

(ii) For current NF residents not later than October 1, 1991;

(iii) For current SNF residents not later than January 1, 1991;

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

(v) In no case less often than once every 12 months.

(5) *Review of assessments.* The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(6) *Use.* The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.

(7) *Coordination.* The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(c) *Accuracy of assessments.* (1) *Coordination.* (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

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

(3) *Penalty for falsification.* An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties. The implementing regulations for this statutory authority are located in part 1003 of this chapter.

(4) *Use of independent assessors.* If a State determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (c)(3) of this section, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(d) *Comprehensive care plans.* (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

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

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

(2) A comprehensive care plan must be—

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

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(e) *Discharge summary.* When the facility anticipates discharge a resident

must have a discharge summary that includes—

(1) A recapitulation of the resident's stay;

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

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

(f) *Preadmission screening for mentally ill individuals and individuals with mental retardation.*

(1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—

(i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission—

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(2) *Definition.* For purposes of this section—

(i) An individual is considered to have *mental illness* if the individual has a serious mental illness as defined in §483.102(b)(1).

(ii) An individual is considered to be *mentally retarded* if the individual is mentally retarded as defined in

§483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1009.

[56 FR 48871, Sept. 28, 1991, as amended at FR 43924, Sept. 23, 1992]

§483.25 Quality of care.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Activities of daily living.* Based on the comprehensive assessment of the resident, the facility must ensure that—

(1) A resident's abilities in activities of daily living do not diminish under circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet;
- (iv) Eat; and
- (v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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

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

(c) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual

clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) *Urinary Incontinence.* Based on the resident's comprehensive assessment, the facility must ensure that—

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) *Range of motion.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) *Mental and Psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) *Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition dem-

onstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) *Accidents.* The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

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

(i) *Nutrition.* Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) *Hydration.* The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) *Special needs.* The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(l) *Unnecessary drugs—(1) General.* Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

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

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

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

(vi) Any combinations of the reasons above.

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

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) *Medication Errors—*The facility must ensure that—

(1) It is free of medication error rates of five percent or greater; and

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

(58 FR 48873, Sept. 26, 1993, as amended at 57 FR 43925, Sept. 23, 1992)

§ 483.30 Nursing services.

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

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

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(b) *Registered nurse.* (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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

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

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

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

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

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review.

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

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

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

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

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

this section, if the Secretary finds that—

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

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

(iii) The facility either—

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

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

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

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

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

[56 FR 48873, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§483.35 Dietary services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

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

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

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

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

(c) *Menus and nutritional adequacy.* Menus must—

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(d) *Food.* Each resident receives and the facility provides—

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food that is palatable, attractive, and at the proper temperature;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) *Therapeutic diets.* Therapeutic diets must be prescribed by the attending physician.

(f) *Frequency of meals.* (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

(g) *Assistive devices.* The facility must provide special eating equipment and utensils for residents who need them.

(h) *Sanitary conditions.* The facility must—

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

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

(3) Dispose of garbage and refuse properly.

[56 FR 48874, Sept. 26, 1991]

§483.40 Physician services.

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

(a) *Physician supervision.* The facility must ensure that—

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

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

(b) *Physician visits.* The physician must—

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

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

(3) Sign and date all orders.

(c) *Frequency of physician visits.*

(1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

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

(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

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

(e) *Physician delegation of tasks in SNFs.* (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;

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

(iii) Is under the supervision of the physician.

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

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

[56 FR 48875, Sept. 26, 1991]

§483.45 Specialized rehabilitative services.

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

(1) Provide the required services; or

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

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

[56 FR 48875, Sept. 26, 1991, as amended at FR 43925, Sept. 23, 1992]

§ 483.55 Dental services.

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

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

(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

(3) Must if necessary, assist the resident—

- (i) In making appointments; and
 - (ii) By arranging for transportation to and from the dentist's office; and
- (4) Promptly refer residents with lost or damaged dentures to a dentist.

(b) *Nursing facilities.* The facility (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, the following dental services to meet the needs of each resident:

(i) Routine dental services (to the extent covered under the State plan); and

(ii) Emergency dental services;

(2) Must, if necessary, assist the resident—

- (i) In making appointments; and
 - (ii) By arranging for transportation to and from the dentist's office; and
- (3) Must promptly refer residents with lost or damaged dentures to a dentist.

[56 FR 48875, Sept. 26, 1991]

§ 483.60 Pharmacy services.

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

(a) *Procedures.* A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) *Service consultation.* The facility must employ or obtain the services of a licensed pharmacist who—

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) *Drug regimen review.* (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

(d) *Labeling of drugs and biologicals.* Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(e) *Storage of drugs and biologicals.*

(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

[56 FR 48875, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.65 Infection control.

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

(a) *Infection control program.* The facility must establish an infection control program under which it—

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) *Preventing spread of infection.* (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

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

(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

(c) *Linens.* Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

[56 FR 48876, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.70 Physical environment.

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

(a) *Life safety from fire.* Except as provided in paragraph (a)(1) or (a)(3) of this section, the facility must meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference). Incorporation of the 1985 edition of the National Fire Protection Association's Life Safety Code (published February 7, 1985; ANS/NFPA) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporations by reference.¹

¹ The Code is available for inspection at the Office of the Federal Register Information Center, room 8301, 1110 L Street NW., Washington, DC Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, MA 02200. If any changes in this code are also to be incorporated by reference, a notice to that effect will be published in the FEDERAL REGISTER.

(1) A facility is considered to be in compliance with this requirement as long as the facility—

(i) On November 26, 1982, complied with or without waivers, with the requirements of the 1967 or 1973 edition of the Life Safety Code and continued to remain in compliance with those editions of the Code; or

(ii) On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continued to remain in compliance with that edition of the Code.

(2) After consideration of State survey agency findings, HCFA may waive specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel.

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

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

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

(c) *Space and equipment.* The facility must—

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

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

(d) *Resident rooms.* Resident room must be designed and equipped for an

quate nursing care, comfort, and privacy of residents.

(1) **Bedrooms must—**

(i) Accommodate no more than four residents;

(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

(iii) Have direct access to an exit corridor;

(iv) Be designed or equipped to assure full visual privacy for each resident;

(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(vi) Have at least one window to the outside; and

(vii) Have a floor at or above grade level.

(2) The facility must provide each resident with—

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

(ii) A clean, comfortable mattress;

(iii) Bedding appropriate to the weather and climate; and

(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) HCFA, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations—

(i) Are in accordance with the special needs of the residents; and

(ii) Will not adversely affect residents' health and safety.

(e) **Toilet facilities.** Each resident room must be equipped with or located near toilet and bathing facilities.

(f) **Resident call system.** The nurse's station must be equipped to receive resident calls through a communication system from—

(1) Resident rooms; and

(2) Toilet and bathing facilities.

(g) **Dining and resident activities.** The facility must provide one or more

rooms designated for resident dining and activities. These rooms must—

(1) Be well lighted;

(2) Be well ventilated, with non-smoking areas identified;

(3) Be adequately furnished; and

(4) Have sufficient space to accommodate all activities.

(h) **Other environmental conditions.** The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—

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

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

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

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

[56 FR 48876, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.75 Level A requirement: Administration.

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

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

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

(c) **Relationship to other HHS regulations.** In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimina-

tion on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

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

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

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

(ii) Responsible for management of the facility.

(e) **Required training of nursing aides—**

(1) **Definitions.**

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

Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.

(2) **General rule.** A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

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

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

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

(3) **Non-permanent employees.** A facility must not use on a temporary, per-

manent, leased, or any basis other than permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.

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

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

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

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

(5) **Registry verification.** Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—

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

(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(6) **Multi-State registry verification.** Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 181(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

(7) **Required retraining.** If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(8) *Regular in-service education.* The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—

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

(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

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

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

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

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

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

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

(ii) The timeliness of the services.

(i) *Medical director.* (1) The facility must designate a physician to serve as medical director.

(2) The medical director is responsible for—

(i) Implementation of resident care policies; and

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

(j) *Level B requirement: Laboratory services.* (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

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

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

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

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

(2) The facility must—

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

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

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

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

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

(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of par-

ticipation for hospitals contained in § 482.26 of this subchapter.

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

(2) The facility must—

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

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

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

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

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

- (i) Complete;
- (ii) Accurately documented;
- (iii) Readily accessible; and
- (iv) Systematically organized.

(2) Clinical records must be retained for—

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

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

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

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

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

- (i) Transfer to another health care institution;
- (ii) Law;
- (iii) Third party payment contract; or
- (iv) The resident.

(5) The clinical record must contain—

- (i) Sufficient information to identify the resident;
- (ii) A record of the resident's assessments;

(iii) The plan of care and, service provided;

(iv) The results of any preadmission screening conducted by the State; and

(v) Progress notes.

(m) *Disaster and emergency preparedness.* (1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

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

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

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

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

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

(o) *Quality assessment and assurance.* (1) A facility must maintain a quality assessment and assurance committee consisting of—

- (i) The director of nursing services;
- (ii) A physician designated by the facility; and
- (iii) At least 3 other members of the facility's staff.

(2) The quality assessment and assurance committee—

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

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

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

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

(p) *Disclosure of ownership.* (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.

(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in—

(i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter;

(ii) The officers, directors, agents, or managing employees;

(iii) The corporation, association, or other company responsible for the management of the facility; or

(iv) The facility's administrator or director of nursing.

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

[56 FR 48877, Sept. 26, 1991, as amended at 56 FR 48918, Sept. 26, 1991; 57 FR 7136, Feb. 28, 1992; 57 FR 43925, Sept. 23, 1992]

Subpart C—Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals

SOURCE: 57 FR 56506, Nov. 30, 1992, unless otherwise noted.

§ 483.100 Basis.

The requirements of §§ 483.100 through 483.138 governing the State's responsibility for preadmission screening and annual resident review (PASARR) of individuals with mental

illness and mental retardation are based on section 1919(e)(7) of the Act.

§ 483.102 Applicability and definitions.

(a) This subpart applies to the screening or reviewing of all individuals with mental illness or mental retardation who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnoses.

(b) *Definitions.* As used in this subpart—

(1) An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

(i) *Diagnosis.* The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987.

Incorporation of the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporation by reference.¹

This mental disorder is—
(A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but

(B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(ii) *Level of impairment.* The disorder results in functional limitations in major life activities within the past 3

¹The Diagnostic and Statistical Manual of Mental Disorders is available for inspection at the Health Care Financing Administration, room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland, or at the Office of the Federal Register, suite 700, 800 North Capitol St. NW., Washington, DC. Copies may be obtained from the American Psychiatric Association, Division of Publications and Marketing, 1400 K Street NW., Washington, DC 20005.

to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

(A) *Interpersonal functioning.* The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

(B) *Concentration, persistence, and pace.* The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

(C) *Adaptation to change.* The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

(iii) *Recent treatment.* The treatment history indicates that the individual has experienced at least one of the following:

(A) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

(B) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(3) An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statis-

tical Manual of Mental Disorders, 3rd edition, revised in 1987, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

(3) An individual is considered to have mental retardation (MR) if he or she has—

(i) A level of retardation (mild, moderate, severe or profound) described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983), incorporated by reference of the 1983 edition of the American Association on Mental Retardation's Manual on Classification in Mental Retardation was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporations by reference;² or

(ii) A related condition as defined in § 435.1009 of this chapter.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, A 28, 1993]

§ 483.104 State plan requirement.

As a condition of approval of the State plan, the State must operate a preadmission screening and annual resident review program that meets the requirements of §§ 483.100 through 483.138.

§ 483.106 Basic rule.

(a) *Requirement.* The State PASARR program must require—
Preadmission screening of all individuals with mental illness or mental retardation who apply as new admissions to Medicaid NFs on or after January 1, 1989;

(2) Initial review, by April 1, 1990, all current residents with mental retardation or mental illness who

²The American Association on Mental Retardation's Manual on Classification in Mental Retardation is available for inspection at the Health Care Financing Administration, Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland, or the Office of the Federal Register Information Center, Suite 700, 800 North Capitol NW., Washington, DC. Copies may be obtained from the American Association on Mental Retardation, 1719 Kalorama Rd., N.W., Washington, DC 20009.

(6) Self-monitoring of nutritional status;

(7) Self-help development such as toileting, dressing, grooming, and eating;

(8) Sensorimotor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity;

(9) Speech and language (communication) development, such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which non-oral communication systems can improve the individual's function capacity, auditory functioning, and extent to which amplification devices (for example, hearing aid) or a program of amplification can improve the individual's functional capacity;

(10) Social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;

(11) Academic/educational development, including functional learning skills;

(12) Independent living development such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills (for individuals with visual impairments);

(13) Vocational development, including present vocational skills;

(14) Affective development such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions; and

(15) The presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

(c) *Data interpretation*—(1) The State must ensure that a licensed psychologist identifies the intellectual functioning measurement of individuals with MR or a related condition.

(2) Based on the data compiled in paragraph (b) of this section, the State mental retardation authority, using appropriate personnel, as designated by the State, must validate that the individual has MR or is a person with a related condition and must determine whether specialized services for mental retardation are needed. In making this determination, the State mental retardation authority must make a qualitative judgment on the extent to which the person's status reflects, singly and collectively, the characteristics commonly associated with the need for specialized services, including—

(i) Inability to—

(A) Take care of the most personal care needs;

(B) Understand simple commands;

(C) Communicate basic needs and wants;

(D) Be employed at a productive wage level without systematic long term supervision or support;

(E) Learn new skills without aggressive and consistent training;

(F) Apply skills learned in a training situation to other environments or settings without aggressive and consistent training;

(G) Demonstrate behavior appropriate to the time, situation or place without direct supervision; and

(H) Make decisions requiring informed consent without extreme difficulty;

(ii) Demonstration of severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and

(iii) Presence of other skill deficits or specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

§ 483.138 Maintenance of services and availability of FFP.

(a) *Maintenance of services.* If a NF mails a 30 day notice of its intent to transfer or discharge a resident, under § 483.12(a) of this chapter, the agency may not terminate or reduce services until—

(1) The expiration of the notice period; or

(2) A subpart E appeal, if one has been filed, has been resolved.

(b) *Availability of FFP.* FFP is available for expenditures for services provided to Medicaid recipients during—

(1) The 30 day notice period specified in § 483.12(a) of this chapter; or

(2) During the period an appeal is in progress.

Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation

SOURCE: 56 FR 48919, Sept. 26, 1991, unless otherwise noted.

§ 483.150 Deemed meeting of requirements, waiver of requirements.

(a) A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the State if he or she successfully completed a training and competency evaluation program before July 1, 1989 if—

(1) The aide would have satisfied this requirement if—

(i) At least 60 hours were substituted for 75 hours in sections 1819(f)(2) and 1919(f)(2) of the Act, and

(ii) The individual has made up at least the difference in the number of hours in the program he or she completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse aide education; or

(2) The individual was found to be competent (whether or not by the State) after the completion of nurse aide training of at least 100 hours duration.

(b) A State may—

(1) Waive the requirement for an individual to complete a competency evaluation program approved by the State for any individual who can demonstrate to the satisfaction of the State that he or she has served as a nurse aide at one or more facilities of the same employer in the state for at least 24 consecutive months before December 19, 1989; or

(2) Deem an individual to have completed a nurse aide training and competency evaluation program approved

by the State if the individual completed, before July 1, 1989, such a program that the State determines would have met the requirements for approval at the time it was offered.

[56 FR 48919, Sept. 26, 1991; 56 FR 59331, Nov. 25, 1991]

§ 483.151 State review and approval of nurse aide training and competency evaluation programs and competency evaluation programs.

(a) *State review and administration.* (1) The State—

(i) Must specify any nurse aide training and competency evaluation programs that the State approves as meeting the requirements of § 483.152 and/or competency evaluations programs that the State approves as meeting the requirements of § 483.154; and

(ii) May choose to offer a nurse aide training and competency evaluation program that meets the requirements of § 483.152 and/or a competency evaluation program that meets the requirements of § 483.154.

(2) If the State does not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, the State must review and approve or disapprove nurse aide training and competency evaluation programs and nurse aide competency evaluation programs upon request.

(3) The State survey agency must in the course of all surveys, determine whether the nurse aide training and competency evaluation requirements of § 483.75(e) are met.

(b) *Requirements for approval of programs.* (1) Before the State approves a nurse aide training and competency evaluation program or competency evaluation program, the State must—

(i) Determine whether the nurse aide training and competency evaluation program meets the course requirements of §§ 483.152;

(ii) Determine whether the nurse aide competency evaluation program meets the requirements of § 483.154; and

(iii) In all reviews other than the initial review, visit the entity providing the program.

(2) The State may not approve a nurse aide training and competency evaluation program or competency

evaluation program offered by or in a facility which, in the previous two years—

(i) In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Act;

(ii) In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;

(iii) Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(1) or 1919(g)(2)(B)(1) of the Act;

(iv) Has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Act of not less than \$5,000; or

(v) Has been subject to a remedy described in sections 1819(h)(2)(B)(i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A)(i), (iii) or (iv) of the Act.

(3) A State may not, until two years since the assessment of the penalty (or penalties) has elapsed, approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, within the two-year period beginning October 1, 1988—

(i) Had its participation terminated under title XVIII of the Act or under the State plan under title XIX of the Act;

(ii) Was subject to a denial of payment under title XVIII or title XIX;

(iii) Was assessed a civil money penalty of not less than \$5,000 for deficiencies in nursing facility standards;

(iv) Operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of its residents; or

(v) Pursuant to State action, was closed or had its residents transferred.

(c) *Time frame for acting on a request for approval.* The State must, within 90 days of the date of a request under paragraph (a)(3) of this section or receipt of additional information from the requester—

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

(d) *Duration of approval.* The State may not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years. A program must notify the State and the State must review that program when there are substantive changes made to that program within the 2-year period.

(e) *Withdrawal of approval.* (1) The State must withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in paragraph (b)(2) of this section.

(2) The State may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the State determines that any of the applicable requirements of §§ 483.152 or 483.154 are not met by the program.

(3) The State must withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the State.

(4) If a State withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program—

(i) The State must notify the program in writing, indicating the reason(s) for withdrawal of approval of the program.

(ii) Students who have started a training and competency evaluation program from which approval has been withdrawn must be allowed to complete the course.

§ 483.152 Requirements for approval of a nurse aide training and competency evaluation program.

(a) For a nurse aide training and competency evaluation program to be approved by the State, it must, at a minimum—

(1) Consist of no less than 75 clock hours of training;

(2) Include at least the subjects specified in paragraph (b) of this section;

(3) Include at least 16 hours of supervised practical training. *Supervised*

practical training means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse;

(4) Ensure that—

(i) Students do not perform any services for which they have not trained and been found proficient by the instructor; and

(ii) Students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse;

(5) Meet the following requirements for instructors who train nurse aides;

(i) The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;

(ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides;

(iii) In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and

(iv) Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields;

(6) Contain competency evaluation procedures specified in § 483.154.

(b) The curriculum of the nurse aide training program must include—

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

(i) Communication and interpersonal skills;

(ii) Infection control;

(iii) Safety/emergency procedures, including the Heimlich maneuver;

(iv) Promoting residents' independence; and

(v) Respecting residents' rights.

(2) Basic nursing skills;

(i) Taking and recording vital signs;

(ii) Measuring and recording height and weight;

(iii) Caring for the residents' environment;

(iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and

(v) Caring for residents when death is imminent.

(3) Personal care skills, including but not limited to—

(i) Bathing;

(ii) Grooming, including mouth care;

(iii) Dressing;

(iv) Toileting;

(v) Assisting with eating and hydration;

(vi) Proper feeding techniques;

(vii) Skin care; and

(viii) Transfers, positioning, and turning.

(4) Mental health and social service needs;

(i) Modifying aide's behavior in response to residents' behavior;

(ii) Awareness of developmental tasks associated with the aging process;

(iii) How to respond to resident behavior;

(iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and

(v) Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

(i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);

(ii) Communicating with cognitively impaired residents;

(iii) Understanding the behavior of cognitively impaired residents;

(iv) Appropriate responses to the behavior of cognitively impaired residents; and

(v) Methods of reducing the effects of cognitive impairments.

- (6) Basic restorative services:
- (i) Training the resident in self care according to the resident's abilities;
 - (ii) Use of assistive devices in transferring, ambulation, eating, and dressing;
 - (iii) Maintenance of range of motion;
 - (iv) Proper turning and positioning in bed and chair;
 - (v) Bowel and bladder training; and
 - (vi) Care and use of prosthetic and orthotic devices.
- (7) Residents' Rights.
- (i) Providing privacy and maintenance of confidentiality;
 - (ii) Promoting the residents' right to make personal choices to accommodate their needs;
 - (iii) Giving assistance in resolving grievances and disputes;
 - (iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;
 - (v) Maintaining care and security of residents' personal possessions;
 - (vi) Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;
 - (vii) Avoiding the need for restraints in accordance with current professional standards.
- (c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).
- (2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

§ 483.154 Nurse aide competency evaluation.

- (a) *Notification to individual.* The State must advise in advance any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the State's nurse aid registry.
- (b) *Content of the competency evaluation program—*(1) *Written or oral examinations.* The competency evaluation must—
- (i) Allow an aide to choose between a written and an oral examination;
 - (ii) Address each course requirement specified in § 483.152(b);
 - (iii) Be developed from a pool of test questions, only a portion of which is used in any one examination;
 - (iv) Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations; and
 - (v) If oral, must be read from a prepared text in a neutral manner.
- (2) *Demonstration of skills.* The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in § 483.152(b)(3).
- (c) *Administration of the competency evaluation.* (1) The competency examination must be administered and evaluated only by—
- (i) The State directly; or
 - (ii) A State approved entity which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.
- (2) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide competency evaluation program may be charged for any portion of the program.
- (3) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide competency evaluation program, the State must provide for the reimbursement of costs incurred in

completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

(4) The skills demonstration part of the evaluation must be—

- (i) Performed in a facility or laboratory setting comparable to the setting in which the individual will function as a nurse aide; and
- (ii) Administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

(d) *Facility proctoring of the competency evaluation.* (1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is described in § 483.151(b)(2).

(2) The State may permit the competency evaluation to be proctored by facility personnel if the State finds that the procedure adopted by the facility assures that the competency evaluation program—

- (i) Is secure from tampering;
- (ii) Is standardized and scored by a testing, educational, or other organization approved by the State; and
- (iii) Requires no scoring by facility personnel.

(3) The State must retract the right to proctor nurse aide competency evaluations from facilities in which the State finds any evidence of impropriety, including evidence of tampering by facility staff.

(e) *Successful completion of the competency evaluation program.* (1) The State must establish a standard for satisfactory completion of the competency evaluation. To complete the competency evaluation successfully an individual must pass both the written or oral examination and the skills demonstration.

(2) A record of successful completion of the competency evaluation must be included in the nurse aide registry provided in § 483.156 within 30 days of the date if the individual is found to be competent.

(f) *Unsuccessful completion of the competency evaluation program.* (1) If the individual does not complete the evaluation satisfactorily, the individual must be advised—

(i) Of the areas which he or she did not pass; and

(ii) That he or she has at least three opportunities to take the evaluation.

(2) The State may impose a maximum upon the number of times an individual upon the number of times an individual may attempt to complete the competency evaluation successfully, but the maximum may be no less than three.

§ 483.156 Registry of nurse aides.

(a) *Establishment of registry.* The State must establish and maintain a registry of nurse aides that meets the requirements of this section. The registry—

(1) Must include as a minimum the information contained in paragraph (c) of this section;

(2) Must be sufficiently accessible to meet the needs of the public and health care providers promptly;

(3) May include home health aide who have successfully completed a home health aide competency evaluation program approved by the State if home health aides are differentiated from nurse aides; and

(4) Must provide that any response to an inquiry that includes a finding of abuse, neglect, or misappropriation of property also include any statement disputing the finding made by the nurse aide, as provided under paragraph (c)(1)(ix) of this section.

(b) *Registry operation.* (1) The State may contract the daily operation and maintenance of the registry to a non-State entity. However, the State must maintain accountability for overall operation of the registry and compliance with these regulations.

(2) Only the State survey and certification agency may place on the registry findings of abuse, neglect, or misappropriation of property.

(3) The State must determine which individuals who (i) have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program; (ii) have been deemed as meeting these requirements; or (iii) have had these requirements waived by the State do not qualify to remain on the registry because they have performed no nursing or nursing-related services for a period of 24 consecutive months.

(4) The State may not impose any charges related to registration on individuals listed in the registry.

(5) The State must provide information on the registry promptly.

(c) **Registry Content.** (1) (The registry must contain at least the following information on each individual who has successfully completed a nurse aide training and competency evaluation program which meets the requirements of § 483.152 or a competency evaluation which meets the requirements of § 483.154 and has been found by the State to be competent to function as a nurse aide or who may function as a nurse aide because of meeting criteria in § 483.150:

(i) The individual's full name.

(ii) Information necessary to identify each individual;

(iii) The date the individual became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation program or by meeting the requirements of § 483.150; and

(iv) The following information on any finding by the State survey agency of abuse, neglect, or misappropriation of property by the individual:

(A) Documentation of the State's investigation, including the nature of the allegation and the evidence that led the State to conclude that the allegation was valid;

(B) The date of the hearing, if the individual chose to have one, and its outcome; and

(C) A statement by the individual disputing the allegation, if he or she chooses to make one; and

(D) This information must be included in the registry within 10 working days of the finding and must remain in the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death.

(2) The registry must remove entries for individuals who have performed no nursing or nursing-related services for a period of 24 consecutive months, unless the individual's registry entry includes documented findings of abuse, neglect, or misappropriation of property.

(d) **Disclosure of information.** The State must—

(1) Disclose all of the information in § 483.156(c)(1) (iii) and (iv) to all requesters and may disclose additional information it deems necessary; and

(2) Promptly provide individuals with all information contained in the registry on them when adverse findings are placed on the registry and upon request. Individuals on the registry must have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

[56 FR 48919, Sept. 26, 1991; 56 FR 50331, Nov. 25, 1991]

§ 483.158 FFP for nurse aide training and competency evaluation.

(a) State expenditures for nurse aide training and competency evaluation programs and competency evaluation programs are administrative costs. They are matched as indicated in § 483.15(b)(8) of this chapter.

(b) FFP is available for State expenditures associated with nurse aide training and competency evaluation programs and competency evaluation programs only for—

(1) Nurse aides employed by a facility;

(2) Nurse aides who have an offer of employment from a facility;

(3) Nurse aides who become employed by a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program; or

(4) Nurse aides who receive an offer of employment from a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program.

Subpart E—Appeals of Discharges, Transfers, and Preadmission Screening and Annual Resident Review (PASARR) Determinations

SOURCE: 57 FR 56514, Nov. 30, 1992, unless otherwise noted.

§ 483.200 Basis.

This subpart implements sections 1819(e)(3), 1819(f)(3), 1919(e)(3), 1919(f)(3), and 1919(c)(7) of the Act.

§ 483.203 Definitions.

For purposes of this subpart and subparts B and C—

Discharge means movement from an entity that participates in Medicare as a skilled nursing facility, a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility, or a Medicaid certified distinct part to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

Individual means an individual or any legal representative of the individual.

Resident means a resident of a SNF or NF or any legal representative of the resident.

Transfer means movement from an entity that participates in Medicare as a skilled nursing facility, a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility or a Medicaid certified distinct part to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility.

§ 483.204 Provision of a hearing and appeal system.

(a) Each State must provide a system for:

(1) A resident of a SNF or a NF to appeal a notice from the SNF or NF of intent to discharge or transfer the resident; and

(2) An individual who has been adversely affected by any PASARR determination made by the State in the context of either a preadmission screening or an annual resident review under subpart C of part 483 to appeal that determination.

(b) The State must provide an appeals system that meets the requirements of this subpart, § 483.12 of this part, and part 431 subpart E of this chapter.

[57 FR 56506, Nov. 30, 1992; 58 FR 25784, Apr. 20, 1993]

§ 483.206 Transfers, discharges and relocations subject to appeal.

(a) "Facility" means a certified entity, either a Medicare SNF or a Medicaid NF (see §§ 483.5 and 483.12(a)(1)).

(b) A resident has appeal rights when he or she is transferred from—

(1) A certified bed into a noncertified bed; and

(2) A bed in a certified entity to a bed in an entity which is certified as a different provider.

(c) A resident has no appeal rights when he or she is moved from one bed in the certified entity to another bed in the same certified entity.

Subparts F-H—(Reserved)

Subpart I—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

SOURCE: 53 FR 20496, June 3, 1988. Redesignated at 58 FR 48918, Sept. 26, 1991.

§ 483.400 Basis and purpose.

This subpart implements section 1905 (c) and (d) of the Act which gives the Secretary authority to prescribe regulations for intermediate care facility services in facilities for the mentally retarded or persons with related conditions.

§ 483.405 Relationship to other HHS regulations.

In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR Part 80), nondiscrimination on the basis of handicap (45 CFR Part 84), nondiscrimination on the basis of age (45 CFR Part 91), protection of human subjects of research (45 CFR Part 46), and fraud and abuse (42 CFR Part 455). Although those regulations are not in themselves considered conditions of participation under this Part, their violation may result in the termination or suspension of, or the refusal to grant or continue, Federal financial assistance.

§ 483.410 Condition of participation: Governing body and management.

(a) *Standard: Governing body.* The facility must identify an individual or individuals to constitute the governing body of the facility. The governing body must—

(1) Exercise general policy, budget, and operating direction over the facility;

(2) Set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility; and

(3) Appoint the administrator of the facility.

(b) *Standard: Compliance with Federal, State, and local laws.* The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health, safety, and sanitation.

(c) *Standard: Client records.* (1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client and that documents the client's health care, active treatment, social information, and protection of the client's rights.

(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

(d) *Standard: Services provided under agreements with outside sources.* (1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement must—

(1) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.

(3) The facility must assure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in § 483.470 (a) through (g), (j) and (k).

(e) *Standard: Licensure.* The facility must be licensed under applicable State and local law.

[53 FR 20498, June 3, 1988. Redesignated at 56 FR 48918, Sept. 26, 1991, and amended at 57 FR 43925, Sept. 23, 1992]

§ 483.420 Condition of participation: Client protections.

(a) *Standard: Protection of clients' rights.* The facility must ensure the rights of all clients. Therefore, the facility must—

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and en-

sure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

(13) Permit a husband and wife who both reside in the facility to share a room.

(b) *Standard: Client finances.* (1) The facility must establish and maintain a system that—

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) *Standard: Communication with clients, parents, and guardians.* The facility must—

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians

and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) *Standard: Staff treatment of clients.* (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(1) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

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

(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

§483.430 Condition of participation: Facility staffing.

(a) *Standard: Qualified mental retardation professional.* Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who—

(1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and

(2) Is one of the following:

(i) A doctor of medicine or osteopathy.

(ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section.

(b) *Standard: Professional program services.* (1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff must work directly with clients and with paraprofessional, non-professional and other professional program staff who work with clients.

(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:

(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupa-

tional therapist by the American Occupational Therapy Association or another comparable body.

(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.

(v) To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school.

(vi) To be designated as a social worker, an individual must—

(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

(vii) To be designated as a speech-language pathologist or audiologist, an individual must—

(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or

(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

(viii) To be designated as a professional recreation staff member, an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5) (i) through (x) of this section are not required—

(A) Except for qualified mental retardation professionals;

(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and

(C) Unless otherwise specified by State licensure and certification requirements.

(c) *Standard: Facility staffing.* (1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing—

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing—

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients.

(4) The facility must provide sufficient support staff so that direct care

staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct care duties.

(d) *Standard: Direct care (residential living unit) staff.* (1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.

(e) *Standard: Staff training program.* (1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

§ 483.440 Condition of participation: Active treatment services.

(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.* (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guard-

ian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.* (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the com-

munity, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence.

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing,

grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(iv) Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) *Standard: Program implementation.*

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

(e) *Standard: Program documentation.*

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measureable terms.

(2) The facility must document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's

ongoing level and quality of functioning.

(f) *Standard: Program monitoring and change.* (1) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client—

(i) Has successfully completed an objective or objectives identified in the individual program plan;

(ii) Is regressing or losing skills already gained;

(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

(iv) Is being considered for training towards new objectives.

(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to—

(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

(ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and

(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.

(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

§ 483.450 Condition of participation: Client behavior and facility practices.

(a) *Standard: Facility practices—Conduct toward clients.* (1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures must—

(i) Promote the growth, development and independence of the client;

(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;

(iii) Specify client conduct to be allowed or not allowed; and

(iv) Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients must participate in the formulation of these policies and procedures.

(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

(b) *Standard: Management of inappropriate client behavior.* (1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures must be consistent with the provisions of paragraph (a) of this section. These procedures must—

(i) Specify all facility approved interventions to manage inappropriate client behavior;

(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

(iii) Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

(iv) Address the following:

(A) The use of time-out rooms.

(B) The use of physical restraints.

(C) The use of drugs to manage inappropriate behavior.

(D) The application of painful or noxious stimuli.

(E) The staff members who may authorize the use of specified interventions.

(F) A mechanism for monitoring and controlling the use of such interventions.

(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with § 483.440(c) (4) and (5) of this subpart.

(5) Standing or as needed programs to control inappropriate behavior are not permitted.

(c) *Standard: Time-out rooms.* (1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)

(ii) The client is under the direct constant visual supervision of designated staff.

(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

(2) Placement of a client in a time-out room must not exceed one hour.

(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

(4) A record of time-out activities must be kept.

(d) *Standard: Physical restraints.* (1) The facility may employ physical restraint only—

(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

(ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or

(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

(2) Authorizations to use or extend restraints as an emergency must be:

(i) In effect no longer than 12 consecutive hours; and

(ii) Obtained as soon as the client is restrained or stable.

(3) The facility must not issue orders for restraint on a standing or as needed basis.

(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept.

(5) Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.

(7) Barred enclosures must not be more than three feet in height and must not have tops.

(e) *Standard: Drug usage.* (1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

(2) Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the

behaviors for which the drugs are employed.

(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

(4) Drugs used for control of inappropriate behavior must be—

(i) Monitored closely, in conjunction with the physician and the drug regimen review requirement at § 483.460(j), for desired responses and adverse consequences by facility staff; and

(ii) Gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

§ 483.460 Condition of participation: Health care services.

(a) Standard: Physician services.

(1) The facility must ensure the availability of physician services 24 hours a day.

(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan must be integrated in the individual program plan.

(3) The facility must provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

(i) Evaluation of vision and hearing.

(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

(iii) Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the

chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

(b) *Standard: Physician participation in the individual program plan.* A physician must participate in—

(1) The establishment of each newly admitted client's initial individual program plan as required by § 483.380 of this chapter that specified plan of care requirements for ICFs; and

(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

(c) *Standard: Nursing services.* The facility must provide clients with nursing services in accordance with their needs. These services must include—

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

(3) For those clients certified as not needing a medical care plan, a review of their health status which must—

(i) Be by a direct physical examination;

(ii) Be by a licensed nurse;

(iii) Be on a quarterly or more frequent basis depending on client need;

(iv) Be recorded in the client's record; and

(v) Result in any necessary action (including referral to a physician to address client health problems).

(4) Other nursing care as prescribed by the physician or as identified by client needs; and

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to—

(i) Training clients and staff as needed in appropriate health and hygiene methods;

(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and

(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

(d) *Standard: Nursing staff.* (1) Nurses providing services in the facility must have a current license to practice in the State.

(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients health needs including those clients with medical care plans.

(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or on-site consultation to the licensed practical or vocational nurse.

(5) Non-licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.

(e) *Standard: Dental services.* (1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility must provide education and training in the maintenance of oral health.

(f) *Standard: Comprehensive dental diagnostic services.* Comprehensive dental diagnostic services include—

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not

later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease; and

(3) A review of the results of examination and entry of the results in the client's dental record.

(g) *Standard: Comprehensive dental treatment.* The facility must ensure comprehensive dental treatment services that include—

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) *Standard: Documentation of dental services.* (1) If the facility maintains an in-house dental service, the facility must keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility must obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

(i) *Standard: Pharmacy services.* The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

(j) *Standard: Drug regimen review.* (1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.

(4) An individual medication administration record must be maintained for each client.

(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

(k) *Standard: Drug administration.* The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must assure that—

(1) All drugs are administered in compliance with the physician's orders;

(2) All drugs, including those that are self-administered, are administered without error;

(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self administration of medications is an appropriate objective, and if the physician does not specify otherwise;

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client;

(6) No client self-administers medications until he or she demonstrates the competency to do so;

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law; and

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

(1) *Standard: Drug storage and record-keeping.* (1) The facility must store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.

(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

(4) The facility must, on a sample basis, periodically reconcile the receipt

and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 *et seq.*, as implemented by 21 CFR part 308).

(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs.

(m) *Standard: Drug labeling.* (1) Labeling of drugs and biologicals must—

(i) Be based on currently accepted professional principles and practices; and

(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility must remove from use—

(i) Outdated drugs; and

(ii) Drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.

(n) *Standard: Laboratory services.* (1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 483 of this chapter.

(2) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 483 of this chapter.

[53 FR 20498, June 3, 1988, as amended at 57 FR 7136, Feb. 28, 1992]

§483.470 Condition of participation—Physical environment.

(a) *Standard: Client living environment.*

(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure dis-

orders, etc., with others of comparable social and intellectual development.

(b) *Standard: Client bedrooms.* (1) Bedrooms must—

(i) Be rooms that have at least one outside wall;

(ii) Be equipped with or located near toilet and bathing facilities;

(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;

(iv) Measure at least 60 square feet per client in multiple client bedrooms and at least 80 square feet in single client bedrooms; and

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it must have a window that—

(i) Is usable as a second means of escape by the client(s) occupying the room; and

(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.

(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional—

(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) Documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility must provide each client with—

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

(ii) A clean, comfortable mattress;

(iii) Bedding appropriate to the weather and climate; and

(iv) Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom

with clothes racks and shelves accessible to the client.

(c) *Standard: Storage space in bedroom.* The facility must provide—

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and

(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

(d) *Standard: Client bathrooms.* The facility must—

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;

(2) Provide for individual privacy in toilets, bathtubs, and showers; and

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110° Fahrenheit.

(e) *Standard: Heating and ventilation.*

(1) Each client bedroom in the facility must have—

(i) At least one window to the outside; and

(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility must—

(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and

(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

(f) *Standard: Floors.* The facility must have—

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface;

(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and

(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

(g) *Standard: Space and equipment.* The facility must—

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

(h) *Standard: Emergency plan and procedures.* (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

(i) *Standard: Evacuation drills.* (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to—

(1) Ensure that all personnel on all shifts are trained to perform assigned tasks;

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility must—

(1) Actually evacuate clients during at least one drill each year on each shift;

(ii) Make special provisions for the evacuation of clients with physical disabilities;

(iii) File a report and evaluation on each evacuation drill;

(iv) Investigate all problems with evacuation drills, including accidents, and take corrective action; and

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occu-

pancies Chapter of the Life Safety Code.

(3) Facilities must meet the requirements of paragraphs (1)(1) and (2) of this section for any live-in and relief staff they utilize.

(j) *Standard: Fire protection—(1) General.* (i) Except as specified in paragraph (j)(2) of this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.³

(ii) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(iii) A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds, must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (appendix F).

(k) *Exceptions.* (1) For facilities that meet the LSC definition of a health care occupancy:

(A) The State survey agency may waive, for a period it considers appropriate, specific provisions of the LSC if—

(1) The waiver would not adversely affect the health and safety of the clients; and

(2) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

³Incorporation of the 1985 edition of the National Fire Protection Association's Life Safety Code (published February 7, 1985; ANSI/NFPA 101) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporations by reference. The Code is available for inspection at the Office of the Federal Register Information Center, 800 North Capitol Street, NW., suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, Mass. 02269.

If any changes in this Code are also to be incorporated by reference, a notice to that effect will be published in the Federal Register.

(B) The State survey agency may apply the State's fire and safety code instead of the LSC if the Secretary finds that the State has a code imposed by State law that adequately protects a facility's clients.

(C) Compliance on November 26, 1982 with the 1967 edition of the LSC or compliance on April 18, 1986 with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the Code.

(ii) For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the State survey agency may apply the State's fire and safety code as specified in paragraph (j)(2)(E) of this section.

(k) *Standard: Paint.* The facility must—

(1) Use lead-free paint inside the facility; and

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

(l) *Standard: Infection control.*

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility must implement successful corrective action in affected problem areas.

(3) The facility must maintain a record of incidents and corrective actions related to infections.

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

§ 483.480 Condition of participation: Diabetic services.

(a) *Standard: Food and nutrition services.* (1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

(b) *Standard: Meal services.* (1) Each client must receive at least three meals daily, at regular times comparable to normal mealtimes in the community with—

(i) Not more than 14 hours between substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast; and

(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section.

(2) Food must be served—

(i) In appropriate quantity;

(ii) At appropriate temperature;

(iii) In a form consistent with the developmental level of the client; and

(iv) With appropriate utensils.

(3) Food served to clients individually and uneaten must be discarded.

(c) *Standard: Menus.* (1) Menus must—

(i) Be prepared in advance;

(ii) Provide a variety of foods at each meal;

(iii) Be different for the same days of each week and adjusted for seasonal changes; and

(iv) Include the average portion size for menu items.

(2) Menus for food actually served must be kept on file for 30 days.

(d) *Standard: Dining areas and service.* The facility must—

(1) Serve meals for all clients, including persons with ambulation deficits

in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to assure that each client receives enough food and to assure that each client eats in a manner consistent with his or her developmental level; and

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

PART 484—CONDITIONS OF PARTICIPATION: HOME HEALTH AGENCIES

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- 484.48 Condition of participation: Clinical records.
- 484.52 Condition of participation: Evaluation of the agency's program.

AUTHORITY: Sec. 1102, 1861, 1886(a), 1871 and 1891 of the Social Security Act (42 U.S.C. 1302, 1396x, 1396cc(a), 1395hh, and 1396bbb).

SOURCE: 54 FR 33367, Aug. 14, 1989, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes affecting part 484 appear at 56 FR 32973, July 18, 1991.

Subpart A—General Provisions

§ 484.1 Basis and scope.

This part implements the requirements of sections 1861(o) and 1891(a) of the Act for HHA services and also sets forth the additional requirements considered necessary to ensure the health and safety of patients.

§ 484.2 Definitions.

As used in this part, unless the context indicates otherwise—*Bylaws* or *equivalent* means a set of rules adopted by an HHA for governing the agency's operation.

Branch office means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

Clinical note means a notation of a contact with a patient that is written and dated by a member of the health team, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition.

HHA stands for home health agency.

Nonprofit agency means an agency exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954.

Parent home health agency means the agency that develops and maintains administrative controls of subunits and/or branch offices.

Primary home health agency means the agency that is responsible for the services furnished to patients and for implementation of the plan of care.

Progress note means a written notation, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient's response during a given period of time.

Proprietary agency means a private profit-making agency licensed by the State.

Public agency means an agency operated by a State or local government.

Subdivision means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for HHAs. A subdivision that has subunits or branch offices is considered a parent agency.

Subunit means a semi-autonomous organization that—

(1) Serves patients in a geographic area different from that of the parent agency; and

(2) Must independently meet the conditions of participation for HHAs because it is too far from the parent agency to share administration, supervision, and services on a daily basis.

Summary report means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician.

Supervision means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity. Unless otherwise specified in this part, the supervisor must be on the premises to supervise an individual who does not meet the qualifications specified in § 484.4.

§ 484.4 Personnel qualifications.

Staff required to meet the conditions set forth in this part are staff who meet the qualifications specified in this section.

Administrator, home health agency. A person who:

- (a) Is a licensed physician; or
- (b) Is a registered nurse; or
- (c) Has training and experience in health service administration and at least 1 year of supervisory or adminis-

trative experience in home health or related health programs.

Audiologist. A person who:

(a) Meets the education and experience requirements for a Certified Clinical Competence in audiometry granted by the American Speech-Language-Hearing Association; or

(b) Meets the educational requirements for certification and the process of accumulating the supervisory experience required for certification.

Home health aide. Effective for licenses furnished after August 14,

person who has successfully completed a State-established or other program that meets the requirements of § 484.30(a) and a competency

evaluation program or State licensure program that meets the requirements

§ 484.36 (b) or (e), or a competency evaluation program or State licensure

program that meets the requirements

§ 484.36 (b) or (e). An individual

considered to have completed a

licensing and competency evaluation

program, or a competency evaluation

program if, since the individual's most

recent completion of this program,

there has been a continuous period of

24 consecutive months during which

the individual furnished services as

described in § 409.40 of this chapter

and received compensation.

Occupational therapist. A person

(a) Is a graduate of an occupational

therapy curriculum accredited by

the Committee on Allied Health

Education and Accreditation of the

American Medical Association and

the American Occupational Therapy

Association; or

(b) Is eligible for the National

Occupational Examination of the American

Occupational Therapy Association;

(c) Has 2 years of appropriate experience as an occupational therapist

has achieved a satisfactory grade on a

proficiency examination conducted

proved, or sponsored by the U.S. Health

Service, except that such examinations

of proficiency do not apply to persons

initially licensed by a State or seeking

licensure as an occupational therapist

after December 31, 1977.

Occupational therapy assistant. A

person who:

resolution timely cannot delay effective date of any enforcement action against the facility.

A facility may not seek a delay of enforcement action against it on grounds that informal dispute resolution has not been completed before effective date of the enforcement action.

If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating deficiencies should not have been identified, the deficiencies are removed, the statement of deficiencies and enforcement actions imposed solely as a result of those cited deficiencies is rescinded.

Notification. Upon request, HCFA and the State must provide the facility with written notification of the informal dispute resolution process.

§ 488.332 Investigation of complaints of violations and monitoring of compliance.

Investigation of complaints. (1) The survey agency must establish procedures and maintain adequate staff to investigate complaints of violations and participation requirements.

The State survey agency takes appropriate precautions to protect a complainant's anonymity and privacy, if feasible.

If arrangements have been made between State components for investigation of complaints, the State must use a means of communicating information among appropriate entities. The State survey agency retains responsibility for the investigation procedure.

If, after investigating a complaint, the State has reason to believe that an identifiable individual neglected or abused a resident, or misappropriated a resident's property, the survey agency must act on the complaint in accordance with § 488.335.

On-site monitoring. The State survey agency conducts on-site monitoring on an as necessary basis when—

(1) A facility is not in substantial compliance with the requirements and in the process of correcting deficiencies;

(2) A facility has corrected deficiencies and verification of continued substantial compliance is needed; or

(3) The survey agency has reason to question the substantial compliance of the facility with a requirement of participation.

(c) **Composition of the investigative team.** A State may use a specialized team, which may include an attorney, auditor and appropriate health professionals, to identify, survey, gather and preserve evidence, and administer remedies to noncompliant facilities.

§ 488.334 Educational programs.

A State must conduct periodic educational programs for the staff and residents (and their representatives) of SNFs and NFs in order to present current regulations, procedures, and policies on the survey, certification and enforcement process under this subpart and subpart F of this part.

§ 488.335 Action on complaints of resident neglect and abuse, and misappropriation of resident property.

(a) **Investigation.** (1) The State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in § 488.332.

(2) If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the State must investigate the allegation.

(3) The State must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property.

(b) **Source of complaints.** The State must review all allegations regardless of the source.

(c) **Notification—(1) Individuals to be notified.** If the State makes a preliminary determination, based on oral or written evidence and its investigation, that the abuse, neglect or misappropriation of property occurred, it must notify in writing—

(i) The individuals implicated in the investigation; and

(ii) The current administrator of the facility in which the incident occurred.

(2) **Timing of the notice.** The State must notify the individuals specified in paragraph (c)(1) of this section in writing within 10 working days of the State's investigation.

(3) **Contents of the notice.** The notice must include the—

(i) Nature of the allegation(s);

(ii) Date and time of the occurrence;

(iii) Right to a hearing;

(iv) Intent to report the substantiated findings in writing, once the individual has had the opportunity for a hearing, to the nurse aide registry or appropriate licensure authority;

(v) Fact that the individual's failure to request a hearing in writing within 30 days from the date of the notice will result in reporting the substantiated findings to the nurse aide registry or appropriate licensure authority.

(vi) Consequences of waiving the right to a hearing;

(vii) Consequences of a finding through the hearing process that the alleged resident abuse or neglect, or misappropriation of resident property did occur; and

(viii) Fact that the individual has the right to be represented by an attorney at the individual's own expense.

(d) **Conduct of hearing.** (1) The State must complete the hearing and the hearing record within 120 days from the day it receives the request for a hearing.

(2) The State must hold the hearing at a reasonable place and time convenient for the individual.

(e) **Factors beyond the individual's control.** A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(f) **Report of findings.** If the finding is that the individual has neglected or abused a resident or misappropriated resident property or if the individual waives the right to a hearing, the State must report the findings in writing within 10 working days to—

(1) The individual;

(2) The current administrator of the facility in which the incident occurred; and

(3) The administrator of the facility that currently employs the individual.

if different than the facility in which the incident occurred;

(4) The licensing authority for individuals used by the facility other than nurse aides, if applicable; and

(5) The nurse aide registry for nurse aides. Only the State survey agency may report the findings to the nurse aide registry, and this must be done within 10 working days of the findings, in accordance with § 483.158(c) of this chapter. The State survey agency may not delegate this responsibility.

(g) *Contents and retention of report of finding to the nurse aide registry.* (1) The report of finding must include information in accordance with § 483.158(c) of this chapter.

(2) The survey agency must retain the information as specified in paragraph (g)(1) of this section, in accordance with the procedures specified in § 483.158(c) of this chapter.

(h) *Survey agency responsibility.* (1) The survey agency must promptly review the results of all complaint investigations and determine whether or not a facility has violated any requirements in part 483, subpart B of this chapter.

(2) If a facility is not in substantial compliance with the requirements in part 483, subpart B of this chapter, the survey agency initiates appropriate actions, as specified in subpart F of this part.

[59 FR 66238, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

Subpart F—Enforcement of Compliance for Long-Term Care Facilities with Deficiencies

SOURCE: 59 FR 66243, Nov. 10, 1994, unless otherwise noted.

§ 488.400 Statutory basis.

Sections 1819(h) and 1919(h) of the Act specify remedies that may be used by the Secretary or the State respectively when a SNF or a NF is not in substantial compliance with the requirements for participation in the Medicare and Medicaid programs. These sections also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under State or Federal law, and, except

for civil money penalties, are imposed prior to the conduct of a hearing.

§ 488.401 Definitions.

As used in this subpart—

New admission means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.

Plan of correction means a plan developed by the facility and approved by HCFA or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected.

[59 FR 56243, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

§ 488.402 General provisions.

(a) *Purpose of remedies.* The purpose of remedies is to ensure prompt compliance with program requirements.

(b) *Basis for imposition and duration of remedies.* When HCFA or the State chooses to apply one or more remedies specified in § 488.406, the remedies are applied on the basis of noncompliance found during surveys conducted by HCFA or by the survey agency.

(c) *Number of remedies.* HCFA or the State may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

(d) *Plan of correction requirement.* (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by HCFA or the survey agency.

(2) *Isolated deficiencies.* A facility is not required to submit a plan of correction when it has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

(e) *Disagreement regarding remedies.* If the State and HCFA disagree on the decision to impose a remedy, the dis-

agreement is resolved in accordance with § 488.452.

(f) *Notification requirement.* Except when the State is taking action against a non-State operator, HCFA or the State (as authorized by HCFA) gives the provider notice of the remedy, including the—

(i) Nature of the noncompliance;
 (ii) Which remedy is imposed;
 (iii) Effective date of the remedy;
 (iv) Right to appeal the action leading to the remedy.

(2) When a State is taking action against a non-State operator, the State's notice must include information required by HCFA in paragraph (f)(1) of this section.

(3) *Immediate jeopardy—2 a.* Except for civil money penalties, State monitoring imposed when there is immediate jeopardy, for all purposes specified in § 488.406 imposed when there is immediate jeopardy, must be given at least 2 calendar days before the effective date of the enforcement action.

(4) *No immediate jeopardy—1 b.* Except for civil money penalties and State monitoring, notice must be given at least 15 calendar days before the effective date of the enforcement action in situations in which there is no immediate jeopardy.

(5) *Latest date of enforcement.* The 2 and 15-day notice periods begin when the facility receives the notice; but, in no event will the effective date of the enforcement action be 20 calendar days after the date the notice is sent.

(6) *Civil money penalties.* For civil money penalties, the notices must be given in accordance with the provisions of §§ 488.434 and 488.440.

(7) *State monitoring.* For State monitoring, no prior notice is required. [59 FR 56243, Nov. 10, 1994; 60 FR 50118, Sept. 28, 1995]

§ 488.404 Factors to be considered in selecting remedies.

(a) *Initial assessment.* In order to select the appropriate remedy, HCFA and the State determine the seriousness of the deficiencies.

(b) *Determining seriousness of deficiencies.* To determine the seriousness of the deficiencies, the State and HCFA consider the—

CERTIFIED NURSE AIDE BILL

Section 1 amends AS 08.01.087 to allow the Department of Commerce (the investigative agency for the Board of Nursing) to designate other state or local agencies (with their consent) to conduct investigations into reports of abuse by CNAs.

Section 2 is a cross-reference to the exemption from the requirements of the Administrative Procedure Act created in AS 08.68.520.

Section 5 amends AS 08.68.100(a) to give the Board of Nursing authority to adopt regulations regarding certified nurse aides.

Section 6 amends AS 08.68.140 to exempt procedures related to the registry of certified nurse aides from the requirements of the Administrative Procedure Act.

Section 7 adds a definition for "certified nurse aide" in AS 08.68. (Note: this section will be renumbered; see section 20.)

Section 8 creates a new article in AS 08.68. It contains several new sections that give the Board of Nursing authority to regulate and certify nurse aides. Under new AS 08.68.510, it would be a class B misdemeanor crime for a person to use the title "certified nurse aide" unless the person is certified by the Board. The Board is required to establish and maintain a registry of certified nurse aides. New AS 08.68.520 establishes the procedures for including findings of abuse and neglect in the registry. New AS 08.68.530 and 08.68.540 establish the grounds for the denial or suspension of a nurse aide's certificate, and the Board's disciplinary authority. AS 08.68.550 provides immunity for good faith reports to the Board, and AS 08.68.560 allows the Department of Commerce to set and collect fees for CNAs as shown.

Section 9 amends AS 44.62.330(a)(10) to exempt functions related to the nurse aide registry from the requirements of the Administrative Procedure Act (APA).

Section 10 amends AS 47.05.010 to add to the duties of the Department of Health and Social Services (DHSS) the investigation of reports of abuse, neglect, or misappropriation of property by certified nurse aides in facilities licensed by DHSS under AS 18.20.

Section 11 requires the DHSS to adopt procedures to report to the Board of Nursing suspected abuse, neglect, or misappropriation of property by CNAs who work as home care providers.

Section 12 is a new section in the DHSS administrative statutes. It gives DHSS the authority to investigate reports of abuse or neglect by CNAs in facilities licensed by DHSS under AS 18.20. The department would be required to hold hearings under regulations it adopts; these need not comply with the APA. Reports of findings of abuse or neglect by a CNA must be reported to the Board of Nursing. If the facility is a long-term care facility covered under 42 CFR sec. 483.5, only the designated state survey and certification agency (IIFL&C) may make the report to the registry. This provision is included to comply with federal law; see 42 CFR sec. 483.156(b)(2).

Section 13 amends AS 47.17.030, regarding investigation by state and local agencies of reports of harm to children, to require that suspected abuse or neglect by CNAs be reported to the Board of Nursing.

Section 14 amends AS 47.17.290(13) to include "certified nurse aides" among the "practitioners of the healing arts" required to report the suspected abuse or neglect of children under their care.

Section 15 amends AS 47.24.010(a) to add CNAs to the list of those required to report the suspected exploitation or abuse of vulnerable adults under their care.

Section 16 amends existing AS 47.24.013, regarding the investigation of abuse of elderly persons, to require that suspected abuse or neglect by CNAs be reported to the Board.

Section 17 amends existing AS 47.24.015, which requires DHSS to investigate reports of harm to elderly that are not addressed under AS 47.24.013. The proposed new subsection requires DHSS to report suspected abuse or neglect by CNAs to the Board.

Section 18 amends existing AS 47.33.500(c), regarding assisted living facilities, to allow information about a complainant or resident to be released to appropriate investigative agencies.

Section 19 amends AS 47.33.520 to require that suspected abuse or neglect by CNAs in assisted living homes be reported to the Board of Nursing.

Section 20 is a housekeeping measure. It directs the revisor of statutes to renumber AS 08.68.395, 08.68.400, and 08.68.410 to make room in the chapter for the new provisions added by section 8 of this bill.

Section 21 is a transition section, allowing the Board and other affected state agencies, before the effective date of the new laws, to begin drafting the regulations necessary to implement the bill.

Section 22 is a transition section providing that persons who are certified as nurse aides immediately before the effective date of the Act retain their certifications, subject to continued eligibility. CNAs whose certifications have expired within two years before the Act takes effect may apply to renew them; certifications expired for five years or more may not be renewed.