AHCA
AMERICAN HEALTH CARE ASSOCIATION

NCAL
NATIONAL CENTER FOR ASSISTED LIVING

IMPROVING LIVES *by*
DELIVERING SOLUTIONS *for*
QUALITY CARE

Requirements of Participation

FINAL RULE SUMMARY

Abstract

This document provides a high level summary of CMS's Reform of Requirements for Long-Term Care Facilities

October 2016

RequirED

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Executive Summary

On Wednesday, September 28, 2016, CMS released a final rule entitled Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. The final rule was published in the federal register on October 4, 2016. It reaffirms some existing requirements, such as existing resident rights, and finalizes a wide range of new requirements, from comprehensive person-centered care planning to compliance and ethics. CMS rejected some of the proposed requirements in the Notice of Proposed Rulemaking issued on July 16, 2015, such as proposed requirements for physician credentialing and for requiring an in-person physician visit prior to a resident's unscheduled transfer from a facility.

The regulations are effective on November 28, 2016. However, in response to comments by AHCA and our members, CMS is implementing the regulations using a phased approach. The phases are as follows:

Phase 1: The regulations included in Phase 1 must be implemented by November 28, 2016.

Phase 2: The regulations included in Phase 2 must be implemented by November 28, 2017.

Phase 3: The regulations included in Phase 3 must be implemented by November 28, 2019.

Some regulatory sections are divided among more than one phase, and some of the more extensive new requirements have been placed in later phases to allow facilities time to successfully prepare to achieve compliance.

How to Use This Document

There are several elements in this document to help you navigate through key requirements in the final rule. Each regulatory section includes:

- Title
- A description of the implementation phase(s)
- An excerpt from the final rule including CMS' summary of the key changes to that section
- Additional Highlights to consider in your review of the new requirements
- A page number reference linking to the public review copy of the final rule found on RequirED **HERE.**

The Additional Highlights are not an exhaustive list of all of the requirements in each regulatory section but are instead meant to draw your attention to some of the important new elements and provide a starting point for investigating further.

Additionally, AHCA hosted a webinar (broadcast twice) with helpful information. Click here to view.

Sections

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§483.1 Basis and scope.	This entire section will be implemented in Phase 1.	607
CMS Summary: We have added the statutory authority citations for sections 1128I(b) and (c) and section 1150B of the Social Security Act (the Act) to include the compliance and ethics program, quality assurance and performance improvement (QAPI), and reporting of suspicion of a crime requirements to this section.		
Additional Highlights: No additional highlights.		
§483.5 Definitions.	This entire section will be implemented in Phase 1.	608
CMS Summary: We have added the definitions for "abuse", "adverse event", "exploitation", "misappropriation of resident property", "mistreatment", "neglect", "person-centered care", "resident representative", and "sexual abuse" to this section.		
Additional Highlights: Important to review definitions and implications of following terms: • "Abuse": includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. • "Person-centered care" (used extensively throughout the rule): focus on the resident as the locus of control and supporting the resident in making their own choices and having control over their daily lives. • "Resident representative": clarifies different types of representatives and limits scope of authority of any representative to the authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.		

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§483.10 Resident rights.	The section will be implemented in Phase 1 with the following exception: (g)(4)(ii) – (v) Providing contact information for State and local advocacy organizations, Medicare and Medicaid eligibility information, Aging and Disability Resources Center and Medicaid Fraud Control Unit — Implemented in Phase 2.	611
CMS Summary: We are retaining all existing residents' rights and updating the language and organization of the resident rights provisions to improve logical order and readability, clarify aspects of the regulation where necessary, and updating provisions to include advances such as electronic communications.		
Additional Highlights: • Includes parallel "facility responsibilities" into resident rights requirements. For example, as a resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, and protect the rights of the resident, including equal access to quality care. • Resident must receive information (oral and written) in language that he or she can understand about various topics, including their rights, medical condition, Medicare and Medicaid benefits, and information about how to contact their physician. • The facility must furnish a written description of legal rights, including a list of and contact information for all pertinent State regulatory and informational agencies and advocacy groups. • Resident representative: o Resident has the right to designate a representative in accordance with State law, and the resident representative has the right to exercise the resident's rights to the extent those rights are delegated them. The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. o The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse. o If the facility has reason to believe the representative is making decisions or taking actions not in the resident's best interest, the facility shall report such concern in a manner required under State law.		

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• Planning and implementing care:
  ○ Resident has the right to participate in the development and implementation of his or her person-centered plan of care, including to identify individuals or roles to be included in the planning process; to request meetings and the right to request revisions to the plan of care; to identify the expected goals and outcomes of care; and to identify the type, amount, frequency, and duration of care, among other factors.
  ○ Resident has the right to be informed, in advance, of the care to be furnished, the type of care giver or professional that will furnish care, and of changes to the plan of care.
  ○ Resident has the right to see the care plan, including the right to sign after changes to it, and to receive the services and/or items included in the plan. This does not include the right to receive treatment or medical services deemed medically unnecessary or inappropriate.
• Facility must have a policy and procedure for and inform residents (or their representative, where appropriate) of the visitation rights of the resident, including any clinical or safety restriction or limitation of such rights when consistent with the regulation.
• Resident has a right to choose his or her attending physician, and that physician must be licensed to practice.
• If resident deposits personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds (NOTE: This was moved from guidance into regulation to strengthen the expectation of facilities).
• Resident has a right to share a room with his or her roommate of choice when practicable, including sharing a room with his or her spouse when married residents live in the same facility.
• Resident has the right to reasonable access to and privacy in their use of electronic communications.
• Facility must have a grievance policy and a Grievance Official responsible for overseeing the grievance process.		

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§483.12 Freedom from abuse, neglect, and exploitation.	This section will be implemented in Phase 1 with the following exceptions: •(b)(4) Coordination with QAPI Plan—Implemented in Phase 3. •(b)(5) Reporting crimes/1150B—Implemented in Phase 2.	638
CMS Summary: We are requiring facilities to investigate and report all allegations of abusive conduct. We also are specifying that facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property.		
Additional Highlights: • Clarifies that a facility must not employ or otherwise engage individuals who have had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding of misappropriation of property. • Requires written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, (3) Include training as required in §483.95, (4) Establish coordination with the QAPI program required under §483.75, and (5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include certain components specified in the rule.		
§483.15 Admission, transfer, and discharge rights.	This section will be implemented in Phase 1 with the following exceptions: • (c)(2) Transfer/Discharge Documentation—Implemented in Phase 2.	640
CMS Summary: We are requiring that a transfer or discharge be documented in the medical record and that specific information be exchanged with the receiving provider or facility when a resident is transferred.		
Additional Highlights: • Reorganized this section and made modifications to existing language and process related to: o Components and processes around the admission rights including what can and cannot be included in admission policies including not being able to deny admission or transfer residents out of facility because of their insurance coverage (“equal access to quality of care”).		

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○ Transfer & discharge requirements that the resident must remain in the facility unless they meet one of six criteria for discharge or transfer that is documented by a physician in the record. ○ The types of information that must be included in a written discharge summary and who it must be shared with. ○ Process and information needed when transferring or discharging a person with respect to the need to provide a written notice to the resident; timing and contents of the notice; "Orientation" of resident about their transfer and rights before transfer; and when transfer involves a room change. ○ Information that must be provided to residents before any discharge or transfer about the facility's: bed-hold policy, and policy and rights to return to the facility and their prior room as well as their rights in the appeals process.		
§483.20 Resident assessment.	This entire section will be implemented in Phase 1.	649
CMS Summary: We are clarifying what constitutes appropriate coordination of a resident's assessment with the Preadmission Screening and Resident Review (PASARR) program under Medicaid. We are also adding references to statutory requirements that were inadvertently omitted from the regulation when we first implemented sections 1819 and 1919 of the Act.		
Additional Highlights: • Expanded requirement to include resident strengths, goals, life history and preferences. • Changed discharge potential to discharge planning. • Assessment process must include direct observation and communication with resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.		

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Comprehensive Person-Centered Care Planning (§483.21) ***New Section***	This section will be implemented in Phase 1 with the following exceptions: • Baseline care plan—Implemented in Phase 2. • (b)(3)(iii) Trauma informed care—Implemented in Phase 3.	652
CMS Summary: • We are requiring facilities to develop and implement a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care. • We are adding a nurse aide and a member of the food and nutrition services staff to the required members of the interdisciplinary team that develops the comprehensive care plan. • We are requiring that facilities develop and implement a discharge planning process that focuses on the resident's discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable re-admissions. We are also implementing the discharge planning requirements mandated by The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) by revising, or adding where appropriate, discharge planning requirements for LTC facilities.		
Additional Highlights: • Baseline care plan must include 6 specified elements. A summary of the plan, including specified information, must be provided to the resident and their representative. NOTE: Phase 2 requirement. • Comprehensive care plan must be person-centered and consistent with resident's rights. It must include specialized services or specialized rehabilitation services as a result of PASARR recommendations; goals for admission and preference for further discharge; and discharge plans. • If resident and representative(s) do not participate in development of plan, an explanation must be included in the resident's medical record. • Services must be culturally - competent and trauma-informed. NOTE: trauma-informed is a Phase 3 requirement. • Discharge summary requires reconciliation of all pre-discharge medications with post-discharge medications and further expands what must be included in the summary.		

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§483.24 Quality of life.	This entire section will be implemented in Phase 1.	657
CMS Summary: We are requiring that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		
Additional Highlights: • Quality of Life applies to all care and services throughout the organization. • The overarching theme draws from the familiar language of OBRA '87 – the call to action for every center – *Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.* The continued use of the word "practicable" in this statement is a reminder that, what was true 20 years ago remains true today- our work is to help individuals live at their highest optimal level of possibility. • The description of activities programs and the staff engaged in them has broadened.		
§483.25 Quality of care.	This section will be implemented in Phase 1 with the following exception: (m) Trauma-informed care—Implemented in Phase 3.	659
CMS Summary: We are requiring that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		
Additional Highlights: • In this section, as with Quality of Life, the definition of Quality of Care has broadened to include all aspects of treatment and care. It relies on the professional standards of practice in delivering high quality care. The language infers that staff have competency in the standards of practice.		

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• Areas specifically noted in the Final Rule that are worth reviewing include: vision & hearing, skin integrity, mobility, incontinence, colostomy, urostomy & ileostomy, assisted nutrition & hydration, parenteral fluids, respiratory care, prostheses, pain management, dialysis, trauma informed care and bed rails. • There is a new section that focuses on support to trauma survivors. Trauma survivors must receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to mitigate triggers. NOTE: trauma-informed is a Phase 3 requirement.		
§483.30 Physician services.	This entire section will be implemented in Phase 1.	664
CMS Summary: We are allowing attending physicians to delegate dietary orders to qualified dietitians or other clinically qualified nutrition professionals and therapy orders to therapists.		
Additional Highlights: • The attending physician can delegate the writing of order to Dietician and to therapists per their state's scope of practice; NPs and PAs and covering physicians cannot delegate authority; only the attending physician. • Physician must approve an admission however an NP or PA can now write the admitting orders.		
§483.35 Nursing services.	This section will be implemented in Phase 1 with the following exception: Specific usage of the Facility Assessment at §483.70(e)in the determination of sufficient number and competencies for staff —Implemented in Phase 2.	666
CMS Summary: We are adding a competency requirement for determining the sufficiency of nursing staff, based on a facility assessment, which includes but is not limited to the number of residents, resident acuity, range of diagnoses, and the content of individual care plans.		
Additional Highlights: • Added assure resident safety. • Other nursing personnel includes nurse aides.		

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§483.40 Behavioral health services.	This section will be implemented in Phase 2 with the following exceptions: • (a)(1) As related to residents with a history of trauma and/or post-traumatic stress disorder—Implemented in Phase 3. • (b)(1), (b)(2), and (d) Comprehensive assessment and medically related social services--Implemented in Phase 1.	669
CMS Summary: • We are adding a new section to subpart B that focuses on the requirement to provide the necessary behavioral health care and services to residents, in accordance with their comprehensive assessment and plan of care. • We are adding "gerontology" to the list of possible human services fields from which a bachelor degree could provide the minimum educational requirement for a social worker.		
Additional Highlights: • Based on the comprehensive assessment, a resident with a mental disorder, psychosocial adjustment difficulty, or a history of trauma and/or post-traumatic stress disorder must receive appropriate treatment and services to correct the problem or attain the highest practicable mental and psychosocial well-being. • Facility must ensure that if assessment does not reveal mental or psychosocial adjustment difficulties or a history of trauma and/or post-traumatic stress disorder, resident does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors unless clinical condition demonstrates development of such a pattern was unavoidable. • Facility must have sufficient direct service staff with appropriate competencies and skills to provide the nursing and related services needed to care for residents with mental and psychological disorders, as well as those with a history of trauma and/or post-traumatic stress disorder. • Facility must provide medically-related social services for highest practicable well-being.		

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§483.45 Pharmacy services.	This section will be implemented in Phase 1 with the following exceptions: • (c)(2) Medical chart review—Implemented in Phase 2. • (e) Psychotropic drugs—Implemented in Phase 2.	672
CMS Summary: • We are requiring that a pharmacist review a resident's medical chart during each monthly drug regimen review. • We are revising existing requirements regarding "antipsychotic" drugs to refer to "psychotropic" drugs and define "psychotropic drug" as any drug that affects brain activities associated with mental processes and behavior. We are requiring several provisions intended to reduce or eliminate the need for psychotropic drugs, if not clinically contraindicated, to safeguard the resident's health.		
Additional Highlights: • Expanded requirement for reporting irregularities to include the facility's medical director. • Expanded requirement for how the pharmacist must document irregularities and how the attending physician must respond. • Added requirement for facility policy and procedures on monthly drug regimen review. • Added limitations to PRN psychotropic drug use.		
§483.50 Laboratory, radiology, and other diagnostic services. ***New Section***	This entire section will be implemented in Phase 1.	674
CMS Summary: We are clarifying that a physician assistant, nurse practitioner or clinical nurse specialist may order laboratory, radiology, and other diagnostic services for a resident in accordance with state law, including scope-of-practice laws.		
Additional Highlights: • The facility is responsible for the timeliness and quality of laboratory, radiology, and other diagnostic services. • The facility must assist the resident in making transportation arrangements to and from the source of laboratory, radiology, and other diagnostic services, if the resident needs assistance.		

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• The facility must file in the resident's clinical record the results of their laboratory, radiology and diagnostic tests and communicate the results promptly to the individual that ordered them. • If the facility provides its own laboratory services or provides blood bank or transfusion service, they must meet the relevant requirements for laboratory services listed in 42 CFR Part 493 – Laboratory Requirements. Additionally, if the facility is working with a referral laboratory or has an agreement to obtain laboratory services than those laboratories must meet the applicable requirements listed in 42 CFR Part 493 – Laboratory Requirements. • If a facility provides its own diagnostic services than those must meet the conditions of participation for hospitals contained in §482.26. If the facility contracts for diagnostic services than the supplier of these services has to be approved to provide these services by Medicare.		
§**483.55 Dental services.**	This section will be implemented in Phase 1 with the following exceptions: • (a)(3) and (a)(5) Loss or damage of dentures and policy for referral—Implemented in Phase 2. • (b)(3) and (b)(4) Referral for dental services regarding loss or damaged dentures—Implemented in Phase 2.	677
CMS Summary: We are prohibiting SNFs and NFs from charging a Medicare resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility, and we are adding a requirement that the facility have a policy identifying those instances when the loss or damage of dentures is the facility's responsibility. We are requiring NFs to assist residents who are eligible to apply for reimbursement of dental services under the Medicaid state plan, where applicable. We are clarifying that with regard to a referral for lost or damaged dentures "promptly" means that the referral must be made within 3 business days unless there is documentation of extenuating circumstances.		

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Additional Highlights: • Facility must have a policy in place regarding the loss or damage of dentures, detailing when the loss is at the facility's responsibility (see summary statement). • Facilities must arrange transportation to and from dental services locations at the request of residents. • If the referral doesn't happen within 3 business days (see summary statement), facilities must document what they did to ensure the resident could eat and drink adequately while awaiting dental services, as well as the extenuating services leading to the delay.		
§483.60 Food and nutrition services.	This section will be implemented in Phase 1 with the following exceptions: • (a) As linked to Facility Assessment at §483.70(e) Implemented in Phase 2. • (a)(1)(iv) Dietitians hired or contracted with prior to effective date—Built in implementation date of 5 years following effective date of the final rule. • (a)(2)(i) Director of food & nutrition services designated to serve prior to effective—Built in implementation date of 5 years following the effective date of the final rule. • (a)(2)(i) Dietitians designated to after the effective date—Built in implementation date of 1 year following the effective date of the final rule.	678
CMS Summary: We are requiring facilities to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. We are also requiring facilities to employ sufficient staff, including the designation of a director of food and nutrition service, with the appropriate competencies and skills sets to carry out the functions of dietary services while taking into consideration resident assessments and individual plans of care, including diagnoses and acuity, as well as the facility's resident census.		
Additional Highlights: • Renamed section: Food and Nutritional Services. • Focus on resident preference. • Staffing: Advances the skills and competencies of those serving in this department and discusses "feeding assistants." • Addresses the procurement of food including locally grown and facility gardens. • Addresses meals and snacks offered outside scheduled or at non-traditional times.		

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§483.65 Specialized rehabilitative services.	This entire section will be implemented in Phase 1.	683
CMS Summary: Current regulations set forth the services that a facility must provide if a resident needs specialized rehabilitative services including, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for a mental disorder. We have added respiratory services to those services identified as specialized rehabilitative services.		
Additional Highlights: • When it is necessary for facilities to obtain these specialized rehabilitative services from an outside source, the outside source must not be excluded from participating in any federal or state health care programs. • The addition of respiratory services explicitly requires facilities to provide or obtain these services when necessary and meet the needs of residents facing respiratory issues. However, this did not change coverage policy regarding respiratory therapy.		
§**483.70 Administration.**	This section will be implemented in Phase 1 with the following exceptions: • (d)(3) Governing body responsibility of QAPI program-Implemented in Phase 3. • (e) Facility assessment—Implemented in Phase 2.	685
CMS Summary: • We have largely relocated various portions of this section into other sections of subpart B as deemed appropriate. • We require facilities to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Facilities are required to address in the facility assessment the facility's resident population (that		

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is, number of residents, overall types of care and staff competencies required by the residents, and cultural aspects), resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment. • Binding Arbitration Agreements: We are requiring that facilities must not enter into an agreement for binding arbitration with a resident or their representative until after a dispute arises between the parties. Thus, we are prohibiting the use of pre-dispute binding arbitration agreements.		
Additional Highlights: • Facility Assessment: o The facility assessment must include the required elements and it must review and update the assessment at least annually, and whenever there is, or the facility plans for, any change that would require substantial modification to any part of the assessment. o The facility must have a governing body that appoints an administrator that is accountable to the governing body. The governing body is also responsible and accountable for the QAPI program. • Binding Arbitration Agreements: o Banned in SNFs as of 11/28/16 (pre-dispute agreements entered into up to 11/27/16 are valid) o Post-dispute arbitration agreements are only allowed when: ▪ The facility explains the agreement to the resident/their representative in a form/manner they understand, and the resident acknowledges that he/she understands; ▪ The agreement is voluntary, provides for a neutral arbitrator, and provides for a convenient venue; ▪ A resident's continuing right to remain in the center cannot be contingent on signing an agreement; ▪ The agreement cannot contain language prohibiting or discouraging communication with federal, state or local officials; ▪ The agreement can only be signed by another individual if it is allowed by state law, all of the requirements above are met, and the individual has no interest in the facility; and ▪ A copy of the signed agreement and the arbitrator's final decision must be retained for 5 years, and available for CMS inspection.		

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§483.75 Quality assurance and performance improvement.	This section will be implemented in Phase 3 with the following exceptions: • (a)(2) Initial QAPI Plan must be provided to State Agency Surveyor at annual survey—Implemented in Phase 2. • (g)(1) QAA committee—All requirements of this section will be implemented in Phase 1 with the exception of subparagraph (iv), the addition of the ICPO, which will be implemented in Phase 3. • (h) Disclosure of information—Implemented in Phase 1. • (i)Sanctions—Implemented in Phase 1.	691
CMS Summary: We are requiring all LTC facilities to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.		
Additional Highlights: • Centers must present their QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation. • A QAPI program must be ongoing, comprehensive, and to address the full range of care and services provided by the center. • Centers must maintain effective systems to identify, collect, and use data and information from all departments, including the facility assessment and including how such information will be used to develop and monitor performance measures. • Centers will need to take action on performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. • Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the center.		

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§483.80 Infection control.	This section will be implemented in Phase 1 with the following exceptions: • (a) As linked to Facility Assessment at §483.70(e)—Implemented in Phase 2. • (a)(3) Antibiotic stewardship—Implemented in Phase 2. • (b) Infection preventionist (IP)—Implemented in Phase 3. • (c) IP participation on QAA committee—Implemented in Phase 3.	695
CMS Summary: We are requiring facilities to develop an Infection Prevention and Control Program (IPCP) that includes an Antibiotic Stewardship Program and designate at least one Infection Preventionist (IP).		
Additional Highlights: • Expanded required elements of facility Infection Prevention & Control Program (IPCP). • Annual review of facility IPCP and update program as necessary. • Specific qualification requirements for Infection Preventionist. • Infection Preventionist must be member of QAA committee and report on IPCP on a regular basis. • Incorporates language change from resident's legal representative to resident's representative.		
§**483.85 Compliance and ethics program.** ***New Section***	This entire section will be implemented in Phase 3.	699
CMS Summary: We are requiring the operating organization for each facility to have in effect a compliance and ethics program that has established written compliance and ethics standards, policies and procedures that are capable of reducing the prospect of criminal, civil, and administrative violations in accordance with section 1128I(b) of the Act.		
Additional Highlights: <u>NOTE: The final rule contains conflicting information about implementation: this will be required in either Phase 2 or Phase 3. AHCA will obtain clarification.</u> • The center must develop, implement and maintain a compliance and ethics (C&E) program that requires, at a minimum, 8 components. For example: a high-level individual designated to oversee the C&E program who has the needed authority and resources to assure compliance; to effectively communicate standards,		

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policies and procedures to staff, contractors and volunteers; and consistent enforcement of standards, policies and procedures through appropriate disciplinary mechanisms. • Additional requirements for companies with 5 or more facilities. • Annual review of program and revision, as necessary, is required.		
§483.90 Physical environment.	This section will be implemented in Phase 1 with the following exceptions: • (f)(1) Call system from each resident's bedside—Implemented in Phase 3. • (h)(5) Policies regarding smoking—Implemented in Phase 2.	703
CMS Summary: In the proposed rule we indicated that the facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. Many of these provisions relate to Life Safety Code (LSC) requirements. We are requiring facilities that are constructed, re-constructed, or newly certified after the effective date of this regulation to accommodate no more than two residents in a bedroom. We are also requiring facilities that are constructed, or newly certified after the effective date of this regulation to have a bathroom equipped with at least a commode and sink in each room.		
Additional Highlights: • Re-construction means that the facility undergoes a reconfiguration of either the entire building or a wing of the building which results in the space not being occupied for a period of time. • The resident's individual assessment, preferences and choices, has been added as an element to consider in the space and equipment requirements of the facility.		

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• Facilities are required to conduct regular inspections of all bed frames, mattresses, and bed rails and to ensure that bed rails are compatible with the bed frame and mattress. • Facility must have a communication system that allows residents to call a staff member or centralized staff work office from their bedside, toilet and bathing facilities. • Facilities must establish smoking policies (i.e. smoking areas, safe smoking) in accordance with applicable Federal, State, and local laws and regulations.		
§483.95 Training requirements. ***New Section***	This entire section will be implemented in Phase 3 with the following exceptions: • (c) Abuse, neglect, and exploitation training—Implemented in Phase 1. • (g)(1) Regarding in-service training, (g)2) dementia management & abuse prevention training, (g)(4) care of the cognitively impaired—Implemented in Phase 1. • (h) Training of feeding assistants—Implemented in Phase 1.	705
CMS Summary: We are adding a new section to subpart B that sets forth all the requirements of an effective training program that facilities must develop, implement, and maintain for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.		
Additional Highlights: • There are eight required training topics that centers are responsible for training new and existing staff, as well as contractors, and volunteers. The topics are communication; resident's rights and facility responsibility; abuse, neglect and exploitation; quality assurance and performance improvement; infection control; compliance and ethics; and behavioral health. • In addition to the required topics additional amounts and types of training that the facility provides should be based on the facility assessment as specified in §483.70(e). • Definitions for abuse, neglect and exploitation are provided in §483.12.		